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Washington v. Glucksberg: Influence of the Court in Care of the Terminally Ill and Physician Assisted Suicide

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WASHINGTON v. GLUCKSBERG: INFLUENCE OF THE COURT
IN CARE OF THE TERMINALLY ILL AND PHYSICIAN
ASSISTED SUICIDE

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I. INTRODUCTION

On June 26, 1997, the United States Supreme Court considered a constitutional challenge to a Washington statute that criminalized acts of deliberate assistance of another in committing suicide.¹ The Court ruled that an asserted right to physician assisted suicide was not a fundamental liberty interest protected by the Fourteenth Amendment of the United States Constitution.² Chief Justice Rehnquist, writing for the Court, concluded the influential decision with a strong statement: “the opinion should not restrict the continuation of the open debate in our society about all aspects of physician assisted suicide.”³

The issue of how to care for the terminally ill patient, whether by use of palliative care techniques, a medical treatment process placing the relief of pain as the primary care goal, or by allowing the patient to voluntarily end their life, has been enriched by the far-reaching implications of the court’s decision.⁴ Timothy Quill, M.D., published an influential article in the *New England Journal of Medicine* which frames the issue of physician assisted suicide.⁵ Dr. Quill wrote about his patient Diane who had recovered from several difficult life circumstances only to discover that she had acute myelomonocytic leukemia.⁶ Dr. Quill described the woman as an

¹Washington v. Glucksberg, 521 U.S. 702 (1997).

²*Id.* at 702.

³*Id.* at 735.

⁴Joan Felice Raymond, *Life and Death Choices*, CLEVELAND PLAIN DEALER SUNDAY MAGAZINE, October 16, 1999, at 9.

⁵Timothy E. Quill, *Death and Dignity, A Case of Individualized Decision Making*, NEW ENG. J. MED., Mar. 7, 1991, at 691.

⁶*Id.* at 692 (Myelomonocytic leukemia is an acute or chronic disease involving the spleen or bone marrow characterized by an abnormal increase in the number of leukocytes in the tissue of the body.).

“incredibly clear, at times brutally honest thinker and communicator” who had finally taken complete control of her life with a strong sense of independence and self-esteem.⁷ Faced with the prospect of a fifty percent survival rate involving extensive chemotherapy treatments and other considerably intrusive and complicated medical care, Diane, with the support of her family, decided not to undergo the recommended therapy.⁸ Dr. Quill stated that she wanted to live her remaining time with her family outside of the hospital.⁹

After considerable discussions between Dr. Quill and Diane about her care, Diane expressed the importance of the need and value of maintaining control of herself and her dignity over the upcoming months.¹⁰ Dr. Quill wrote “that Diane expressed that when the time came, she wanted to take her life in the least painful way possible.”¹¹ A short time later, Dr. Quill prescribed barbiturates after carefully considering the brief conversation between the two about Diane’s trouble sleeping.¹² Dr. Quill noted that it was evident to him that Diane then felt secure knowing that if the time came she would be able to voluntarily end the suffering at her moment of choice.¹³ Diane did take the medications and quietly passed away at home with her family one hour after ingesting the drugs.¹⁴ Dr. Quill wrote: “[s]uffering can be lessened to some extent, but in no way eliminated or made benign, by careful intervention of a competent, caring physician, given current social constraints.”¹⁵

This Note will examine current issues pertaining to the medical care of the terminally ill individual, particularly with respect to palliative care and how the continuum of medical care incorporates the voluntary termination of a patient’s life. Part II of this Note will look at the decision reached in *Washington v. Glucksberg* and how the Supreme Court has contributed to the molding of care for the terminally ill. Part III will review relevant aspects of end of life care concepts and their relationship and impact upon the assisted suicide alternative. Any analysis of physician assisted suicide must include the evolution of Oregon’s legislative approach to the topic.¹⁶ Oregon is the only state which provides terminally ill citizens the option of assisted suicide by legislative initiative, *viz.*, the Death with Dignity Act.¹⁷ The Act will be reviewed at length in Part IV.

⁷*Id.*

⁸*Id.*

⁹*Id.* at 693.

¹⁰Quill, *supra* note 5, at 694.

¹¹*Id.* at 692.

¹²*Id.*

¹³*Id.*

¹⁴*Id.*

¹⁵Quill, *supra* note 5, at 694.

¹⁶OR. REV. STAT. § 127.800 (2000) (The statute is titled *The Oregon Death with Dignity Act*, and became law on October 27, 1997.).

¹⁷*Id.*

The final portion of this note will take a hard look at how the United States Congress has addressed the issue of care of the terminally ill with such initiatives as the Lethal Drug Abuse Prevention Act of 1998.¹⁸ The 106th Congress is also considering legislation to promote pain management and palliative care under the Pain Relief Promotion Act of 1999.¹⁹ However well intended this legislation is, the proposed law may drastically impact Oregon's physician assisted suicide law and could repress the possible improvements needed in palliative care by physicians. This Note will conclude with the proposition that physician assisted suicide, not euthanasia, is merely an option in the continuum of care for the terminally ill patient. When all practical and available medical procedures fail to provide the terminally ill patient with comfort and dignity during the final stages of life, the affected patient has a medical and, arguably, a legal right to end life with dignity.

II: THE SUPREME COURT INFLUENCE UPON HEALTH CARE OF THE TERMINALLY ILL

Physician assisted suicide began to evolve as a constitutional issue when two different United States Courts struck down state statutes prohibiting physician assisted suicide.²⁰ In *Compassion In Dying v. Washington*, the Ninth Circuit Court of Appeals considered a substantive due process attack on a Washington statute prohibiting the aiding of another person to commit suicide.²¹ The Ninth Circuit held that the statute violated the Due Process Clause of the Fourteenth Amendment as applied to terminally ill patients who wished to end their life by taking medications prescribed by their physician.²² The appellate court reasoned that a person had a liberty interest in choosing how and when to die.²³

Shortly after the Ninth Circuit's decision in *Compassion In Dying*, the Second Circuit Court of Appeals considered a physician's action in *Quill v. Vacco*.²⁴ This case challenged the constitutionality of a New York statute, similar to the Washington law, which also made it a crime to assist someone in committing suicide.²⁵ The physicians asserted that because New York allowed a competent person to refuse life-sustaining medical treatment, which was "essentially similar" to physician assisted suicide, that similarly-situated persons were treated differently.²⁶

¹⁸The Lethal Drug Abuse Prevention Act of 1998, H.R. 4006, 105th Cong. (1998) (The bill was introduced to the House of Representatives on June 5, 1998, and was referred to the Committee on the Judiciary, which held hearings on July 14, 1998. The bill never reached the house floor for a vote.).

¹⁹The Pain Relief Promotion Act of 1999, H.R. 2260, 106th Cong. (1999) (The bill was introduced to the House of Representatives on June 17, 1999 and was referred to the Committee on the Judiciary, which held hearings on June 24, 1999. The bill passed the House by a margin of 271 to 156.).

²⁰*Compassion In Dying v. Washington*, 79 F.3d 790 (9th Cir. 1996).

²¹*Id.* at 838.

²²*Id.* at 793.

²³*Id.* at 816.

²⁴80 F.3d 716 (2d Cir. 1996).

²⁵*Id.*

²⁶*Id.* at 718.

In reversing a district court decision, the court of appeals held that the New York statute did not treat competent persons equally in the final stages of life, and therefore, violated the Equal Protection Clause.²⁷

The Supreme Court consolidated and reviewed the Ninth Circuit decision in *Compassion In Dying v. Washington* and the Second Circuit decision in *Quill*.²⁸ The issue before the Supreme Court in *Glucksberg* involved the existence of a liberty interest in selecting the manner and time in which an individual may die.²⁹ In *Quill*, the Court considered whether the New York law prohibiting physician assisted suicide was a violation of the Equal Protection Clause.³⁰ Thus, the constitutional review focused upon the application of the Fourteenth Amendment to an individual's right to voluntarily terminate life with the assistance of a physician.³¹

In *Glucksberg*, the action was brought by three terminally ill plaintiffs, four physicians and the non-profit Washington organization, Compassion In Dying.³² The three terminally ill patients had died before the Court's decision, which illustrates the important nature of the right to die at a time selected by the individual.³³ Compassion In Dying is a non-profit organization that counsels people considering physician assisted suicide and is a strong supporter of an individual's right to die in Washington.³⁴

The respondents asserted that the Fourteenth Amendment Due Process Clause extended a personal choice by a mentally competent, terminally ill adult to consent to and to commit suicide with the assistance of a physician.³⁵ The Court provided two lines of reasoning in ruling that no such liberty interest was protected by the Constitution. First, the Court concluded that the liberty interest to end life voluntarily was not a fundamental right which was so deeply rooted in the nation's history and tradition deserving of protection under the Due Process Clause.³⁶ The Court analyzed the physician assisted suicide issue based upon whether the right to end life was so rooted in the traditions and consciousness of the people that the right was implicit in the concept of ordered liberty.³⁷ The Court determined that the nation's legal history of prohibiting suicide, coupled with the fact that many states had enacted statutes making it a crime to help someone kill himself or herself was sufficient to find the issue of physician assisted suicide lacking the muster to grant

²⁷*Id.* at 731.

²⁸*Glucksberg*, 521 U.S. at 702.

²⁹Simon M. Canick, *Constitutional Aspects of Physician-Assisted Suicide After Lee v. Oregon*, 23 AM. J.L. & MED. 69 (1997).

³⁰*Vacco v. Quill*, 521 U.S. 793, 798 (1997).

³¹*Glucksberg*, 521 U.S. at 702.

³²*Id.*

³³*Id.*

³⁴*Id.* at 708.

³⁵*Id.* at 723.

³⁶*Glucksberg*, 521 U.S. at 721.

