Physician-Assisted Suicide
(Aid in Dying)

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Overview: Here, we examine two important ethical issues. The first is physician-assisted suicide which, at the time of this writing, is legal only in Oregon, Washington, and Montana. The second is palliative sedation, which is legal in each of the United States.

Changing terminology: Some academic communities have recognized that in the context of appropriate state law, the term *physician-assisted suicide* is inaccurate and inappropriate. These academics have recently adopted the less emotionally-charged, value-neutral, and more accurate terms *Aid in Dying* or *Physician-Assisted Dying*. Where appropriate in historical context, the term *aid in dying* will appear in this chapter.

Introduction: For centuries, physicians have discreetly helped the terminally ill hasten their deaths; and despite widespread opposition, Americans tacitly approve. By 1996, popular support for the practice reached 75%; but other than in Oregon, Washington, and Montana, American law has condemned it. This chapter will present the law that governs the practice of hastening death in terminally ill Americans.

Basic Definitions: Suicide is the act of taking one's own life. Assisted suicide is the act of providing medical means or knowledge that allows others to take their lives. In assisting suicide, a facilitator, usually a physician, provides drugs that can end life and instruction in their use. The patient then administers the lethal dose.

Euthanasia is the act of causing death in one suffering from an incurable, usually painful condition for reasons of mercy. In active euthanasia, a facilitator, usually a physician, provides drugs that can end life and administers the lethal dose. In contrast, passive euthanasia is the act of allowing a terminally ill person to die by withholding or
withdrawing life-sustaining medical treatment, so the patient dies from the consequences of the underlying illness.\textsuperscript{7}

Palliative sedation allows physicians to relieve extreme pain, agitation, delirium, or breathing difficulty by sedating dying patients into unconsciousness. Sedated into coma, the patient often dies within days.\textsuperscript{8}

American law treats suicide, assisted suicide, active euthanasia, passive euthanasia, and palliative sedation differently. Understanding those differences requires understanding some basic legal precepts.

**Basic Legal Precepts:** Federalism defines the division of power between states and the federal government; and the law of hastening death in America invokes its precepts.\textsuperscript{9} Medical practice has long been regulated by the individual states; and federal law will preempt state law only where federal and state law conflict.\textsuperscript{10} Before making policies that may affect the states, the federal government must first inform the states, then, analyzing potential conflicts “with the greatest caution,” must defer to state law.\textsuperscript{11}

Citizens derive their rights from constitutions, statutes, and the common law. A constitution defines a government’s fundamental laws, character, and sovereign power and guarantees individual civil rights and civil liberties.\textsuperscript{12} The United States and each state have a separate constitution and a court that acts as its final arbiter. In the federal system, that court is the United States Supreme Court.
Statutes are laws passed by legislators. In republican democracies, we elect state and federal legislators, respectively, in state legislatures and in Congress. Those legislators then enact statutes that govern their constituents’ conduct.

Common law is the body of law derived from judicial decisions, and American common law devolves from the English law that appears in commentaries dating to the thirteenth century. A respected commentator has described common law as “the power of judges to create new law under the guise of interpreting it.”

An admixture of constitutional, statutory, and common law has created America’s law of suicide, assisted suicide, euthanasia, and palliative sedation.

The Laws That Govern Hastening Death in America:

**Suicide:** Under medieval English law, suicide was considered a felony. Thus under the common law, early Colonial Americans courts punished suicide with forfeiture of the decedent’s estate. But later Colonial American courts and legislatures, discerning the injustice in punishing a decedent’s family for the decedent’s wrongdoing, viewed suicide as a grave public wrong, and not a crime. Currently, no state views suicide or attempted suicide as a crime. But assisting suicide is another matter.

**Assisted Suicide:** Under the common law and statutes respectively, Colonial American courts and legislatures forbade assisting suicide. Neither the patient’s consent, nor extremity of suffering, nor the imminence of death from illness, injury, or condemnation by a jury provided a defense against criminal charges.
Currently, 44 states and the District of Columbia view assisting suicide as a crime. Conflicting legal doctrine, however, leaves uncertain whether North Carolina, Ohio, Utah, Virginia, and Wyoming view assisting suicide as a crime. Under, respectively, its Death with Dignity Acts and a state court decision, Oregon, Washington, and Montana are the only states that allow assisted suicide—but only by a physician under expressly prescribed, closely monitored circumstances.\textsuperscript{20}

\textit{Active Euthanasia:} Euthanasia involves inducing a gentle and easy death.\textsuperscript{21} But no matter how well-intentioned, active euthanasia remains the intentional taking of another human’s life. In each of the 50 United States and the District of Columbia, therefore, active euthanasia is punishable as murder or as manslaughter.

