

PHYSICIAN-ASSISTED SUICIDE: IN DEFENSE OF THE STATUS QUO

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INTRODUCTION

The taking of life is an emotional issue. This is true whether the topic is war, capital punishment, abortion or physician-assisted suicide. People are passionate on both sides of these arguments. Passion has its proper place in our legal system. When channeled correctly with proper restraint, emotion can drive the parties to research the issue at hand, as well as potential alternatives and put forth well-reasoned arguments to support their position. Current law is based upon tradition, precedent and the values to which we hold as a society. Laws should be created by legislators elected by the citizens of each state, and it is the duty of the lawmakers to represent the wishes of those citizens. Those seeking to change a law must meet the burden of proving both a legal right to the change and that the current law fails to adequately protect that right. Those charged with making new law must understand the proper role of precedent, hold proponents of change to their legal burden and faithfully represent the wishes of their citizens.

In June 1997, the United States Supreme Court reversed two circuit court decisions which held that individuals have a general constitutional right to physician-assisted suicide.¹ Almost a decade later, the Court refused to allow the United States Attorney General to interfere with

¹ *Washington v. Glucksberg*, 521 U.S. 702 (1997); *Vacco v. Quill*, 521 U.S. 793 (1997).

Oregon’s administration of its “Death with Dignity Act.”² The result of these decisions is to leave to the individual states whether or not to implement statutes allowing physician-assisted suicide.³ Only two state legislatures have adopted the practice of PAS.⁴ The Oregon Death with Dignity Act⁵ was passed by voters in 1994. The Washington Death with Dignity Act⁶ was passed by voters in 2008. In December 2008, a state district court judge in Montana ruled that mentally competent patients with terminal illnesses have the right to physician-assisted suicide under the state’s

² *Gonzales v. Oregon*, 546 U.S. 243 (2006). The Oregon statute is codified at Or. Rev. Stat. §§ 127.800 - .995 (2005).

³ Ken Levy, *Gonzales v. Oregon and Physician-Assisted Suicide: Ethical and Policy Issues*, 42 *Tulsa L. Rev.* 699, 728 (2007); Kathryn L. Tucker, *In the Laboratory of the States: The Progress of Glucksberg’s Invitation to States to Address End-of-Life Choice*, 106 *Michigan L. Rev.* 1593 (2008); see *Washington*, 521 U.S. at 788.

⁴ It is popular among those favoring PAS to voice loud protestations against the use of the term “physician assisted suicide,” preferring the terms “Assisted Dying” or “Aid in Dying.” Kathryn L. Tucker, *Letter to the Editor: State of Washington, Third State to Permit Aid in Dying*, 12 *Journal of Palliative Medicine* 583 (2009); Rebecca C. Morgan & D. Dixon Sutherland, *Last Rights? Confronting Physician-Assisted Suicide in Law and Society: Legal Liturgies on Physician-Assisted Suicide*, 26 *Stetson L. Rev.* 481 (1996), at n. 1; Sheila A.M. McLean, *Assisted Dying: Reflections on the Need for Law Reform* 12 (2007). Use of the word “suicide” is purportedly confusing, value-based and inappropriate. According to Ms. Tucker, “Terminally ill patients who choose aid in dying are hurt and offended by use of emotionally charged terms such as ‘suicide’ or ‘assisted suicide’ to refer to their choice for a peaceful death.” Tucker, (hereafter *State of Washington*), *supra*, at 583; Kathryn L. Tucker & Fred B. Steele, *Patient Choice at the End of Life: Getting the Language Right*, 28 *Journal of Legal Medicine* 305, 308 (2007). Proponents argue that use of the term “suicide” should be determined by the motive of the actor. “It is important to remember that the reasoning on which a terminally ill person (whose judgments are not impaired by mental disorders) bases a decision to end his or her life is fundamentally different from the reasoning a clinically depressed person uses to justify suicide.” Brief of Amicus Curiae, Coalition of Mental Health Professionals, *Gonzales v. Oregon*, 546 U.S. 243 (2006). According to Morgan and Sutherland, a “suicide risk” is a person who is considered not be in their right mind and who may be able to recover, while a terminally ill patient, with no hope of recovery, is seeking “ultimate exercise of autonomy: the timing, method and moment of death.” Morgan & Sutherland, *supra*, at n.1. “Suicide” is defined as “the intentional taking of one’s life.” “Suicide,” *Dictionary.com Unabridged*. Random House, Inc. 06 Dec. 2009. <Dictionary.com, <http://dictionary.reference.com/browse/suicide>>. *The American Heritage Stedman’s Medical Dictionary* defines “suicide” as “The act or an instance of intentionally killing oneself.” “Suicide.” *The American Heritage Stedman’s Medical Dictionary*. Houghton Mifflin Company. 06 Dec. 2009.<Dictionary.com, <http://dictionary.reference.com/browse/suicide>>. Finally, the Law Dictionary definition is “The intentional killing of oneself.” Since the term is defined as an action, without regard to the mental or physical condition of the actor, this article will use the term “physician-assisted suicide” when referring to the action of an individual taking his or her own life with the assistance of a physician.