³⁷*Id.*

Constitutional protection.³⁸ Secondly, the Court found that Washington's ban on physician assisted suicide was rationally related to a legitimate state government interest.³⁹ Even though the Court's decision was unanimous in both cases, careful examination of the written opinions of the Court and their suggests that the Court was supportive of the right to die. The Court was not about to overturn centuries of legal rulings and establish a fundamental right to end life without greater justification. The rulings arguably may indicate judicial support for the voluntary termination of life under the direction of a physician in more appropriate circumstances.

Chief Justice Rehnquist's opinion for the Court in *Washington v. Glucksberg* provides many indications of the Court's concern and understanding for the terminally ill patient's choice to end his or her life. The Court recognized that because of the advances made in medicine, Americans were more likely to die in institutions from chronic illnesses.⁴⁰ The Court acknowledged that the public was very concerned about the issue of protecting an individual's dignity and independence in the final stages of life.⁴¹ One may consider whether this is a signal by the Court that death with dignity may eventually evolve into a constitutionally protected right.⁴² In another context, the Court did not consider the right to refuse medical treatment as a constitutionally protected right after review of only one case; on the contrary, the recognition of the right was an evolutionary process which took many circumstances and legal determinations to culminate in the protection outlined by the Court in *Cruzan v. Missouri*.⁴³ In *Cruzan*, the Court held a competent person had a liberty interest under the Due Process Clause to refuse unwanted medical treatment.⁴⁴

The Court in *Glucksberg* took notice that many states were "currently engaged in serious, thoughtful examinations for physician assisted suicide and other similar issues."⁴⁵ The Court was concerned about the potential dangers a protection of a right to physician assisted suicide might create; such a sudden change in public policy would outweigh any benefit achieved.⁴⁶ The legalization of assisted suicide could create considerable risks of social harm to individuals who are ill and vulnerable to the influence of third parties.⁴⁷ These individuals could be at risk of coercion, or they might make the decision to end their lives because of pressure from a third party. One could argue that if the potential dangers of physician assisted

³⁸*Id.* at 728.

³⁹*Id.*

⁴⁰*Id.* at 716.

⁴¹*Glucksberg*, 521 U.S. at 716.

⁴²David A. Pratt, *Too Many Physicians: Physician Assisted Suicide After Glucksberg/Quill*, 9 ALB. L.J. SCI. & TECH. 161, 221 (1999).

⁴³*Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 302 (1990).

⁴⁴*Id.*

⁴⁵*Glucksberg*, 521 U.S. at 719.

⁴⁶*Id.*

⁴⁷*Id.*

suicide failed to materialize, the public policy argument of social harm becomes less influential under the Court's analysis. The Court's public policy position could also weaken by a shift in the public demand for increased improvements in the care of the terminally ill. Therefore, the public policy argument may prove less of a legal ground to support a constitutional rejection of the voluntary right to terminate life. Of greater significance to the Court may be the prospect that, as medical experts predict, the population of aging baby boomers will increase its demand for improvements in how we die.⁴⁸

The majority in *Glucksberg* took the position that the Court has historically been reluctant to expand the concept of substantive due process because the "guideposts for responsible decision making in this uncharted area are scarce and open-ended."⁴⁹ It would follow that with a progressive expansion of care and improvement in the methods of care for the terminally ill, combined with a greater precision to diagnose and treat the symptoms of a terminal illness, one could expect to see that the guideposts for responsible decision-making beginning to emerge. Such an evolution will help pave the way for a more comfortable legal base from which to establish conditions for physician assisted suicide. Oregon's experience with the Death with Dignity Act, reviewed later in this Note, may provide a wealth of information to better determine protective guideposts required by the Court.

The concurring opinions of Justices Souter, O'Connor, Stevens, and Breyer offer support for the position that the Court's posture may be subject to a future shift.⁵⁰ In each of the concurring opinions the Justices acknowledge the importance of how a person faces death and that many people will spend his or her last days in pain and discomfort.⁵¹ The concurring opinions also highlight each Justice's concern for avoiding severe pain during the final stages of a terminal illness and in the manner in which the terminally ill patient may be forced to suffer during the last days of life.⁵² Each Justice recognized the need of the terminally ill patient to die with dignity.⁵³ Arguably, the Supreme Court seems to be concerned that the terminally ill patient must have available reasonable palliative care for the treatment of severe pain.⁵⁴ Justice Souter's opinion acknowledged that providing terminally ill patients, such as the respondents, with prescribed medication that went beyond the relief of pain and hastened death would be consistent with medical standards.⁵⁵ He agreed that the Washington statute prevented a physician from exercising his best professional judgment in prescribing medications to terminally ill patients in dosages that would enable the patients to end their lives.⁵⁶ Justice Souter accepted that physician

⁴⁸Raymond, *supra* note 4, at 16.

⁴⁹*Glucksberg*, 521 U.S. at 720.

⁵⁰*See generally id.* at 736-92.

⁵¹*Id.* at 716.

⁵²*See generally id.* at 736-92.

⁵³*Id.*

⁵⁴Pratt, *supra* note 42, at 174.

⁵⁵*Glucksberg*, 521 U.S. at 753.

⁵⁶*Id.*

assisted suicide would fall within the accepted tradition of medical care in our society by relating the physician's role in abortion cases to that of the role in assisted suicide: as a role ministering to the needs of the patient.⁵⁷ Justice Souter wrote:

The patients here sought not only an end to pain (which they might have had, although perhaps at the price of stupor) but an end to their short remaining lives with a dignity that they believed would be denied them by powerful pain medication, as well as by their consciousness of dependency and helplessness as they approached death.⁵⁸

Souter concluded that during the period of time when death was imminent, to end one's life is generally accepted as a proper exercise of autonomy over one's body with a recognized Constitutional protection.⁵⁹ Justice Souter concurred because of the substantial nature of the disagreement regarding the facts on assisted suicide and the alternatives for resolving the dispute.⁶⁰ One can conclude from Justice Souter's position that there are patients suffering from a terminal illness that may have a constitutionally protected right to end life. However, the patient's circumstances in *Glucksberg* were not persuasive enough for the Court to extend due process protection.

One of the more striking statements made by Justice Souter, which contributed to his position against assisted suicide, was his concern that mistaken decisions may result from inadequate palliative care, or a terminal prognosis that was made in error.⁶¹ Souter stated that the day may come when one side of the assisted suicide argument will prevail, but his considerable disagreement with the facts and the choices for solution were sufficient to reject the protection of due process.⁶² He did provide a powerful conclusion to his concurrence when he stated that the facts necessary for resolving the issue were not ascertainable through the judicial process, but were more likely to be identified through legislative fact-finding and experimentation at the state and federal level.⁶³

Justice O'Connor also wrote a concurring opinion in *Glucksberg* whereby she indicated confidence that the democratic process would identify the necessary balance between the interests of the terminally ill who wish to end life, and the interests of those who would be influenced to make the same choice by other factors.⁶⁴ She concluded that in such circumstances, the challenge of constructing the safeguards to the interests of the terminally ill was best left to "the laboratory of the States."⁶⁵ Justice O'Connor considered that the States' interests in protecting the

⁵⁷*Id.* at 779.

⁵⁸*Id.*

⁵⁹*Id.*

⁶⁰*Glucksberg*, 521 U.S. at 786.

⁶¹*Id.*

⁶²*Id.*

⁶³*Id.*

⁶⁴*Id.* at 737.

⁶⁵*Glucksberg*, 521 U.S. at 737.

individuals who were not truly competent or terminally ill were sufficiently important to justify laws against physician assisted suicide.⁶⁶ Again it is apparent that some members of the Supreme Court are signaling that the States under their sovereign right to regulate medical care may address the assisted suicide issue. Similarly, the Court appears to be sending a message that medical care for the terminally ill was considered a dominant factor when each Justice reached his or her respective decision.

Equally supportive to the proponents of the right to end life was Justice Stevens' position that he would not rule out the possibility that a patient seeking suicide assistance from a physician could prevail in a more "particularized" challenge.⁶⁷ Justice Stevens was the most vocally supportive of the voluntary termination of life issue, and his use of the term "particularized challenge" may suggest that a more specific set of circumstances will be needed in order to gain constitutional protection for assisted suicide.⁶⁸ Stevens joined in the majority's conclusion that the potential harm from granting a liberty interest in assisted suicide was sufficient to support the State's public policy interest.⁶⁹ Stevens commented that a State such as Washington, which authorizes use of the death penalty, has in essence determined that the sanctity of life does not require preservation in all instances.⁷⁰ Stevens stated that Washington must also acknowledge that there will be other situations in which hastening death is legitimate.⁷¹ Justice Stevens was convinced that there are instances when the interest is entitled to constitutional protection.⁷² He also stated that end of life decisions were central to personal dignity and autonomy and such matters would fall within the protection of the constitution.⁷³ His position focused upon the avoidance of intolerable pain and the indignity of living one's final days incapacitated and in agony.⁷⁴ Justice Stevens acknowledged conceptually that patients whose physical pain is inadequately treated will be more likely to request assisted suicide.⁷⁵ He suggested that encouragement for the development and endurance of palliative care would prevent some instances of life-terminating actions.⁷⁶ He also indicated that greater use of palliative care would not eliminate all pain and suffering.⁷⁷ However, greater use of palliative care would reduce the

⁶⁶*Id.*

⁶⁷*Id.* at 749; *see also* Pratt, *supra* note 42, at 174.

⁶⁸*Glucksberg*, 521 U.S. at 750.

⁶⁹*Id.* at 741.

⁷⁰*Id.*

⁷¹*Id.* at 742.

⁷²*Id.*

⁷³*Glucksberg*, 521 U.S. at 744.

⁷⁴*Id.* at 751.

⁷⁵*Id.* at 747.

