

# Chapter 24

## Physician-Assisted Suicide and Palliative Sedation

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In this chapter we examine two important ethical issues: physician-assisted suicide, which is legal only in Oregon, and palliative sedation, which is legal in each of the United States.

For centuries, physicians have discreetly helped the terminally ill hasten their deaths, and despite widespread opposition, Americans tacitly approve.<sup>1</sup> By 1996, popular support for the practice reached 75%, but other than in Oregon, American law has condemned it.<sup>2</sup> Here, we 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.<sup>3</sup> Assisted suicide is the act of providing medical means or knowledge that allows others to take their lives.<sup>4</sup> 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.<sup>5</sup> 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 that the patient dies from the consequences of the underlying illness.<sup>6</sup>

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.<sup>7</sup>

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.<sup>8</sup> Medical practice has long

been regulated by the individual states, and federal law will preempt state law only where federal and state law conflict.<sup>9</sup> 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.<sup>10</sup>

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.<sup>11</sup> 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.<sup>12</sup> 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.<sup>13</sup> A respected commentator has described common law as "the power of judges to create new law under the guise of interpreting it."<sup>14</sup>

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.<sup>15</sup> Thus under the common law, early Colonial Americans courts punished suicide with forfeiture of the decedent's estate.<sup>16</sup> 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

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grave public wrong, and not a crime.<sup>17</sup> 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.<sup>18</sup>

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 its Death with Dignity Act, Oregon is the only state that allows assisted suicide—but only by a physician under expressly prescribed, closely monitored circumstances.<sup>19</sup>

### Active Euthanasia

Euthanasia involves inducing a gentle and easy death.<sup>20</sup> 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 will spend 10–25 years in prison because, unlike his conduct in his other cases, Dr. Kevorkian, and not the patient, administered the lethal drug.<sup>21</sup>

### Refusing Medical Treatment and Passive Euthanasia

The law distinguishes refusing medical treatment from suicide.<sup>22</sup> The common law right to preserve one's bodily integrity permits competent adults, defined as those with decision-making capability, to refuse medical treatment.<sup>23</sup>

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.<sup>24</sup> Since *Quinlan*, courts have invariably held that no distinction exists between withholding or withdrawing life-sustaining medical treatment.<sup>25</sup> 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. 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.<sup>26</sup>

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.<sup>27</sup> 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.<sup>28</sup> 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.<sup>29</sup> But the American Medical Association (AMA) has incorporated it into its Code of Ethics.<sup>30</sup> Thus the Attorney General, Congress, and the Supreme Court have proclaimed the double-effect doctrine legitimate practice.<sup>31</sup> As a result, the double-effect doctrine has become the bedrock on which hospices, and now hospitals, manage severe pain in the terminally ill.<sup>32</sup>

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?<sup>33</sup> 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.<sup>34</sup> In treating the terminally ill, physicians rarely act with only one intent. Instead, they act with several intents—which may include a real possibility of hastening their patient's death.<sup>35</sup> 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.<sup>36</sup> 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.”<sup>37</sup> And in “. . . relying on [palliative] sedation,” writes Dr. Orentlicher, “. . . the [Supreme Court] Justices rejected assisted suicide only by embracing euthanasia.”<sup>38</sup>

## 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.<sup>39</sup> 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.<sup>40</sup> 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.<sup>41</sup> 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.<sup>42</sup> 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.<sup>43</sup>

In *Quill* and in *Glucksberg* respectively, the Supreme Court held that neither the equal protection clause nor the due process clause confer a constitutional right to assisted suicide.<sup>44</sup> But these decisions do not prevent state legislatures from conferring a right to assisted suicide.<sup>45</sup> To the contrary, the Court encouraged continued debate over the “morality, legality, and practicality of physician-assisted suicide” by the states.<sup>46</sup> With the Supreme Court's urging states to protect “terminally ill, mentally competent individuals who would seek to end their suffering,”<sup>47</sup> 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.<sup>48</sup> But responding to a lawsuit, a federal district court quickly prevented Oregon from

implementing the Act.<sup>49</sup> The injunction continued for three years, until a federal appeals court vacated it.<sup>50</sup> On November 4, 1997, Oregon's voters rejected a legislative proposal to repeal the Act. By a 60% to 40% margin, voters ensured that obtaining a physician's aid in hastening the death of the terminally ill would remain legal in Oregon.<sup>51</sup>

The terminally ill have incurable, irreversible disease that is expected to cause death within 6 months.<sup>52</sup> 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.”<sup>53</sup> 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.<sup>54</sup> 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.<sup>55</sup> Outside the Act, aiding suicide is second-degree manslaughter.<sup>56</sup> Health care providers must file reports with Oregon's Department of Human Services documenting their actions taken under the Act.<sup>57</sup> 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.