Thus in 1999, a jury convicted Dr. Jack Kevorkian of second-degree murder. He was sentenced to spend ten-to-twenty-five years in prison because unlike his conduct in his other cases, Dr. Kevorkian, and not the patient, administered the lethal drug.\textsuperscript{22}

\textit{Refusing Medical Treatment and Passive Euthanasia:} The law distinguishes refusing medical treatment from suicide.\textsuperscript{23} The common-law right to preserve one’s bodily integrity permits competent adults, defined as those with decision-making capability, to refuse medical treatment.\textsuperscript{24}

Before 1976, the relatively few treatment-refusal cases that courts decided involved treatment that the patient’s religious beliefs forbade, such as blood-transfusion. But with the advent of respirators and artificial nutrition, courtroom battles forced Americans to confront the legitimacy of their right-to-die.
The seminal case, *In re Quinlan*, was the first state-court decision to allow physicians to withdraw a respirator from a patient who was in a persistent vegetative state.\textsuperscript{25} Since *Quinlan*, courts have invariably held that no distinction exists between withholding or withdrawing life-sustaining medical treatment.\textsuperscript{26} Those who facilitate passive euthanasia by withholding or withdrawing life-sustaining treatment under relevant state law therefore risk no criminal liability.

**Palliative Sedation:** Palliative sedation and the double-effect doctrine on which it is based have become a centerpiece in ethical discussions and court decisions that address the right to die and the legitimacy of physician-assisted suicide (aid in dying). Palliative sedation is legal in each of the United States.

**Palliative Sedation and the Double-Effect Doctrine:** Formerly called terminal sedation, palliative sedation allows physicians to relieve extreme pain, agitation, delirium, or breathing difficulty by sedating dying patients into unconsciousness. Sedated into coma, the patient often dies within only a few days.\textsuperscript{27}

Allowing an action that causes serious harm such as death as a side effect of promoting some good invokes the ancient doctrine of double effect.\textsuperscript{28} Attributed to Thomas Aquinas, the double-effect doctrine states that one may *not* deliberately cause harm in order to promote some good. But one *may* promote some good even if serious harm comes from a foreseeable side-effect.\textsuperscript{29} Physicians thus prescribe controlled substances to relieve pain, agitation, delirium, or breathing difficulty in the terminally-ill, even if doing so foreseeably hastens the patient’s death.
The double-effect doctrine has long been controversial in moral philosophy, in medical ethics, and in law. But the American Medical Association [AMA] has incorporated it into its Code of Ethics. Thus the Attorney General, Congress, and the Supreme Court have proclaimed the double-effect doctrine legitimate practice. As a result, the double-effect doctrine has become the bedrock on which hospices, and now hospitals, manage severe pain in the terminally ill.

But in purporting to be a reasonable option in caring for the terminally ill, the double-effect doctrine invites scrutiny. Under the double-effect doctrine, the morality or legality of physicians’ conduct turns on intent. Did the physician intend to hasten death? Or did the physician intend only to relieve pain, agitation, delirium, or breathing difficulty—with death foreseeably following? Deciding intent mires physicians in ethical and legal quandaries.

From an idealized ethical perspective, intent is clear and distinct. But in real end-of-life situations, physician intent is complex, ambiguous, and contradictory. In treating the terminally ill, physicians rarely act with only one intent. Instead, they act with several intents—that may include a real possibility of hastening their patients’ death. Where physicians may incur civil, criminal, or administrative penalties based on their intent, their ethical and legal quandaries turn on just who may rightfully determine that intent.

Under basic jurisprudence, intent may be inferred from conduct. But under the double-effect doctrine, what physicians say becomes more important than what they do. To avoid civil, criminal, or administrative penalties for their prescribing practices, physicians must never admit to honoring a patient’s or a family’s request for a patient’s death. Instead,
physicians must assert that they have prescribed only to relieve pain and suffering; and that perpetuates their ethical and legal quandaries, because of who may rightfully determine physicians’ prescribing intent.