⁷⁶*Id.*

⁷⁷*Id.* at 748.

demand for assisted suicide and under such developments the more “particularized” challenge may begin to evolve.⁷⁸

Justice Breyer’s concurrence cited the possibility that the right to die with dignity may be the legal tradition required for protection under the Due Process Clause.⁷⁹ Breyer acknowledged that the core right would be personal control over the manner of how one should die, which included the avoidance of unnecessary and severe physical suffering.⁸⁰ Justice Breyer was more direct in his position on the liberty interest issue by stating that the avoidance of severe physical pain would have to comprise an essential part of any successful constitutional claim.⁸¹ He pointed out, as did Justice O’Connor, that the laws of Washington and New York did not force a dying person to undergo severe physical pain.⁸² *Glucksberg* appears to have left open the possible extension of constitutional protection for the voluntary right to end life.⁸³ How will the Court apply the provisions expounded upon in *Glucksberg* to a patient who has undergone appropriate and extensive palliative care while the severe pain is unrelieved to the point of affecting dignity and personal autonomy? Or, in the alternative, if a state has not taken reasonable measures to provide reasonably available palliative care for pain, is the state forcing a patient to die with severe physical pain and therefore violating his or her right to dignity? The Court may be suggesting that the medical community and the states will need to more aggressively and comprehensively address the patients’ need to end life with dignity and absent less suffering. Some suggest that the five Supreme Court Justices were in effect saying that palliative care may be a constitutional right.⁸⁴

III: IS ASSISTED SUICIDE A CONSEQUENCE OF A LACK OF PALLIATIVE CARE OR IS CHOICE THE DOMINANT FACTOR?

Glucksberg contains some significant implications for the medical care of terminally ill patients and the relief of their pain and suffering. The right-to-end-life issue before the Court in *Glucksberg* identified the importance of palliative care for the terminally ill patient.⁸⁵ A report by the Institute of Medicine at the National Academy of Science identified the under-treatment of pain and the use of ineffectual and intrusive medical procedures that may prolong suffering are major problems in end of life care.⁸⁶ Terminally ill patients are concerned about loss of personal

⁷⁸*Glucksberg*, 521 U.S. at 750.

⁷⁹*Id.* at 790.

⁸⁰*Id.*

⁸¹*Id.* at 791.

⁸²*Id.*

⁸³521 U.S. at 735.

⁸⁴Alexandra Dylan Lowe, *Facing the Final Exit: The U.S. Supreme Court Has Left The Issue of Physician Assisted Suicide Up To The States*, 83 A.B.A. J. 48, 51 (1997).

⁸⁵*Glucksberg*, 521 U.S. at 736. (O’Connor, J., concurring) (arguing that patients living in a state where there were no legal barriers to obtaining medication to alleviate suffering will have no liberty protection of due process). The question remains that if a state allows barriers to exist or encourages them to develop, will there be a constitutional due process protection?

⁸⁶Lowe, *supra* note 84, at 51.

autonomy, loss of control of bodily functions, and the control of severe pain.⁸⁷ Pain at the end of life is the most common reason people seek medical care.⁸⁸ The treatment of pain is often neglected in medical education and in care for the patient. The assisted suicide issue has made end of life care the focal point in the decision making process of how one dies.

Assisted suicide has been practiced by physicians without statutory authorization or medical protection.⁸⁹ In April 1998, the Massachusetts Medical Society published the results of a 1996 national survey involving 3102 physicians in ten specialty firms throughout the country.⁹⁰ The survey reported that a substantial number of physicians in the United States had received requests for assisted suicide, and that about six percent complied with the request at least one time.⁹¹ The study demonstrated that region of practice, religion, and specialty influenced a physician's participation in assisted death.⁹² The report suggested that the open debate in the states of California, Oregon, and Washington may account for the higher frequency of assisted suicide requests and physician compliance with such requests in these states.⁹³

The study found that a majority of the patients who requested assisted suicide would have met regulatory safeguards similar to a those in Oregon's statute authorizing assisted suicide.⁹⁴ The study discovered that in a majority of the cases, hospitalized patients who received a lethal injection had less than twenty-four hours to live and were experiencing severe discomfort or pain.⁹⁵ The study suggested that by delaying treatment of the patients' pain symptoms, the physician could protect against an accusation that he or she was intending to hasten death.⁹⁶ The report

⁸⁷Arthur E. Chin, *Physician Assisted Suicide In Oregon—The First Year's Experience*, NEW ENG. J. MED., Feb. 18, 1999, at 577.

⁸⁸*Id.* at 579.

⁸⁹Diane E. Meier, *A National Survey of Physician Assisted Suicide and Euthanasia in the United States*, NEW ENG. J. MED., Apr. 23, 1998, at 1192.

⁹⁰*Id.* at 1193.

⁹¹*Id.* (The study reported that eleven percent of the physicians indicated they would be willing under current law to assist a suicide while thirty-six percent would if it were legal. The study also reported that seven percent responded that they would provide a lethal injection while twenty-four percent reported they would if it were legal. Seventy percent of the prescribed lethal medications were opioids and twenty-five percent were barbiturates.).

⁹²*Id.*

⁹³*Id.* at 1199.

⁹⁴Meier, *supra* note 89, at 1192. See also Charles H. Baron, *A Model State Act to Authorize and Regulate Physician Assisted Suicide*, 33 HARV. J. ON LEGIS. 1, (1996) (stating it is consistent with the fundamental values underlying the legal and ethical requirements of respect for the right of competent patients to give or withhold consent to any treatment, including life-sustaining treatment, and providing an overview of a model act allowing a responsible physician to practice assisted suicide and placing a series of responsibilities on that physician).

⁹⁵Meier, *supra* note 89, at 1200.

⁹⁶*Id.*

recommended additional research to evaluate the possibility that better access to palliative care might eliminate some of the requests for physician assisted suicides.⁹⁷ The survey also noted that the demand for assisted suicide, and a corresponding compliance by a doctor, might differ in communities where palliative care is easily accessible, suggesting fewer requests where palliative care is readily available.⁹⁸ In *Glucksberg*, the Supreme Court also vocalized recognition of these circumstances, while suggesting that the legislature was the appropriate body to address the palliative care issue.⁹⁹

The use of lethal injection seemed to be the method of choice by physicians for patients having less than twenty-four hours to live and were experiencing severe discomfort and pain.¹⁰⁰ The report suggested that additional research was necessary because the study was conducted when palliative care education was not available and the provision of end-of-life care was inconsistent throughout the country.¹⁰¹ The attitudes and choices of patients and physicians might change when palliative care becomes readily available and the needs of the patient become a larger factor in the medical treatment plan. The report also stated that current proposals for assisted suicide guidelines would bear little relation to the clinical circumstances involving physician care for the terminally ill patients.¹⁰² Current data indicates that physicians are inadequately trained to assess and manage the complex symptoms of pain, that are commonly related to a patient's request for suicide.¹⁰³ The appropriate and aggressive use of pain-relieving drugs is recommended even if the use of the drug hastens death.¹⁰⁴ There have been improvements in the sensitivity of the medical community in relating to the needs and desires of the dying patient.¹⁰⁵ Physicians have a responsibility to undertake timely and adequate discussions with patients for agreement, not only about life-sustaining treatment, but also on how they want to be cared for in the terminal stages of life.¹⁰⁶ The involvement of the physician in end-of-life care planning is deficient in part because inadequate training provided to medical students.¹⁰⁷ Consequently, practitioners may not sufficiently understand or

⁹⁷*Id.* at 1199.

⁹⁸*Id.*

⁹⁹*Glucksberg*, 521 U.S. at 736.

¹⁰⁰See Meier, *supra* note 89, at 1193.

¹⁰¹*Id.*

¹⁰²*Id.*

¹⁰³Kathleen M. Foley, *Competent Care for the Dying Instead of Physician-Assisted Suicide*, NEW ENG. J. MED., Jan. 2, 1997, at 55.

¹⁰⁴Sidney H. Wanzer, *The Physician's Responsibility Toward Hopelessly Ill Patients: A Second Look*, NEW ENG. J. MED., Mar. 30, 1989, at 844.

¹⁰⁵*Id.* at 845.

¹⁰⁶*Id.* at 846.

¹⁰⁷*Id.*

value the role of the terminally ill patient in making decisions about terminal care issues.¹⁰⁸

According to American Medical Association reports, only five of the 126 medical schools in the United States require a course that specifically concentrates on palliative care.¹⁰⁹ Patients do not have confidence that the health care system will take care of the needs of a terminally ill patient; particularly with regard to the care necessary to deal with pain.¹¹⁰ Some health care providers have expressed that “there is no doubt that the debate and high degree of tolerance shown for assisted suicide has been a wake up call to the medical system.”¹¹¹

While there is considerable support for the contention that the field of medicine has had a long track record of under treating the pain of terminally ill patients, the health care community is beginning to respond to the public debate on assisted suicide.¹¹² Pain control is now part of many specialty areas of medicine, and experts report that ninety-five percent of patients with intractable pain can experience relief without intolerable sedation.¹¹³ Patients with severe and intractable pain do not have to end their life, and palliative care opportunities offer the most crucial element in caring to the needs of the terminally ill patient.¹¹⁴ Under current guidelines for assisted suicide, the terminally ill patient is the only individual who is permitted the choice of ending his or her life.¹¹⁵

The care of the dying patient is an art that not only prepares the patient to cope with the technology of the medical environment; it is an art of deliberately developing the circumstances that allow the patient to experience a peaceful death.¹¹⁶ The physician must balance the inadequate treatment of the dying patient with the intolerable use of aggressive life-sustaining procedures in order to achieve a level of care that maximizes the comfort and dignity of the dying patient.¹¹⁷

The humanness of death is not only a matter of avoiding pain and physical suffering, it is also about being consistent with the basic values of the patient.¹¹⁸ Patients fear and resent the experience of death which could be preceded by a period of dependency or deterioration.¹¹⁹ Consequently, the World Health Organization has

¹⁰⁸*Id.*

¹⁰⁹*See* Foley, *supra* note 103, at 54.