### The Controlled Substances Act

In 1970, Congress enacted the Controlled Substances Act.<sup>58</sup> Enacted to deal with drug abuse in the United States, the Act ensures that legally available drugs remain legally distributed and legally used.<sup>59</sup> Physicians who violate the Act risk losing their prescribing privileges, and they risk severe criminal penalties.<sup>60</sup>

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.”<sup>61</sup> But nothing in the Controlled Substances Act or its implementing regulations defines “a legitimate medical purpose.”<sup>62</sup>

A 1984 amendment to the Act targeted physicians who divert legitimate prescription drugs to illegitimate uses.<sup>63</sup> The 1984 amendment thus empowers the Attorney General to deny registration under the Act for conduct “inconsistent with the public interest.”<sup>64</sup> In determining the public interest, the Attorney General must consider compliance with state law and threats to public health.<sup>65</sup> But nothing in the Controlled Substances Act or its implementing regulations defines conduct “inconsistent with the public interest” or threats to public health.<sup>66</sup>

The Act empowers the Attorney General to place drugs on, or to remove drugs from, any of the Act's five schedules.<sup>67</sup> 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.<sup>68</sup>

In enacting the Controlled Substances Act, Congress did not intend to regulate physicians as the states do.<sup>69</sup> Nor did Congress intend to regulate medical practices allowed by

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state law—and that are unrelated to drug abuse or trafficking.<sup>70</sup> And in determining accepted medical practice, the Attorney General can make no credible claim to any medical expertise.<sup>71</sup> 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.<sup>72</sup> 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.<sup>73</sup> She ruled that in enacting the Controlled Substances Act, Congress intended to block drug trafficking but *not* physician-assisted suicide.<sup>74</sup> She upheld that the "morality, legality, and practicality" of physician-assisted suicide was to be resolved in state legislatures.<sup>75</sup> 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."<sup>76</sup>

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.<sup>77</sup> But prescribing controlled substances to assist suicide would not be legitimate medical practice.<sup>78</sup> 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.<sup>79</sup> Even complying with the Death with Dignity Act's every provision would not furnish a defense.<sup>80</sup> Ostensibly aimed at pain relief and not the Death with Dignity Act, either proposed federal statute would, if enacted into law, effectively annul it.<sup>81</sup>

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.<sup>82</sup> Many ascribe that to the position opposing physician-assisted suicide championed by the AMA.

#### The American Medical Association

The AMA Code of Ethics condemns assisting suicide for being "fundamentally incompatible with the physician's

role as healer."<sup>83</sup> 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.<sup>84</sup> Fully two-thirds of America's physicians do not even belong to the AMA.<sup>85</sup> 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.<sup>86</sup> Still, Congress and the Supreme Court accord AMA positions pivotal deference.<sup>87</sup>

The AMA supports "providing effective palliative treatment even though it may foreseeably hasten death."<sup>88</sup> The AMA therefore praised the Pain Relief Promotion Act for "reducing physicians' exposure to criminal investigation and prosecution for legitimate medical practices."<sup>89</sup> 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.<sup>90</sup>

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.<sup>91</sup> When physicians prescribe controlled substances, DEA agents would interpret physicians' intent.<sup>92</sup> In settings where even physicians disagree, DEA agents—not physicians—would determine appropriate prescribing practices.<sup>93</sup> Finally, the Attorney General would act as though Oregon's Death with Dignity Act, a duly enacted state law, does not exist.<sup>94</sup> Still this has not lessened the AMA's resolve.<sup>95</sup>

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—which 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."<sup>96</sup> 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.<sup>97</sup> 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.<sup>98</sup>

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 *not* a "legitimate

medical purpose."<sup>99</sup> Under the Ashcroft Directive, even when done under Oregon law, prescribing, dispensing, or administering controlled substances to assist suicide violates the Controlled Substances Act.<sup>100</sup>

Under the Ashcroft Directive, the assisted-suicide records required by Oregon law would self-incriminate physicians who obey that law.<sup>101</sup> 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.<sup>102</sup>

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.<sup>103</sup>

### The Ashcroft Directive in Federal District Court

In his April 17, 2002, decision, the Honorable Robert E. Jones restrained the Ashcroft Directive permanently.<sup>104</sup>

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."<sup>105</sup>

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."<sup>106</sup> Thus ". . . the Ashcroft Directive is not entitled to deference under any standard and is invalid."<sup>107</sup>

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."<sup>108</sup>

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 2–1 vote, declared the Ashcroft Doctrine invalid.<sup>109</sup>

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."<sup>110</sup>

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."<sup>111</sup> And under ". . . our concept of federalism, which requires that state lawmakers, not the federal government, are the primary regulators of professional medical conduct,"<sup>112</sup> the states do.