By embracing the double-effect doctrine, the AMA, the Attorney General, Congress, and the Supreme Court may therefore have created a physician dilemma. Under the double-effect doctrine, prescribing intent may be determined by federal law enforcement agents—who can make no credible claim to medical expertise.

The double-effect doctrine creates other ethical and legal quandaries; and it may do nothing more than rationalize euthanasia. Legal scholar David Orentlicher, MD, JD, observes that the double-effect doctrine has blurred the distinction between withdrawing treatment and euthanasia.37 Dr. Orentlicher, who served as general counsel to the AMA and chaired its Council on Ethical and Judicial Affairs, wrote: “... [palliative] sedation is essentially a form of euthanasia.”38 And in “... relying on ... [palliative] sedation,” writes Dr. Orentlicher, “... the [Supreme Court] Justices rejected assisted suicide only by embracing euthanasia.39

Regulating Medical Practice in the Context of End-of-life Care: End-of-life decisions, at first, involved only patients and their physicians; and Quinlan held that in end-of-life decisions, patient judgments must prevail over physician judgments.40 Since 1976, when Quinlan was decided, courts and legislatures have struggled to fix medical management’s legal boundaries in the context of end-of-life care.

In Cruzan v. Department of Health, in 1990, the Supreme Court made its first foray into end-of-life issues.41 The Court held that should a competent adult become incompetent,
states can require clear and convincing evidence of that patient’s wishes before allowing the family to discontinue life support. The Supreme Court thus recognized that regulating medical practice in the context of end-of-life care is a right reserved by the states.

Seven years later, in 1997, the Supreme Court reaffirmed that regulating medical practice in the context of end-of-life care is a right reserved by the states. And it did so in reversing decisions in which two federal appeals courts held that state bans on physician-assisted suicide violate the federal constitution. Reversing the appeals courts in *Vacco v. Quill* and in *Washington v. Glucksberg*, the Supreme Court held that New York’s and Washington’s bans on physician-assisted suicide do *not* violate the federal constitution.

In *Quill* and in *Glucksberg* respectively, the Supreme Court held that the neither the Equal Protection Clause nor the Due Process Clause confer a constitutional right to assisted suicide. But these decisions do not prevent state legislatures from conferring a right to assisted suicide. To the contrary, the Court encouraged continued debate over the “morality, legality, and practicality of physician-assisted suicide” by the states. With the Supreme Court’s urging states to protect “terminally ill, mentally competent individuals who would seek to end their suffering,” Oregon’s legislature did just that.

**Oregon’s Death with Dignity Act:** When its voters approved the Death with Dignity Act in 1994, Oregon became the first—and only—state to make physician-assisted suicide legal. But responding to a lawsuit, a federal district court quickly prevented Oregon from implementing the Act. The injunction continued for three years, until a federal appeals court vacated it. On November 4, 1997, Oregon’s voters rejected a legislative proposal to repeal
the Act. By a 60-40% margin, voters ensured that obtaining a physician’s aid in hastening the death of the terminally ill would remain legal in Oregon.\textsuperscript{52}

The terminally ill have incurable, irreversible disease that is expected to cause death within six months.\textsuperscript{53} Under the Death with Dignity Act, competent, terminally-ill Oregonians may make a written request for self-administered medication to end their lives in a “humane and dignified manner.”\textsuperscript{54} The patient must sign and date the request, which two unrelated, disinterested individuals must witness. A physician must inform the patient of the alternatives to hastening death, and two physicians must confirm the patient’s medical diagnosis and mental competence to make health-related decisions.\textsuperscript{55} Physicians who are unwilling to aid suicide have no duty to do so; and physicians and pharmacists who participate in the Act risk no civil, criminal, or professional-disciplinary actions.\textsuperscript{56} Outside the Act, aiding suicide is second-degree manslaughter.\textsuperscript{57} Health care providers must file reports with Oregon’s Department of Human Services documenting their actions taken under the Act.\textsuperscript{58} Because barbiturates have been the drugs-of-choice in effecting physician-assisted suicide, Oregon’s Death with Dignity Act incorporates the federally-enacted Controlled Substances Act.

\textit{The Controlled Substances Act:} In 1970, Congress enacted the Controlled Substances Act.\textsuperscript{59} Enacted to deal with drug abuse in the United States, the Act ensures that legally available drugs remain legally distributed and legally used.\textsuperscript{60} Physicians who violate the Act risk losing their prescribing privileges; and they risk severe criminal penalties.\textsuperscript{61}

A 1971 regulation adopted under the Attorney General’s limited power to implement the Act states that controlled substances must be prescribed for “a legitimate medical
purpose.” But nothing in the Controlled Substances Act or its implementing regulations defines “a legitimate medical purpose.”