¹¹⁰Raymond, *supra* note 4, at 9.

¹¹¹*Id.*

¹¹²Guy Franklin, *Physician Assisted Suicide: Misconceptions and Implications From A Physician's Perspective*, 1 DEPAUL J. HEALTH CARE L. 579, 583 (1997).

¹¹³*Id.*

¹¹⁴*Id.*

¹¹⁵Baron, *supra* note 94, at 5.

¹¹⁶*See* Raymond, *supra* note 4, at 9.

¹¹⁷*See* Foley, *supra* note 103, at 55.

¹¹⁸*See* Brief for Bioethics Professors Amicus Curiae Supporting Petitioners, at 5, *Washington v. Glucksberg*, 521 U.S. 702 (1997) [hereinafter Brief of Amicus Curiae].

¹¹⁹*Id.*

endorsed palliative care as an integral component of a national health care policy.¹²⁰ The World Health Organization has also taken the position that its member countries are not to consider the legalization of assisted suicide without having adequately addressed the need for pain relief and palliative care.¹²¹ There is considerable evidence which suggests that a request for assistance in suicide may mask an underlying need for pain relief.¹²²

The goal of palliative care is to relieve suffering and place the utmost importance on the quality of the patient's life.¹²³ Palliative medicine focuses on improving the control of pain, and management of the symptoms of the disease, while at the same time addressing the psychological needs of patients and families facing a life-limiting illness.¹²⁴ Palliative medicine attempts to influence how a patient dies.¹²⁵ The terminally ill patient must be prescribed whatever is medically necessary to control pain.¹²⁶

According to the Massachusetts Medical Society, narcotics or other pain medications should be given in whatever dose and by whatever route is necessary for relief.¹²⁷ It further advocates that it is morally appropriate to increase the dosage to levels needed even to the point where death is hastened, provided that the primary objective of the necessary treatment plan is to relieve pain.¹²⁸ This result is commonly referred to as the double effect.¹²⁹ The double effect occurs when a terminally ill patient, in consultation with a physician, chooses to receive major doses of pain-killing drugs under palliative care with knowledge that the treatment may, as a secondary effect, result in death.¹³⁰ Physicians have continuously argued that there is a critical difference between the intent of a course of care that results in death secondary to the intent of the treatment of pain even when the death is foreseeable and the primary intent to assist in a suicide and the intent of administering a lethal injection purely because it is lethal.¹³¹ The American Medical Association Code of Ethics supports the role of the physician using an aggressive treatment plan for pain in a palliative care circumstance even when the foreseeable result could produce death.¹³²

¹²⁰See Foley, *supra* note 103, at 55.

¹²¹See Brief of Amicus Curiae, *supra* note 118, at 5.

¹²²Pratt, *supra* note 42, at 188.

¹²³See Raymond, *supra* note 4, at 9.

¹²⁴*Id.* at 10.

¹²⁵*Id.*

¹²⁶*Id.*

¹²⁷See Wanzer, *supra* note 104, at 847.

¹²⁸*Id.*

¹²⁹*Id.*

¹³⁰Paul Moore, *Physician Assisted Suicide: Does "The End" Justify The Means?*, 40 ARIZ. L. REV. 1471, 1490 (1998).

¹³¹*Id.* at 1491.

¹³²*Id.*

The practice of palliative health care is beginning to evolve; a recent survey by the Association of American Medical Colleges reported that 122 of 125 accredited medical schools offered end of life studies as part of required medical courses.¹³³ Fifty of those schools offered separate elective courses focusing on caring for the dying patient.¹³⁴ Health care professionals see that making physicians and nurses aware of end of life issues is just the first step.¹³⁵ The second step is to increase awareness and opportunities in the hospital care setting.¹³⁶

In the article *Life and Death Choices*, the author writes about a fifty-two year old woman receiving palliative care, and who is dying from cancer of her brain and neck.¹³⁷ The patient was described as a terminally ill patient who had undergone multiple surgeries resulting in the removal of part of her jaw and larynx.¹³⁸ The patient had received state of the art radiation therapy, but the progress the disease had made would eventually end her life.¹³⁹ The patient chose palliative medicine to help her cope with the progression of her illness.¹⁴⁰ She wore a transdermal patch which releases an opioid drug into her system over the period of a few days.¹⁴¹ She must also take an anti-convulsant drug twice a day to help her control nerve pain.¹⁴² The patient was described as requiring a moderately high dose of morphine to effectively manage her pain.¹⁴³ The patient stated that her pain management care plan was working and allowed her to continue the enjoyment of life.¹⁴⁴

The availability of palliative care provides for the relief of severe pain and symptom management for the terminally ill patient. The terminally ill patient considers assisted suicide only as a viable alternative to suffering severe pain during the final stages of life. The use of assisted suicide as a means of end of life care will be effectively reduced by improvements in palliative care options. The political debate on assisted suicide must focus on the needs of the terminally ill patient and the choices he or she must make to die with dignity and individual autonomy. Viewed from this perspective, the legal and medical community can address the

¹³³See Raymond, *supra* note 4, at 10.

¹³⁴*Id.*

¹³⁵*Id.* at 11.

¹³⁶*Id.* (Palliative medicine in the hospital delivery system will be problematic because of fragmentation where the type of site (i.e., hospital or nursing home) organizes the delivery of care by the disease, and by treatment offered. Such a delivery system structure is difficult for patients with terminal illnesses because they may require care from many different specialists for short time periods and receive care in a variety of locations.)

¹³⁷*Id.* at 9.

¹³⁸Raymond, *supra* note 4, at 9.

¹³⁹*Id.*

¹⁴⁰*Id.*

¹⁴¹*Id.* at 14.

¹⁴²*Id.*

¹⁴³Raymond, *supra* note 4, at 14

¹⁴⁴*Id.*

palliative care needs, thereby the assisted suicide choice becomes a less desirable option in the care for terminally ill patients. Assisted suicide is a choice about self determination, and terminally ill patients deserve the chance to make an individual decision about how and when to die.

IV. AN ANALYSIS OF LABORATORY EXPERIMENTATION IN OREGON

In *Glucksberg*, Justice O'Connor wrote that the states' consideration of the assisted suicide issue held the challenging task of crafting appropriate procedures for safeguarding liberty interests that were entrusted to the "laboratory of the States."¹⁴⁵ The Court in *Glucksberg* noted that forty-four states, the District of Columbia and two territories prohibited, or were against, assisted suicide.¹⁴⁶ The right to end life is, for now, an issue which has been left for the states to address.¹⁴⁷ Currently there is only one state, Oregon, that has enacted a statute permitting an individual to voluntarily end his or her life.¹⁴⁸ Hawaii is currently considering a statute similar to Oregon's Death with Dignity Act.¹⁴⁹ California's legislature considered legislation permitting assisted suicide; however, the bill never reached the floor for a vote and died in committee on February 3, 2000.¹⁵⁰

Oregon's attempt to address the right to end life issue may represent the answer to the questions raised in *Glucksberg*. The Court was not able to distinguish which set of facts were persuasive enough to determine which side of the assisted suicide argument was correct. The Oregon experiment is the only source of factual data available in the United States and it is therefore essential to carefully examine the impact on state legislation permitting physician assisted suicide.¹⁵¹

The Oregon assisted suicide initiative, the Death with Dignity Act, established a statutory framework in which a competent terminally ill patient could legally receive a prescription of medication for the purpose of ending their life.¹⁵² The voters passed the ballot issue in November 1994 by a slim margin of fifty-one percent to forty-nine percent. On November 23, 1994, fifteen days before the law was to take effect, a suit was filed in the United States District Court for the District of Oregon delaying the implementation of the Death with Dignity Act.¹⁵³ In *Lee v. Oregon*, the court issued a permanent injunction to prevent the law from taking effect, finding that the Act failed to provide sufficient safeguards to prevent an incompetent terminally ill adult from committing suicide.¹⁵⁴ The court, therefore, concluded that the Act

¹⁴⁵*Glucksberg*, 521 U.S. at 737.

¹⁴⁶*Id.* at 710.

¹⁴⁷*Id.*

¹⁴⁸Pratt, *supra* note 42, at 188.

¹⁴⁹*Id.* at 187.

¹⁵⁰Rena Patel, *Physician Assisted Suicide: Is It About Time*, 35 CAL. W.L. REV. 333, 348 (1999).

¹⁵¹Pratt, *supra* note 42, at 185.

¹⁵²*Lee v. Oregon*, 107 F.3d 1382, 1386 (9th Cir. 1997).

¹⁵³*Id.*

¹⁵⁴*Id.*

violated the Equal Protection Clause of the Constitution.¹⁵⁵ On February 27, 1997, the Ninth Circuit Court of the Appeals ruled that the district court lacked jurisdiction and vacated the injunction imposed by the lower district court.¹⁵⁶ On October 27, 1997, the injunction was lifted and physician assisted suicide became a legal alternative for the terminally ill in Oregon.¹⁵⁷

Glucksberg did not limit the ability of a state to enact provisions for individuals to end his or her life by assisted suicide.¹⁵⁸ The Court concluded that the state was the proper place to decide the end of life liberty issue, and the political process was responsible to determine the appropriate safeguards.¹⁵⁹ The legal arguments presented in *Lee* led the Oregon legislature to once again bring the assisted suicide issue before the voters.¹⁶⁰ Subsequently, there was serious concern that the Oregon electorate may have changed position after the public and legal debate.¹⁶¹ Responding to this political possibility, the Oregon Judiciary Committee sponsored a legislative bill calling for the repeal of the Death with Dignity Act.¹⁶² The Oregon Legislative Assembly responded by passing the legislation that brought the repeal of assisted suicide issue to the voters in a special election held on November 4, 1997.¹⁶³ Oregon voters supported the Act by a wider margin than the previous election, sixty percent voting to retain the law against forty percent voting to repeal it.¹⁶⁴

Oregon's Death with Dignity Act is the only such legislation in the United States.¹⁶⁵ Several circumstances in Oregon may have played a role in the development of this one-of-a-kind law. In 1996, Oregon's per capita distribution of morphine, the drug of choice for use in palliative care, was fifty percent higher than the United States average.¹⁶⁶ This may have been the result of a greater commitment by Oregon working with the medical community to provide better care to the

¹⁵⁵*Id.*

¹⁵⁶*Id.* at 1392.