⁵ Or. Rev. Stat. §§ 127.800 - .995 (2005).

⁶ Revised Code of Washington (RCW), Title 70, Chapter 70.245 (2009).

constitution.⁷ Even though the United States Supreme Court has held that no such federal constitutional right currently exists, and although no Montana statute or other legal basis supported this ruling, the judge refused to allow a stay of her ruling until it could be reviewed by the Montana Supreme Court.⁸ All forty-eight states, save for Oregon and Washington, have entertained legislation legalizing PAS and each state has rejected the concept.⁹ Since the states may now accept or reject PAS through legislation, lawmakers should look to the citizens who they represent for direction, while being careful to study the history of the controversy, including the controlling Supreme Court decisions and experiences in both domestic and foreign jurisdictions where this practice has been embraced. Conversely, they should be wary of “national” groups who aggressively attempt to impose a minority political agenda.

Proponents of PAS view their position as a progressive, natural evolution whose mainstream acceptance and legalization is inevitable, even in the face of vocal opposition by the American Medical Association.¹⁰ They believe that “contemporary American society” approves of this practice.¹¹ One article claims that there is actually no controversy, but that traditional medical professionals and members of the “Religious Right” “strive to create the impression that there is a

⁷ *Baxter v. State*, No. ADV-2007-787, 2008 Mont. Dist. LEXIS 482, December 5, 2008.

⁸ The judge denied the request of the Attorney General of Montana Steven Bullock to stay the ruling pending appeal in January 2009, stating that to do so “would deny the fundamental right of Montanans to die with dignity for a lengthy period of time while the case is being appealed.”

⁹ See *Washington*, 521 U.S. at 717-18, 723; Levy, *supra* at 728; see also Courtney S. Campbell, *Ten Years of “Death with Dignity,”* 22 *New Atlantis: A Journal of Technology & Society* 33, 37 (2008) for a discussion of why other states are refusing to follow the Oregon experiment.

¹⁰ See Morgan & Sutherland, *supra*, at 481-83.

¹¹ Norman L. Cantor, *On Kamisar, Killing, and the Future of Physician-Assisted Death*, 102 *Mich. L. Rev.* 1793, 1841 (2004).

genuine scientific disagreement in the field that deserves to be aired.”¹² Another proponent suggests that the burden of proving the case against PAS has not been met by opponents and therefore, “[i]f none of the arguments against PAS are strong, then we have no reason not to legalize it.”¹³

It is the universal position of PAS proponents that faith-based morality objections are “without merit” in our “pluralistic society,” concluding that “religious arguments have no place in public policy debates.”¹⁴ Not only are “sanctity of life” arguments seen as “unconvincing,” but PAS is “regarded as a human right within our society” and is “seen as conceptually acceptable.”¹⁵ Proponents are so adamantly opposed to Christian principles being interjected into this debate that their chief legal spokesperson regularly reviles both Catholic and Protestant church leaders, as well as faith-based physicians and other medical professionals who do not share her views.¹⁶

This article will discuss reasons why the status quo in the PAS controversy should be maintained at this time. In support of this position, I will address (1) the legal history of the debate which has resulted in current federal and state laws, (2) the majority view as reflected by the consistent rejection of PAS by citizens, government representatives and professional organizations, (3) the deterioration of safeguards in the Netherlands resulting in involuntary euthanasia and other abuses and (4) the failure of proponents to prove that the rights of the terminally ill can be adequately

¹² Kathryn L. Tucker & Fred B. Steele, *Patient Choice at the End of Life: Getting the Language Right*, 28 *Journal of Legal Medicine* 305, 308 (2007).