A 1984 amendment to the Act targeted physicians who divert legitimate prescription drugs to illegitimate uses. The 1984 amendment thus empowers the Attorney General to deny registration under the Act for conduct “inconsistent with the public interest.” In determining the public interest, the Attorney General must consider compliance with state law and threats to public health. But nothing in the Controlled Substances Act or its implementing regulations defines conduct “inconsistent with the public interest” or threats to public health.

The Act empowers the Attorney General to place drugs on, or to remove drugs from, any of the Act’s five schedules. But first, the Secretary of Health and Human Services must provide a “scientific and medical” evaluation and advice that the Attorney General must accept and follow.

In enacting the Controlled Substances Act, Congress did not intend to regulate physicians as the states do. Nor did Congress intend to regulate medical practices allowed by state law—and that are unrelated to drug abuse or trafficking. And in determining accepted medical practice, the Attorney General can make no credible claim to any medical expertise. But some government officials who oppose Oregon’s Death with Dignity Act have tried to subvert it by amending or interpreting the Controlled Substances Act.
Assisted Suicide’s Opponents:

Congressional Conservatives and the Drug Enforcement Administration: Only a day after voters approved Oregon’s Death with Dignity Act—for the second time—Congressional conservatives induced the Drug Enforcement Administration [DEA] to act against Oregon’s law. With neither Justice Department nor Congressional approval, the DEA proclaimed that physicians who prescribe controlled substances to assist suicide could find their prescribing privileges subject to revocation. Oregon’s physicians immediately refused to assist suicide, even under the duly enacted Death with Dignity Act, because of their fear of DEA reprisals.

But in 1998, after a seven-month long, thorough investigation by the Justice Department, then-Attorney General Janet Reno rejected the DEA’s position. She ruled that in enacting the Controlled Substances Act, Congress intended to block drug trafficking but not physician-assisted suicide. She upheld that the “morality, legality, and practicality” of physician-assisted suicide was to be resolved in state legislatures. She ruled 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 Controlled Substances Act.”

Only hours after receiving Ms. Reno’s ruling, conservatives in both Houses of Congress sprung into action to amend the Controlled Substances Act. Under two separate proposed statutes, an amended Controlled Substances Act would proclaim prescribing controlled substances to relieve pain—even if death follows—legitimate medical practice. But prescribing controlled substances to assist suicide would not be legitimate medical practice. Prescribing controlled substances to assist suicide would therefore subject
physicians’ federal controlled-substances registration to revocation. And it would subject physicians to criminal prosecution and a 20-year mandatory prison term.\textsuperscript{80} Even complying with the Death with Dignity Act’s every provision would not furnish a defense.\textsuperscript{81} Ostensibly aimed at pain relief and not the Death with Dignity Act, either proposed federal statutes would, if enacted into law, effectively annul it.\textsuperscript{82}

The attempts to amend the Controlled Substances Act, first under the Lethal Drug Abuse Prevention Act and later under the Pain Relief Promotion Act, stalled indefinitely in the Senate. Yet the Pain Relief Promotion Act passed in the House of Representatives by a 271-156 majority.\textsuperscript{83} Many ascribe that to the position opposing physician-assisted suicide (aid in dying) championed by the AMA.\textsuperscript{84}

*The American Medical Association:* The AMA Code of Ethics condemns assisting suicide for being “fundamentally incompatible with the physician's role as healer.”\textsuperscript{84} Under the AMA Code of Ethics, even physicians who comply with every provision of Oregon’s Death with Dignity Act behave unethically.

But the AMA does not acknowledge that substantial numbers of America’s physicians support assisted suicide (aid in dying).\textsuperscript{85} Fully two-thirds of America’s physicians do not even belong to the AMA.\textsuperscript{86} And the AMA’s Council on Ethical and Judicial Affairs, which authors its Code of Ethics, is an appointed body that routinely issues ethical guidelines without polling America’s physicians.\textsuperscript{87} Still, Congress and the Supreme Court accord AMA positions pivotal deference.\textsuperscript{88}
The AMA supports “providing effective palliative treatment even though it may foreseeably hasten death.” The AMA therefore praised the Pain Relief Promotion Act for “reducing physicians’ exposure to criminal investigation and prosecution for legitimate medical practices.” But the AMA’s reasoning, on which Congress relied in debating the Pain Relief Promotion Act, and on which the Supreme Court relied in deciding *Vacco v. Quill* and *Washington v. Glucksberg*, raises constitutional concerns.