¹⁵⁷CENTER FOR DISEASE PREVENTION AND EPIDEMIOLOGY, OREGON DEP'T OF HUMAN RESOURCES, OREGON'S DEATH WITH DIGNITY ACT: THE FIRST YEARS EXPERIENCE (1999) [hereinafter "CENTER FOR DISEASE PREVENTION"].

¹⁵⁸*Glucksberg*, 521 U.S. at 735.

¹⁵⁹*Id.*

¹⁶⁰CENTER FOR DISEASE PREVENTION, *supra* note 157, at 1.

¹⁶¹LORI LONG, OREGON LEGISLATIVE POLICY & RESEARCH OFFICE, BASICS ON ... BALLOT MEASURE 51 5 (1997).

¹⁶²*See* H.B. 2954, 69th Leg., Reg. Sess. (Or. 1997). (The bill passed the House on May 13, 1997, and the Senate on June 9, 1997. It was placed on the November 4, 1997 ballot as Measure 51.).

¹⁶³LONG, *supra* note 161, at 1.

¹⁶⁴CENTER FOR DISEASE PREVENTION, *supra* note 157, at 1.

¹⁶⁵*See* Pratt, *supra* note 42, at 189.

¹⁶⁶LONG, *supra* note 161, at 6; *see also Oregon Use of Morphine Tops That of Nation*, THE OREGONIAN, Sept. 26, 1997.

terminally ill patient.¹⁶⁷ Oregon law provided protection for physicians prescribing controlled substances for the treatment of patients suffering from intractable pain.¹⁶⁸ A 1996 survey of 321 Oregon psychiatrists reported that sixty-six percent supported permitting a physician to write a prescription for life ending medication under certain circumstances.¹⁶⁹ The survey also found that fifty-six percent of the psychiatrists were in favor of the Act and seventy-four percent indicated that if they were victimized by a terminal illness, they might consider the option of physician assisted suicide.¹⁷⁰ The report suggested that the medical community within Oregon was more supportive of voluntary life termination than in other parts of the country.¹⁷¹ This possibility may be a result of the progressive nature of care for the terminally ill in the state.¹⁷² Something different happened in Oregon because it continues to be the only state offering assisted suicide.¹⁷³ Other states may be watching the results of Oregon's experiment, seeing if it fails to adequately address the necessary safeguards to protect individuals from undue influence and liberal utilization of assisted suicide.

Before the implementation of the Death with Dignity Act, a survey on physician assisted suicide was conducted by the Massachusetts Medical Society in 1995.¹⁷⁴ The survey rate of response was seventy percent.¹⁷⁵ The survey reported that sixty percent of the responding physicians thought physician assisted suicide should be legal in some instances and found that forty-six percent of the physicians might be willing to prescribe a lethal dose of medication if it were legal to do so.¹⁷⁶ The survey reported that twenty-one percent of the respondents had received requests for assisted-suicide and seven percent had indicated that they had complied with the request without a law protecting them.¹⁷⁷ The results indicated that Oregon physicians expressed a higher acceptance of physician assisted suicide than other surveyed physicians.¹⁷⁸ Seventy-three percent of the responding physicians reported that they would refer a patient who requested physician assisted suicide or would investigate the possibility of complying with the patient's request.¹⁷⁹ The survey found no published information on the effectiveness of drugs and the proper dosage

¹⁶⁷LONG, *supra* note 161, at 6.

¹⁶⁸OR. REV. STAT. § 127.885 (2000).

¹⁶⁹LONG, *supra* note 161, at 5.

¹⁷⁰*Id.*

¹⁷¹*Id.*

¹⁷²*Id.*

¹⁷³Pratt, *supra* note 42, at 185.

¹⁷⁴Melinda A. Lee, *Assisted Suicide—Views of Physicians in Oregon*, NEW ENG. J. MED. Feb. 1, 1996, at 310.

¹⁷⁵*Id.*

¹⁷⁶*Id.*

¹⁷⁷*Id.* at 312.

¹⁷⁸*Id.* at 314.

¹⁷⁹Lee, *supra* note 174, at 312.

needed to effectively terminate a patient's life.¹⁸⁰ In Oregon, the only source of information found was through the Hemlock Society.¹⁸¹

The Death with Dignity Act makes it legal for a physician to prescribe lethal medication to terminally ill Oregon residents only for self-administration.¹⁸² The statute continues to provide criminal penalties for individuals who assist others in committing suicide.¹⁸³ The Act legalizes physician assisted suicide while specifically prohibiting euthanasia.¹⁸⁴ The adult must be at least eighteen years of age and able to make and communicate health care decisions, make a voluntary expression of a wish to die, and make a written request for medication for the purpose of ending their life in a humane and dignified manner.¹⁸⁵ To receive a prescription for lethal

¹⁸⁰*Id.*

¹⁸¹*Id.* (The Hemlock Society was founded in 1980 by Derek Humphry. It is the oldest and largest right-to-die organization in the United States and has more than 27,000 members. Hemlock Society believes that people who wish to retain their dignity and choice at the end of life should have the option of a peaceful, gentle, certain and swift death in the company of their loved ones. The Society believes the means to accomplish this is with legally prescribed medication as part of the continuum of care between a patient and a doctor.)

¹⁸²OR. REV. STAT. § 127.880 (1997).

¹⁸³§ 127.880, § 3.14. Euthanasia is defined as the act or practice of painlessly putting to death persons suffering from incurable and distressing disease as an act of mercy. BLACK'S LAW DICTIONARY 234 (pocket ed. 1996).

¹⁸⁴OR. REV. STAT. § 127.880, § 3.14 (1997). See also *A Model State Act To Authorize and Regulate Physician Assisted Suicide*, PBS Online News Hour, at <<http://www.pbs.org/newshour/bb/health.die.html>> (website expired).

¹⁸⁵OR. REV. STAT. § 127.805, § 2.01 (1997). A request for a medication as authorized by §§ 127.800 to 127.897 shall be in substantially the following form:

REQUEST FOR MEDICATION
TO END MY LIFE IN A HUMANE
AND DIGNIFIED MANNER

I, _____, am an adult of sound mind.
I am suffering from _____, which my attending physician
has determined is a terminal disease and which has been
medically confirmed by a consulting physician.
I have been fully informed of my diagnosis, prognosis, the
nature of medication to be prescribed and potential associated
risks, the expected result, and the feasible alternatives,
including comfort care, hospice care and pain control.
I request that my attending physician prescribe medication
that will end my life in a humane and dignified manner.

INITIAL ONE:

_____ I have informed my family of my decision and taken
their opinions into consideration.
_____ I have decided not to inform my family of my decision.
_____ I have no family to inform of my decision.

medication, the patient must make two verbal requests to their physician that are separated by at least fifteen days.¹⁸⁶ As a final safeguard, the Oregon statute provides that no less than fifteen days shall elapse between the patient's initial request and the writing of the prescription.¹⁸⁷ There is an additional requirement that no less than forty-eight hours shall elapse between the patient's written request and the issuance of the prescription.¹⁸⁸

In order to monitor compliance with the Death with Dignity Act, the Oregon Health Division has incorporated reporting requirements and procedures into administrative rules.¹⁸⁹ When a physician prescribes the medication to a patient, the

I understand that I have the right to rescind this request at any time.

I understand the full import of this request and I expect to die when I take the medication to be prescribed.

I make this request voluntarily and without reservation, and I accept full moral responsibility for my actions.

Signed: _____ Dated : _____

DECLARATION OF WITNESSES

We declare that the person signing this request:

- (a) Is personally known to us or has provided proof of identity;
- (b) Signed this request in our presence;
- (c) Appears to be of sound mind and not under duress, fraud or undue influence;
- (d) Is not a patient for whom either of us is attending physician.

_____ Witness 1/Date _____
 _____ Witness 2/Date _____

NOTE: One witness shall not be a relative (by blood, marriage or adoption) of the person signing this request, shall not be entitled to any portion of the person's estate upon death and shall not own, operate or be employed at a health care facility where the person is a patient or resident. If the patient is an inpatient at a health care facility, one of the witnesses shall be an individual designated by the facility.

¹⁸⁶*Id.* OR. REV. STAT. § 127.810, § 2.02 (1997). (The prescribing physician and a consulting physician must confirm the diagnosis and prognosis. Impaired judgment concerns must be referred to a psychiatrist or psychologist for counseling. The patient must be informed of other alternatives. The prescribing physician must request notification of next of kin, but, may not require it. The physician must report all prescriptions written to the Oregon Health Department.).

¹⁸⁷ § 127.850, § 3.08.