Two months later, on July 13, 2004, Mr. Ashcroft sought rehearing 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, *Gonzalez v. Oregon*, and on January 17, 2006, dealt the Ashcroft Doctrine its final rebuke.<sup>113</sup>

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."<sup>114</sup>

Justice Kennedy found that Mr. Ashcroft acted ". . . without consulting Oregon or apparently anyone outside his department."<sup>115</sup> 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."<sup>116</sup>

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

## OREGON'S DEATH WITH DIGNITY ACT IN ACTION

As the Act requires, Oregon's experience with its Death with Dignity Act has been documented and evaluated in detail.<sup>117</sup> Reports published in the *New England Journal of Medicine* confirm that the Death with Dignity Act works very well.<sup>118</sup>

Patients who chose to hasten death under the Act were educated, overwhelmingly white, and motivated by issues relating to quality of life.<sup>119</sup> Most suffered from end-stage cancers and dreaded their progressive, inexorable loss of

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body functions, autonomy, and their ability to interact meaningfully with loved ones.<sup>120</sup> 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.<sup>121</sup> And 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.<sup>122</sup>

The Eighth Annual Report on Oregon's Death with Dignity Act provides statistics amassed over the eight years during which assisted suicide has been legal in Oregon.<sup>123</sup> In 2005, 39 physicians wrote 64 prescriptions for controlled substances in lethal doses, representing the second decrease in the number of prescriptions written since PAS became legal in Oregon. This follows 60 prescription written in 2004, 68 in 2003, 58 in 2002, 44 in 2001, 39 in 2000, 33 in 1999, and 24 in 1998.<sup>124</sup>

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. In 1999, 27 died; in 2000, 27 died; in 2001, 21 died; in 2002, 38 died; in 2003, 42 died; and in 2004, 37 died (Table 24-1).<sup>125</sup>

Two 2001 deaths resulted from lethal ingestion in December 2000. Three 2003 deaths include two patients who received prescriptions in 2002 and one who received a prescription in 2001. Two 2004 deaths include patients who received prescriptions in 2003. Six 2005 deaths include patients who received prescriptions in 2004.<sup>126</sup>

In 2005, the most frequently reported concerns were: decreasing ability to participate in activities that make life enjoyable (89%), loss of dignity (89%), and loss of autonomy (79%). 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.<sup>127</sup>

The number of terminally-ill patients ingesting lethal medication under the Act has remained small. About one of every 800 deaths among Oregonians in 2004 resulted from physician-assisted suicide.

### SOME FINAL THOUGHTS

More than two centuries ago, Sir William Blackstone observed that "Law is the embodiment of the moral sentiment of the people."<sup>128</sup> The law of assisted suicide blends

Year	Lethal Doses	Patients Died	Deaths/10,000
1998	24	16	5.5
1999	33	27	9.2
2000	39	27	9.1
2001	44	21	7.1
2002	58	38	12.2
2003	68	42	13.6
2004	60	37	12.3
2005	64	38	12.0
totals	390	246	

**Table 24-1** Oregon Death with Dignity Act; Eighth Annual Report

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 assisted suicide's and palliative sedation's morality and wisdom.<sup>129</sup>

The legal issues that surround assisted suicide affect the balance of power between the state and federal governments in the realm of medical practice. Those issues especially concern Oregonians facing critical end-of-life decisions—and health care's lawful role in those decisions.<sup>130</sup> Deep disagreements about the limits of legitimate medical practice and of physicians' conduct pervade medical and medical-ethics communities.<sup>131</sup> For physicians, patients, religious groups, ethicists, philosophers, and legislators, whether Oregon's Death with Dignity Act 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 Oregon's sovereign interests.<sup>132</sup>

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

### Endnotes

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3. *Black's Law Dictionary* 1475 (8th ed. 2004).
4. *Id.*
5. *Id.* at 594.
6. *Id.*
7. Timothy E. Quill & Ira R. Byock, *Responding to Intractable Terminal Suffering: The Role of Terminal Sedation and Voluntary Refusal of Food and Fluids*, 132 *Ann. Intern. Med.* 408 (2000).
8. *Black's Law Dictionary* 644 (8th ed. 2004).
9. *Dent v. West Virginia*, 129 U.S. 114 (1889); *Linder v. United States*, 268 U.S. 5 (1925); H.R. 3, 84th Cong. (1955); H.R. 3, 85th Cong. (1957); H.R. 3, 86th Cong. (1959); *Kelly v. Washington*, 302 U.S. 1 (1937).
10. President's Executive Order on Federalism 13132.
11. *Black's Law Dictionary* 330 (8th ed. 2004).
12. *Id.* at 1448.
13. *Id.* at 293.
14. Glanville Williams, *Learning the Law* 29–30 (11th ed. 1982).

AU: OK to insert Annual Report as Table 24-1?

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23. *Cruzan v. Director, Mo. Dept. of Health*, 497 U.S. 261 (1990); *Black's Law Dictionary* 302 (8th ed. 2004).
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62. 21 U.S.C. § 802; 21 C.F.R. §§ 1306.01, 1306.02, 1306.04 (2002).
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