The Pain Relief Promotion Act would impose a national solution on issues that historically have been handled by the states. DEA agents would intrude into the physician-patient relationship. When physicians prescribe controlled substances, DEA agents would interpret physicians’ intent. In settings where even physicians disagree, DEA agents—not physicians—would determine appropriate prescribing practices. Finally, the Attorney General would act as though Oregon’s Death with Dignity Act, a duly enacted state law, does not exist. Still this has not lessened the AMA’s resolve.

When the Pain Relief Promotion Act stalled in the Senate, assisted suicide’s opponents found staunch allies in the Department of Justice.

*The United States Department of Justice*: Undaunted by their failing to thwart physician-assisted suicide in Oregon, assisted suicide’s opponents tried a new tactic—that would avoid the open, thorough legislative debate required by Congress. Seeking refuge with then-Attorney General John Ashcroft, they tried to “get through the administrative door that which they could not get through the congressional door.” They found Mr. Ashcroft ready to
reverse the Justice Department’s earlier interpretation of the Controlled Substances Act with an administrative directive that attempted to rewrite federal law.

John Ashcroft’s closed-door process took only a few months.\textsuperscript{98} He acted without public hearings or debate, without warning to the medical community, and without the data or input from Oregon that he had earlier agreed to consider.\textsuperscript{99}

In what has become known as the “Ashcroft Directive,” the then-Attorney General, who can make no credible claim to medical expertise, defined “legitimate medical purpose.” Under the Ashcroft Directive issued on November 6, 2001, using controlled substances to aggressively manage pain is a “legitimate medical purpose.” But under the Ashcroft Directive, using controlled substances to assist suicide is “inconsistent with the public interest” and is \textit{not} a “legitimate medical purpose.”\textsuperscript{100} Under the Ashcroft Directive, even when done under Oregon law, prescribing, dispensing, or administering controlled substances to assist suicide violates the Controlled Substances Act.\textsuperscript{101}

Under the Ashcroft Directive, the assisted-suicide records required by Oregon law would self-incriminate physicians who obey that law.\textsuperscript{102} Under the Ashcroft Directive, physicians who assist suicide, even under Oregon law, risk investigation, prosecution, and punishment. Under the Ashcroft Directive, those physicians risk having their prescribing privileges suspended or revoked—and 20 years in prison.

The Ashcroft Directive, which disclaimed Janet Reno’s 1998 ruling that reached the opposite conclusion, effectively annulled the Death with Dignity Act and Oregon’s then four-year experience in applying it.\textsuperscript{103}
The Ashcroft Directive’s unwarranted intrusion into Oregon’s sovereign interests caused physicians, terminally-ill patients, and Oregon’s Government to sue to prevent giving the Ashcroft Directive any legal effect.104

**The Ashcroft Directive in federal district court:** In his April 17, 2002, decision, the Honorable Robert E. Jones restrained the Ashcroft Directive permanently.105

Judge Jones first noted: “Many of our citizens, including the highest respected leaders of this country, oppose assisted suicide.” But, he warned, while “opposition to assisted suicide may be fully justified ... [that] ... does not permit a federal statute to be manipulated from its true meaning to satisfy even a worthy goal.”106

Judge Jones wrote: “The determination of what constitutes a legitimate medical practice or purpose traditionally has been left to the individual states. State statutes, state medical boards, and state regulations control the practice of medicine.”107 Thus “... the Ashcroft Directive is not entitled to deference under any standard and is invalid.”108

Judge Jones admonished: “To allow an attorney general—an appointed executive whose tenure depends entirely on whatever administration occupies the White House—to determine the legitimacy of a particular medical practice without a specific congressional grant of such authority would be unprecedented and extraordinary.”109

Five months later, on September 23, 2002, Mr. Ashcroft appealed his defeat in the federal district court to the Ninth Circuit Court of Appeals.
The Ashcroft Directive in the Ninth Circuit Court of Appeals: A three-judge panel from the Ninth Circuit Court of Appeals took almost two years to affirm the district court, and in a two-to-one vote, declared the Ashcroft Doctrine invalid.\textsuperscript{110}