¹⁸⁸*Id.*

¹⁸⁹CENTER FOR DISEASE PREVENTION, *supra* note 157.

doctor must either submit the required forms to the Health Division or make relevant parts of the medical record available to health officials.¹⁹⁰ After a patient's death, the death certificate is reviewed against data provided by the required report forms.¹⁹¹ The Health Division has also developed an interview format for physicians participating under the Act.¹⁹² The questions were developed in cooperation with the Oregon Task Force to Improve the Care of Terminally Ill Oregonians.¹⁹³

On February 18, 1999, the Oregon Department of Human Resources, Center for Disease Prevention and Epidemiology issued a report: *Oregon's Death with Dignity Act: The First Year's Experience*.¹⁹⁴ The report covered information on all reported patients who received a prescription for lethal medication and died during calendar year 1998.¹⁹⁵ During 1998, twenty-three individuals received prescriptions for lethal medications under the Death with Dignity Act as reported by physicians to the Oregon Center for Disease Prevention and Epidemiology.¹⁹⁶ The following summarizes some of the key findings provided by the report:

- (A) of the twenty-three reported deaths, fifteen died after taking the lethal medication, six died from their underlying illness, and two were alive on January 1, 2000;¹⁹⁷
- (B) twenty of the patients had been residents of Oregon for longer than six months when they received their prescriptions;¹⁹⁸
- (C) eighteen of the deceased patients suffered from cancer;¹⁹⁹
- (D) twenty of the patients were prescribed nine grams of secobarbital or penobarbital combined with a number of non lethal prescriptions to be used in conjunction with the lethal medication;²⁰⁰
- (E) the median time from taking the oral medication to unconsciousness was five minutes and the median time to death was twenty-six minutes. No complications such as vomiting or seizures were reported;²⁰¹

¹⁹⁰*Id.*

¹⁹¹*Id.*

¹⁹²*Id.* at 3.

¹⁹³*Id.*

¹⁹⁴Arthur E. Chin, *Physician Assisted Suicide In Oregon—The First Year's Experience*, NEW ENG. J. MED., Feb. 18, 1999, at 577 (On February 23, 2000 the Oregon second year experience report was published in the New England Journal of Medicine. The report found that twenty-seven patients died from lethal prescriptions issued under the Death with Dignity statute.).

¹⁹⁵*Id.*

¹⁹⁶*Id.*

¹⁹⁷*Id.* at 580.

¹⁹⁸*Id.* at 579.

¹⁹⁹Chin, *supra* note 194, at 579.

²⁰⁰*Id.*

²⁰¹*Id.*

- (F) none of the patients expressed concern to their physicians about the financial impact of their illness;²⁰²
- (G) the patients prescribed the lethal medications were more likely than the control group used to express concern about loss of autonomy or loss of control of bodily functions;²⁰³
- (H) the study found no evidence to support the concern that voluntary suicide would be used more by the poor, uneducated, or uninsured terminally ill patient.²⁰⁴

One interesting observation identified in the study was the consistency of the amount of drugs prescribed by the physicians.²⁰⁵ The report attributes this to the availability of this information through advocacy groups such as the Hemlock Society.²⁰⁶ The report also discovered that fourteen of the fifteen patients did not express concern about pain control at the end of life, which may have been attributable to the quality of palliative care available in Oregon.²⁰⁷ Oregon ranks among the top five states in per capita use of morphine for medical purposes that statistic is often used as a measure of the extent to which palliative care is available.²⁰⁸ The report also found that the patients were concerned about controlling the time of their death.²⁰⁹ The report stated: “many physicians reported that their patients had been decisive and independent throughout their lives or that the decision to request the lethal prescription was consistent with a long held belief about the importance of controlling the manner in which they died.”²¹⁰ The Oregon advocacy group, Compassion In Dying, reported, according to its records, fifty-nine patients had contacted the group since the Oregon law passed and indicated assisted suicide was under consideration.²¹¹ The group reported that thirty-eight of those contacts had died, eleven by assisted suicide, and five by receiving high doses of morphine for pain as a result of the double practice.²¹²

While many groups opposed to assisted suicide would prefer that the terminally ill person in Oregon would not chose assisted suicide, most groups agree that the law was implemented with care and thoughtfulness.²¹³ One of the key elements under the Oregon statue that makes assisted suicide more acceptable to the public is the patient

²⁰²*Id.*

²⁰³*Id.*

²⁰⁴Chin, *supra* note 194, at 579.

²⁰⁵*Id.*

²⁰⁶*Id.*

²⁰⁷*Id.*

²⁰⁸*Id.*

²⁰⁹Chin, *supra* note 194, at 583.

²¹⁰*Id.*

²¹¹Michael Vitez, *Oregon Assisted Suicide Law Little Used But Well Regarded*, PHILADELPHIA INQUIRER, Jan. 19, 1999.

²¹²*Id.*

²¹³*Id.*

must take the medication without help from a third party.²¹⁴ This feature lessens the possibility of undue influence or other influences upon a person's choice to end their life.²¹⁵ Some acknowledge that the Oregon law gives residents of the state one more option among many others at the end of life.²¹⁶

Health care practitioners in the field of end of life care express that the law is working well and there has been an overall improvement in the care of dying in Oregon since the first initiative was voted into law in 1994.²¹⁷ The reason Oregon has been the experimental ground for assisted suicide may be found in the fact that thirty percent of the deaths in the state had hospice support compared with nineteen percent nationally.²¹⁸ Only thirty percent of terminally ill patients die in hospitals, which is a much lower rate than any other state.²¹⁹ This would indicate greater availability and acceptance of palliative care of patients in their natural home environment.²²⁰ Many of the major hospitals in Oregon have been found to have established strong pain management programs since *Glucksberg*.²²¹ After enactment of the Death with Dignity Act, referrals to hospice programs increased significantly.²²² Additionally, physicians increased the use of morphine and other pain control medications which improve the end of life care and treatment of the terminally ill patient.²²³

The successful implementation of a physician assisted suicide statute requires well defined guidelines. The Oregon statute has existed for two years and early indications are that the statute is meeting the needs of the terminally ill patient in Oregon.²²⁴ The success of the Oregon statute can be traced to several factors. First, the detailed guidelines provided by the statute reduces any serious doubts physicians may have concerning the legality of prescribing lethal medication.²²⁵ Second, the enactment of a statute eliminates the need for a physician to practice assisted suicide in secret and will enable the physician to take part in public discussions, which will enable public debate of the medical and legal issues.²²⁶ Third, terminally ill patients

²¹⁴*Id.*

²¹⁵*Id.*

²¹⁶Baron, *supra* note 94, at 5.

²¹⁷*Id.*

²¹⁸*Id.*

²¹⁹*Id.*

²²⁰*Id.*

²²¹Baron, *supra* note 94, at 5.

²²²*Id.*

²²³*The Death with Dignity Act, 1999: Hearings on AB 1592 Before the State Assembly Committee on Judiciary*, Judiciary Committee Report 1999-2000 Reg. Sess. (Cal. 1999) (Analysis Prepared by Daniel Pone and Drew Liebert).

²²⁴*Id.*

²²⁵Baron, *supra* note at 94, at 8.

²²⁶*Id.*

will no longer need to seek assisted suicide without adequate information about other health care options.²²⁷ Fourth, terminally ill patients will not be as likely to chose to end their life early for fear that the choice may not be available at a later time.²²⁸ Finally, the law allows for patients to die in the presence of loved ones instead of in isolation.²²⁹

The Oregon Death with Dignity statute provides the terminally ill patient another important health care option in the final stages of life. Physician assisted suicide accounted for approximately five of every 10,000 deaths in Oregon in 1998, which represented no abnormality in the state suicide rate.²³⁰ The choice of assisted dying did not open a flood gate for people to start committing suicide. In fact the converse is true, the individual selecting assisted dying in Oregon made the decision after careful consideration of the choices while under the consultation of his or her physician.²³¹ The Oregon experience supports the contention that the terminally ill patient requires a comprehensive choice of medical care options in order to effectively manage the final stages of death. The Oregon law is also credited with causing a significant increase in the terminally ill patient's choice of hospice care and providing a valuable model for other states to use in addressing the assisted dying option. Assisted suicide is merely one choice available to the terminally ill patient and will most likely be the preferred choice of medical care that helps the

²²⁷*Id.*

²²⁸*Id.*

²²⁹*Id.* (A physician assisted suicide bill modeled upon the Oregon Death with Dignity Act was introduced to the California State Legislature on February 26, 1999. The authors of the bill believed that terminally ill patients needed choices throughout the continuum of palliative care. Legislative findings reported that medical studies found between five to ten percent of terminally ill patients experienced severe pain which was not sufficiently controlled by established end of life hospice and comfort care practices. The author of the bill was strongly opposed to suicide, but believed that each individual should be given the freedom to make end of life choices. The Committee on Judiciary held public hearings on April 20, 1999, and members of the Judiciary Committee voted eleven to nine for passage of assisted suicide legislation. The proposal has been designated as inactive and will not come before the full body of the California legislature.

This was not the first attempt by the California legislature to consider a physician assisted suicide act. In 1995, two bills were introduced to the legislature, again modeled after the Oregon Death with Dignity Act. The proposed Act was referred to the Assembly Judiciary Committee without further action by the California Assembly. A second attempt to legalize assisted suicide was made on November 3, 1992, when the voters of California rejected Proposition 161 which would have allowed either administration of lethal medications by the physician or patient. Proposition 161 was rejected by voters by a margin of fifty-four percent to forty-six percent. The proposition included the administration of medication by the physician which may have contributed to the voters rejection.

Hawaii is currently considering a legislative proposal for physician assisted suicide also modeled after the Oregon Death with Dignity Act. Hawaii House Bill 1155 was introduced on January 27, 1999, and was referred to two legislative committees. On February 6, 1999, the Hawaii House Committee on Health voted by a margin of seven to zero to hold the bill in committee. The bill is still active and has been carried over to the 2000 Regular Session.).

²³⁰CENTER FOR DISEASE PREVENTION, *supra* note 157, at 7.

²³¹*Id.*

patient die with dignity and control. Assisted suicide is a medical option and not a criminal act.

V. THE SOCIAL DEBATE ON ASSISTED SUICIDE AT THE FEDERAL LEVEL

The Oregon Death with Dignity Act and other similar legislative proposals are not without legal challenges. End of life care issues came under intense scrutiny while the *Companion In Dying* and *Quill* cases worked through the judicial system.²³² Advocates on both sides of the assisted suicide issue brought vast amounts of information before the *Glucksberg* Court which ultimately impacted not only the general public, but also influenced legislative leaders at the state and federal levels. One national study on physician assisted suicide reported that regulatory guidelines that are used by legislatures to draft end of life care and assisted suicide statutes may have limited relationships to the actual clinical experiences under which physicians care for the terminally ill patient.²³³ Federal legislation on palliative care will have a significant impact on how well the medical needs of the terminally ill patient are addressed by the medical community.

The first federal response to the assisted suicide issue involved attempts to invalidate the Oregon Death with Dignity Act. On November, 11 1997, Thomas K. Constantine, the Administrator of the Drug Enforcement Agency [hereinafter "DEA"], authored a letter representing that the DEA would consider a prescription of a drug under the Oregon Act as a violation of the federal Controlled Substances Act because the prescription would not serve a legitimate medical purpose.²³⁴ As a result, the Oregon Medical Society advised physicians to refrain from prescribing lethal medications under the act.²³⁵ On June 5, 1998, Attorney General Janet Reno issued a letter to U.S. Representative Henry J. Hyde, Chairman of the Judiciary Committee advising him that "adverse action against a physician who assisted in suicide in full compliance with the Oregon Act would not be authorized by the Controlled Substances Act."²³⁶ Attorney General Reno justified her position based upon the premise that the intent of the Controlled Substances Act was to keep legally available controlled substances in legal channels of distribution for use while preventing illegal trafficking.²³⁷ She stated that there was no congressional intent to

²³²Patel, *supra* note 150, at 345.

²³³Meier, *supra* note 89, at 1193.

²³⁴Letter from Henry Hyde, U.S. Representative, to Thomas K. Constantine, Administrator of the Drug Enforcement Agency (July 7, 1998), *available at* <<http://house.gov/judiciary/htm>>. The Controlled Substance Act was passed by the United States Congress for the purpose to control the distribution, classification, sale, and use of drugs. *See* 21 U.S.C. § 801 (1999) (A controlled substance is any drug so designated by law whose availability is restricted by federal or state Controlled Substances Acts. Included in most classifications are narcotics, stimulants, depressants, hallucinogens, and marijuana.).

²³⁵Pratt, *supra* note 42, at 188.

²³⁶Letter from Janet Reno, U.S. Attorney General, to Henry Hyde, U.S. Representative (June 5, 1998), *available at* <<http://house.gov/judiciary/attygen.htm>>.

²³⁷*Id.*

supersede state authority to regulate the medical profession or override a state determination of a legitimate medical practice.²³⁸

On the same day the Attorney General issued her letter, Henry Hyde introduced the Lethal Drug Abuse Prevention Act of 1998 to the House of Representatives.²³⁹ The purpose of the Act was to prohibit the dispensing or distributing of a controlled substance for the purpose of causing, or assisting in causing, the suicide of any individual.²⁴⁰ The proposed legislation exempted from prohibition the use of controlled substance for the purpose of pain management even if its use increased the risk of death.²⁴¹

The Act placed the burden of proof on the prosecutor, using a clear and convincing evidence standard, to establish that the practitioner's intent was to cause a death or assist in causing a death.²⁴² The legislation was the first attempt at the federal level to negate the Oregon assisted suicide statute.²⁴³

Hearings on the bill were conducted by the Judiciary Committee in July 1998.²⁴⁴ In August, the Committee issued its report on the Lethal Drug Abuse Prevention Act of 1998 and recommended passage of the Act.²⁴⁵ The report indicated that the bill would affirm, for the first time, within the Controlled Substances Act, the use of controlled substances for pain management as a legitimate medical purpose, exempting practitioners from penalties under the law.²⁴⁶ The committee reported that the bill would make a clear distinction between the medical practice of pain management which increased the risk of death and the practice of assisted suicide.²⁴⁷ The committee report stated that the need for legislation was due to the use of controlled substances in Oregon under the Death with Dignity Act and the ruling by Attorney General Reno to exclude the Oregon law from the jurisdiction of the DEA.²⁴⁸ The report went on to emphasize three critical reasons for the proposed legislation.²⁴⁹ First, the bill would reaffirm the legal prohibition and ethical rejection of the intentional causing of another individual's death.²⁵⁰ Second, the legislation would apply "social brakes" to a destructive trend toward assisted suicide.²⁵¹ And

²³⁸*Id.*

²³⁹H.R. REP. NO. 105-683, Part 1, at 2 (1998).

²⁴⁰H.R. 4006, 105th Cong. (1998).

²⁴¹H.R. REP. NO. 105-683, *supra* note 239, at 3.

²⁴²H.R. 4006, *supra* note 240, at § 2(a)(i)(2).

²⁴³H.R. REP. NO. 105-683, *supra* note 239, at 4.

²⁴⁴*Id.* at 1.

²⁴⁵*Id.*

²⁴⁶*Id.* at 3.

²⁴⁷*Id.* at 8.

²⁴⁸H.R. REP. NO. 105-683, *supra* note 239, at 6.

²⁴⁹*Id.* at 4.

²⁵⁰*Id.*

²⁵¹*Id.*

finally, the Act continued to provide the essential supports for the appropriate use of controlled substances for pain management.²⁵² The Judiciary Committee report openly identified, as did the language of the bill, that the bill was designed to reverse the decision of the voters of Oregon to pass the assisted suicide law.²⁵³ This legislation raised important concerns about the right of the state to control the practice of medicine that could be superseded by federal laws controlling the use of drugs.²⁵⁴ The Act never reached the House floor for a vote and died in committee.²⁵⁵

In June 1999, Hyde introduced the Pain Relief Promotion Act of 1999 to the 106th Congress.²⁵⁶ The Act would provide for the alleviation of pain or discomfort by amending the Controlled Substance Abuse Act and by making the dispensing of medications for treatment a legitimate medical purpose even if use increased the risk of death.²⁵⁷ The bill would clarify that nothing in the Controlled Substance Abuse Act authorized the use of controlled substances for the purposes of assisted suicide.²⁵⁸ The legislation outlined that the Controlled Substance Abuse Act did not authorize intentional dispensing, distribution, or administration of a controlled substance for the purpose of causing the death or assisting another person in dying.²⁵⁹

The Act would invalidate state laws that permit assisted suicide, such as in the State of Oregon, by requiring that the Attorney General give no force and effect to

²⁵²*Id.* at 3.

²⁵³H.R. REP. NO. 105-683, *supra* note 239, at 4.

²⁵⁴*Id.* at 24. (This issue may ultimately find its way to the Supreme Court. Another important point to consider is that the Oregon first year experience report was not available when the committee report was released on August 6, 1998. Many of the points argued in the committee report were the same arguments brought before the Supreme Court in *Washington v. Glucksberg*. Congress has taken up the cause to prohibit assisted suicide at same time the Supreme Court expressed support for state experimentation. The issue of overriding the voters' choice in Oregon was raised by eight members of the judicial committee in their opposition to the recommendation for passage of the Lethal Drug Abuse Prevention Act. The dissenters stated that the legislation raised serious federalism concerns because it inserts the federal government into what was traditionally been a local oversight process. The dissenters were of the opinion that one of the fundamental aspects of federalism is that states were free to act independently and experiment. They wanted to see how the Oregon law operated before reaching any conclusions might support federal intervention. Another concern of the dissenting legislators was overturning the expressed desires of voters of a state who had passed a law by referendum. The dissenters offered other important reasons for their lack of support for the legislation: First, the bill would subject physicians and pharmacists to criminal liability for providing necessary palliative care. Second, the bill would substantially burden the effective treatment of pain. Finally, the bill exceed the fundamental purpose and intent of the Controlled Substances Act. They concluded that the bill was drafted solely to reverse the decision of the Oregon electorate, and enactment of such a law would violate the principle of federalism.).

²⁵⁵*Id.*

²⁵⁶H.R. REP. NO. 106-378, Part I, at 2 (1999).

²⁵⁷*Id.* at 10.

²⁵⁸H.R. REP. NO. 106-378, Part II, at 5 (1999).

²⁵⁹H.R. 2260, 106th Cong. § 101(i)(1) (1999).

state law authorizing or permitting assisted-suicide or euthanasia.²⁶⁰ The Act effectively overrides Attorney General Reno's decision of June 5, 1998 to not interfere with the Oregon voters' passage of the Death with Dignity Act.²⁶¹ On October 27, 1999, the bill passed in the House of Representatives, by a vote of 271-156, and was introduced in the Senate on November 19, 1999, and referred to the Judiciary Committee.²⁶²

The Act would make the dispensing of a controlled substance for the purpose of intentional ending life a violation of federal law, regardless of whether or not it violated state law.²⁶³ Physician survey results suggest that many physicians currently prescribe controlled substances for causing death in the course of treatment of the terminally ill patient.²⁶⁴ The Act would provide medical practitioners protection only when controlled substances are used for appropriate pain relief.²⁶⁵ The Act provides several programs and grants intending to develop and advance scientific understanding of palliative care.²⁶⁶

The proposed legislation would end the Oregon experience with assisted suicide.²⁶⁷ The Act would also have a serious impact on palliative care because the line between acceptable palliative care and illegal assistance with suicide would rest solely upon the intent of the physician.²⁶⁸ A subjective basis for interpretation could make the application of the law very difficult with regard to physician treatment decisions at the end of life and could threaten the ability of doctors to improve the quality of palliative care by discouraging aggressive and appropriate treatment of

²⁶⁰Marcia Angell, *Caring for the Dying—Congressional Mischief*, NEW ENG. J. MED., Dec. 16, 1999, at 1924.

²⁶¹*Id.*

²⁶²H.R. 2260, *supra* note 259.

²⁶³*Id.*

²⁶⁴Meier, *supra* note 89, at 1193.