On May 26, 2004, a year after oral arguments, Judge Richard C. Tallman, writing for the majority, observed that: “The attorney general’s unilateral attempt to regulate general medical practices historically entrusted to state lawmakers interferes with the democratic debate about physician-assisted suicide and far exceeds the scope of his authority under federal law.”\textsuperscript{111}

Judge Tallman wrote: “We express no opinion on whether the practice is inconsistent with the public interest or constitutes illegitimate medical care.” “This case is simply about who gets to decide.”\textsuperscript{112} And under “... our concept of federalism, which requires that state lawmakers, not the federal government, are the primary regulators of professional medical conduct,”\textsuperscript{113} the states do.

Two months later, on July 13, 2004, Mr. Ashcroft sought re-hearing by the full, eleven-judge panel of Ninth Circuit Court of Appeals judges. But no judge agreed.

The Ashcroft Directive in the United State Supreme Court: On November 9, 2004, the day on which Americans learned that John Ashcroft had resigned as Attorney General, he asked the U.S. Supreme Court to review the Ninth Circuit’s decision. Three months later, on February 22, 2005, the Court agreed. Thus on October 5, 2005, the Court heard oral arguments under the case’s new name, \textit{Gonzalez v. Oregon}, and on January 17, 2006, dealt the Ashcroft Doctrine its final rebuke.\textsuperscript{114}
In a 6-3 ruling that was notably focused and technical, the Court based its decision on administrative, and not constitutional law to uphold the earlier decisions made by the federal district and appellate courts. The Court did not address whether there is a constitutional right to die, nor did it find Congress powerless to override state laws that allow physicians to help their patients hasten their deaths. Writing for the majority, Justice Anthony Kennedy held only that the Controlled Substances Act “... does not authorize the Attorney General to bar dispensing controlled substances for assisted suicide in the face of a state medical regime permitting such conduct.”

Justice Kennedy found that Mr. Ashcroft acted “... without consulting Oregon or apparently anyone outside his department.” Justice Kennedy also found that: “The authority claimed by the attorney general is both beyond his expertise and incongruous with the statutory purposes and design.”

Unless Congress enacts legislation to the contrary, the Supreme Court’s decision allows Oregonians to retain their right of choice at the end of life.

Other states allow aid in dying: Incorporating the same safeguards and procedures as Oregon's Death with Dignity Act, Washington's Death with Dignity Act became reality on November 4, 2008.

Soon afterwards, citing concerns for privacy and dignity, a Montana State court followed suit. Declaring that the state legislature had not moved fast enough to recognize aid-in-dying rights, Judge Dorothy McCarter decided that she was obligated to decide for it: “Montana constitutional rights of individual privacy and human dignity, taken together,
encompass the right of a competent terminally (ill) patient to die with dignity.” By an only 4-3 margin on December 31, 2009, Montana’s Supreme Court affirmed.¹¹⁹

**Oregon’s Death with Dignity Act in action:** Because it has been in effect for over a decade, we will look at how the Oregon Death with Dignity Act really works. As the Act requires, Oregon’s experience with its Death with Dignity Act has been documented and evaluated in detail.¹²⁰ The Eleventh Annual Report on Oregon’s Death with Dignity Act provides statistics amassed over the 11 years during which aid in dying has been legal in Oregon.¹²¹ Reports published in the New England Journal of Medicine confirm that the Death with Dignity Act works very well.¹²²

Patients who chose to hasten death under the Act were educated, overwhelmingly white, and motivated by issues relating to quality-of-life.¹²³ Most suffered from end-stage cancers and dreaded their progressive, inexorable loss of body functions, autonomy, and their ability to interact meaningfully with loved ones. Almost all (97%) had medical insurance.¹²⁴ Fears that the Act would be disproportionately chosen by, or forced on, patients who were poor, uneducated, uninsured, or afraid of the financial consequences of their illness proved unfounded.¹²⁵ The Act has reduced the underground practice of physician-assisted dying that was widespread in Oregon—and remains underground throughout the rest of the nation.¹²⁶

In 2008, under Oregon’s Death with Dignity Act, 60 patients died; in 2007, 49 died; in 2006, 46 died; in 2005, 38 died; in 2004, 37 died; in 2003, 42 died; in 2002, 38 died; in 2001, 21 died; in 2000, 27 died; in 1999, 27 died; and in 1998, the first year during which terminally-ill patients could legally hasten their deaths under the Death with Dignity Act, 16 Oregonians died under the Act.  