²⁶⁵H.R. REP. NO. 106-378, Part II, *supra* note 258, at 10 (The Act defines palliative care as the active, total care of patients whose disease or medical condition is not responsive to curative treatment or when the prognosis is limited to advanced stages of the disease. Under the Act, the goal of such care is to alleviate pain and other distressing symptoms of the disease, provide for enhancement of the quality of life for the patient while not hastening death. The Pain Promotion Relief Act directs the establishment of a program to develop and advance scientific understanding of palliative care with the collection and advance scientific understanding of palliative care. The bill also authorizes the collection and dissemination of palliative care protocols to public and private health care programs. The Act further authorizes the Secretary of Health and Human Services to award grants for the development and implementation of programs to provide education and training to professionals in palliative care. The legislation effectively packages needed palliative care legislation for use of controlled substances in pain management with a provision which will kill the Oregon experiment in assisted suicide.).

²⁶⁶H.R. 2260, *supra* note 259, at § 906 (The Act would act as a deterrent to the use of controlled substances for use in assisted-suicide.).

²⁶⁷Angell, *supra* note 260, at 1924.

²⁶⁸*The Pain Relief Promotion Act of 1999, Hearings on H.R. 2260 Before the Subcomm. on the Constitution, 106th Cong. (1999)* (statement of David Orentlicher, MD, JD).

pain.²⁶⁹ The drug of choice under the Oregon Death with Dignity Act has been Secobarbital and Phenobarbital which are classified as Schedule IV drugs under the Controlled Substances Act.²⁷⁰ Therefore, passage of the Pain Relief Promotion Act of 1999 would in effect make the Oregon statute illegal under federal law.²⁷¹ Physicians would be reluctant to change the type of drugs used in assisted suicide because there is no source available to provide information on reliable alternatives.²⁷²

The Judiciary Committee report outlined the possibility of a constitutional state rights issue caused by modifying the Controlled Substance Abuse Act.²⁷³ Members of the Committee argued that the Act was a federal intrusion of the states' right to regulate medical care.²⁷⁴ The concern for many legislators was that the Act overrode the Oregon Death with Dignity Act; thirteen members of the committee concluded that the 1999 bill disregarded the Supreme Court's ruling in *Washington v. Glucksberg*, authorizing and encouraging the states to engage in meaningful debate and experiment in the case of assisted-suicide.²⁷⁵ During testimony before the Judiciary Committee, many commentators recommended consideration of other, more appropriate Legislative proposals before Congress.²⁷⁶

²⁶⁹*Id.*

²⁷⁰Chin, *supra* note 194, at 579 (The Oregon Center for Disease Prevention and Epidemiology report on the first year of assisted suicide stated that barbiturates had been the drug used by physicians for causing death in the terminally ill patient.).

²⁷¹Angell, *supra* note 260, at 1924.

²⁷²Lee, *supra* note 174, at 312 (Another aspect of the Act that presents physicians serious concerns involves the DEA's subpoena power to request state reports, which could be used to monitor whether drugs were dispensed in violation of federal law.).

²⁷³H.R. REP. NO. 106-378, Part II, *supra* note 258, at 32.

²⁷⁴*Id.*

²⁷⁵*Id.*

²⁷⁶*Id.* (The Pain Promotion Relief Act was referred to two House Subcommittees for study. The House Committee on Commerce issued a report on the Pain Relief Promotion Act in October 1999. The Committee recommended passage of the bill, taking the position that it clarified the standard that controlled substances used for the intention of assisting suicide where not authorized under the Controlled Substances Act. The committee also reported that in implementing the Act, the Attorney General must employ a uniform standard in enforcement of the Act without regard to state laws that permit assisted suicide instead of euthanasia. The Committee supported the invalidation of the Oregon assisted suicide statute. The Committee on Commerce conducted no hearings and rejected an attempt to insert the provisions of another palliative care bill, the Conquering Pain Act of 1999 in place of the Pain Promotion Relief Act.

The bill had not gone through the appropriate committee process. Members of the Committee expressed concern about the lack of hearings on the important issues of assisted suicide and palliative care. These Committee members justified recommending passage without hearing because of the considerable number of medically related organizations opposed to the legislation. The Committee qualified the recommendation stating that this contentious area of public policy demands careful subcommittee consideration and expert testimony by educated witnesses. The report also expressed concern about second guessing by the Drug Enforcement Administration over the "intent and purpose" of physician care for a terminally ill patient. The committee identified, as others had suggested, that the conduction

In May 1999, Senator Ron Wyden introduced the Conquering Pain Act of 1999 to the U.S. Senate.²⁷⁷ This legislative proposal has no reference to the Oregon Death with Dignity Act and takes no federal action to override that law.²⁷⁸ The legislative approach in this bill is to singularly address the palliative care issue without any attempt to amend the Controlled Substances Act.²⁷⁹ The Act amends the Public Health Service Act in order to establish a method of dealing with the public health crisis of pain.²⁸⁰ Pain has been identified as a major public health problem in the United States estimated fifty million Americans are partially or totally disabled by chronic pain.²⁸¹ The Act requires the development of an internet web site for the purpose of providing evidence-based practice guidelines for pain management.²⁸² The proposal also requires the Medicaid and Medicare programs to inform individuals what to expect under pain management care.²⁸³ The Act directs the Secretary of Health and Human Services to determine how to include measurements of pain and symptom management in the Medicare, Medicaid, and other federal medical programs.²⁸⁴

Other provisions of the Act authorize funding to implement special education projects by peer review organizations to improve pain and symptom management care.²⁸⁵ The Act mandates grants to health care provider training facilities for the establishment of six national family support networks in pain and symptom management. Most importantly, the proposed legislation authorizes a study and report to the Senate on ways federal insurance programs may provide palliative care services.²⁸⁶ The bill mandates grants to establish at least five demonstration projects on effective methods to measure improvement in the skills and knowledge of health care pain and systems management.²⁸⁷ In October 1999, the Senate Committee on

of a Drug Enforcement Administration investigation would scare physicians from providing quality palliative care. The committee members concluded that a more comprehensive consideration was necessary in order to provide a better opportunity to resolve the difference in view points with regard to palliative care. The committee stated that by careful consideration of the issues, the result would be better palliative care legislation. In the same month, the House Judiciary Committee issued a report after conducting hearings, recommending the passage of the Pain Relief Promotion Act for many of the same reasons used to advance the Lethal Drug Abuse Prevention Act of 1998.).

²⁷⁷S. 941, 106th Cong. (1999).

²⁷⁸*Id.*

²⁷⁹*Id.*

²⁸⁰*Id.*

²⁸¹*Id.* at 2.

²⁸²S. 941, *supra* note 277, at § 101.

²⁸³*Id.*

²⁸⁴*Id.*

²⁸⁵*Id.* at § 103.

²⁸⁶*Id.* at § 301.

²⁸⁷S. 941, *supra* note 277, at § 501.

Health Education, Labor, and Pensions held hearings but, there had been no other reported activity by the Senate.²⁸⁸

In March 1999, Senator John D. Rockefeller introduced the Advance Planning and Compassionate Care Act of 1999 to the U.S. Senate.²⁸⁹ The Compassionate Care Act would amend the Social Security Act by requiring the development of outcome standards and measures to evaluate programs that provide end of life care.²⁹⁰ The Act also requires the Secretary of Health and Human Services to report evaluation findings, including an annual Medicare report on the quality of end of life care, to Congress.²⁹¹ The Act would establish a central clearinghouse and a twenty-four hour-toll free telephone hotline to provide information to individuals making end of life medical care decisions.²⁹² The Act also requires that the Medicaid program provide coverage of self-administered prescription drugs for relief of pain to terminally ill patients.²⁹³

VI. CONCLUSION

The State of Oregon may ultimately make a constitutional challenge in the event the Pain Relief Promotion Act of 1999 becomes law. The challenge may be based on the premise that the Act impinges on traditional state powers to regulate medicine and physicians. The political debate has had a positive impact on health care for the terminally ill patient. One of the legislative proposals for palliative care will eventually pass and Congress, with a presidential approval, become law. Each proposal before Congress underscores the pain management crisis in the United States. Palliative care legislation as a recognized end of life option is finally coming of age.

Many federal legislators, however, interpret assisted suicide as a direct assault upon the ability of Congress to efficiently control drug usage. Noting this, the Pain Relief Promotion Act of 1999 has simply rearranged the priorities first outlined in the Lethal Drug Abuse Prevention Act of 1998. The 1999 version is aimed at invalidating the Oregon assisted suicide statute. Some members of Congress have the intent of insuring that the assisted suicide experiment never takes place in any other state, while eliminating the current law in Oregon. States' rights proponents are concerned that any federal legislation against assisted suicide would represent misuse of Congressional authority to regulate drugs.²⁹⁴ The Controlled Substances Abuse Act was designed to control drug abuse, not to define the medical uses of drugs. This is not the direction suggested by Justice O'Connor when she offered the

²⁸⁸S. 941, 106th Cong. (1999), at <<http://www.senate.gov/labor/hearings>>. (The committee report had not been published and was not available at the time this article was completed.)

²⁸⁹S. 628, 106th Cong. (1999).

²⁹⁰*Id.*

²⁹¹*Id.* at § 2.

²⁹²*Id.* at § 6.

²⁹³*Id.* at § 8.

²⁹⁴S. 628, *supra* note 289.

premise that the question should be addressed in the “laboratory of the states.”²⁹⁵ Assisted suicide is a means for states to provide individuals greater choice in end of life care. These decisions should be left up to each state to decide, free from Congressional influence and obstruction. On February 29, 2000, the State of Oregon released a second year report required under the Death with Dignity Act.²⁹⁶ This may provide advocates on both sides of the assisted suicide issue more information so that better end of life decisions can be made for the terminally ill patient. Assisted suicide is an end of life care choice that many patients need so they may die with dignity and self-determination.

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²⁹⁵*Glucksberg*, 521 U.S. at 737.

²⁹⁶CENTER FOR DISEASE PREVENTION, *supra* note 157.