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In each year of the study, deaths resulted from ingesting prescriptions that had been written earlier than the patients’ year of death: two in 2001; two in 2002; three in 2003; two in 2004; six in 2005; eleven in 2006; three in 2007; and six in 2008.
In 2008, the most frequently reported concerns were: loss of autonomy (95%); decreasing ability to participate in activities that make life enjoyable (92%); and loss of dignity (92%). The overwhelming number of Oregonians who chose to hasten their death under the Death With Dignity Act did not cite uncontrollable pain as a major factor.\textsuperscript{130}

**Some final thoughts:** More than two centuries ago, Sir William Blackstone observed that “Law is the embodiment of the moral sentiment of the people.”\textsuperscript{131} The law of aid in dying blends ethics, philosophy, and morality with medicine and the law. It touches our fundamental beliefs about life, death, illness, religion, autonomy, and dignity. Thus people of good conscience can disagree about aid in dying’s and palliative sedation’s morality and wisdom.\textsuperscript{132}

The legal issues that surround aid in dying affect the balance of power between the state and federal governments in the realm of medical practice. Those issues especially concern Oregonians, Washingtonians, and Montanans who face critical end-of-life decisions—and health care’s lawful role in those decisions.\textsuperscript{133} Deep disagreements about the limits of legitimate medical practice and of physicians’ conduct pervade medical and medical-ethics communities.\textsuperscript{134} For physicians, patients, religious groups, ethicists, philosophers, and legislators, whether Oregon’s and Washington’s Death with Dignity Acts, and Montana’s state court decision should allow the terminally ill to hasten their deaths understandably ignites controversy.

Many believe that the Attorney General should interpret the Controlled Substances Act in a way that effectively subverts the Death With Dignity Act. But many believe that
doing so subverts federalism’s basic precepts, the Supreme Court’s guidance, and sovereign state interests.\textsuperscript{135}

Our thoughts, our beliefs, and our disagreements will affect and then determine how the law of aid in dying evolves. The only absolute in this ever-changing venue is that the law of aid in dying in America will affect each of us.


5. Id.

6. Id. at 594.

7. Id.


11. President’s Executive Order on Federalism 13132.


13. Id. at 1448.

14. Id. at 293.


29. Saint Thomas Aquinas, *Summa Theologica* (II-II, Qu. 64, Art.6) 1265-1272.

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36. *Id.*


38. *Id.* at 948.

39. *Id.* at 954.


42. *Id.*


44. *Id.*

45. *Quill*, 521 U.S. 793 (Equal Protection); *Glucksberg*, 521 U.S. 702 (Due Process).

47. *Glucksberg*, 521 U.S. at 734 (Renquist, C.J.); 521 U.S. at 737 (O’Connor, J., concurring); 521 U.S. at 787 (Souter, J., concurring).


55. *Id.*

56. *Id.*; Or. Admin. Rule 847-010-0081 (citing Or. Rev. Stat. §§ 677.190[1], 677.188[4]).


62. 21 C.F.R. § 1306.04.

66. 21 U.S.C. §§ 823(b) & [c], 824[a][4].  
67. *Id.*  
68. 21 U.S.C. § 811[b].  
69. *Id.*  
70. 21 U.S.C. §§ 823[g][2][H][I].  
72. *Id.*; See also: 21 U.S.C. § 811[b].  
75. *Id.*  
76. *Id.*  
77. *Id.*  
79. *Id.*  

84. AMA Code of Medical Ethics § 2.211 (issued 1994).


86. Historical membership chart, American Medical Association.


88. See, e.g.: *Glucksberg*, 521 U.S. at 730.


95. Id.

96. AMA position on the Pain Relief Promotion Act.


101. *Id.*


103. *Id.*; See also: Reno letter.


106. *Id.* at 1093.

107. *Id.* 192 F. Supp. 2d at 1092.

108. *Id.*

109. *Id.*

110. *Oregon v. Ashcroft*, 368 F.3d 1118 (9th Cir. 2004).

111. *Id.* at 1144.

112. *Id.* at 1148.

113. *Id.* at 1133.


115. *Id.* at 28.

116. *Id.* at 6.

117. *Id.* at 20.


123. Id.

124. Id.

125. Id.


128. Id.

129. Id.

130. Id.