¹³ J.M. Dieterle, *Physician Assisted Suicide: A New Look at the Arguments*, 21 *Bioethics* 127, 139 (2007).

¹⁴ *Id.*

¹⁵ Morgan & Sutherland, *supra*, at 514.

¹⁶ Tucker & Steele, *supra*. at 308.

protected under current law. It is not my intention pronounce a final verdict in this debate, nor to discredit the concept or those who support it. Instead, this study is intended to make state legislatures aware of the pressure with which they may be confronted from political activists who currently *discourage* honest dialog, and to encourage state lawmakers to seriously study all facets of the controversy, including current precedents and alternatives available in palliative care. The failure to understand all relevant components of this debate could eventually lead down the slippery slope toward the potential and actual abuses which have followed the adoption of PAS.

Public policy determinations on such critical matters should be reserved to the citizens of the individual states. This article will briefly discuss, and give examples of, judicial activism such as was displayed in Montana. The growing practice of judges who undermine the will of the people for the purpose of furthering their personal political agenda has no place in our legal system.

Finally, this article is meant to encourage honest debate on the subject. Individuals and organizations from both sides should be respected for their views, should respect each other and will hopefully continue to make scholarly, rather than emotional, contributions to this public policy discussion. The most important participants in this controversy are the terminally ill. It is their welfare and safety which should guide us all.

For the purposes of this article, I will apply the following definitions: (1) “Letting die” – sometimes referred to as “passive euthanasia” – The refusal to accept, or withdrawal of, life sustaining treatment; (2) Physician-assisted suicide – Having lethal drugs provided to a competent patient, at the patient’s request, but with no action by a physician or other individual to actively assist in the administration of the drugs which cause the patient’s death; (3) Voluntary Euthanasia – The active assistance by a third party in the administration of the drugs which cause the patient’s death

at the request of a mentally competent patient; and (4) Involuntary Euthanasia – Administration of lethal drugs to end the life of a patient who is not competent or who has not requested to die in such a manner.¹⁷

Parts I and II will review the legal and legislative developments in the PAS debate since 1990. Part III will examine the political activists and the tactics they are using to fuel this controversy. Part IV will define the status quo and explain how this position represents the majority view. The article will conclude with discuss why any change in the direction of PAS would be insupportable, irresponsible and dangerous in light of the documented abuses where PAS has become a way of life – or death.

I. The Legal History

A. The Ninth Circuit

On March 6, 1996, the United States Court of Appeals for the Ninth Circuit reached its decision in *Compassion in Dying v. Washington*.¹⁸ For the first time, a United States Circuit Court held that a competent, terminally-ill, adult patient has a right to the assistance of a physician in committing suicide as a liberty protected by the Fourteenth Amendment Due Process Clause. Specifically, the Court held that a Washington state law which made it a criminal offense for a physician to assist an individual to commit suicide was unconstitutional.¹⁹

¹⁷ See Susan Martyn & Henry J. Borguignon, *Physician-Assisted Suicide: The Lethal Flaws of the Ninth and Second Circuit Decisions*, 85 Cal. L. Rev. 371, 384 (1997); See also Susan Martyn & Henry J. Borguignon, *Physician's Decisions About Patient Capacity: The Trojan orse of Physician-Assisted Suicide*, 6 Psychology, Public Policy and Law 388 (2000) for a discussion of the capacity prong of a voluntary request for PAS.

¹⁸ 79 F.3d 790 (9th Cir.) (en banc), cert. granted sub nom. *Washington v. Glucksberg*, 117 S. Ct. 37 (1996).

¹⁹ Susan R. Martyn & Henry J. Bourguignon, *Physician-Assisted Suicide: The Supreme Court's Wary Rejection*, 31 U. of Tol. L. Rev. 253 (2000).

B. The Second Circuit

Less than a month after the Ninth Circuit decision, on April 2, 1996, a panel of the United States Court of Appeals for the Second Circuit issued its decision in *Quill v. Vacco*.²⁰ Unlike the rationale of the Ninth Circuit, the Second Circuit held that the practice of allowing certain patients to die by the withdrawal of life support while refusing to allow other patients to choose assistance in dying is a violation of persons similarly situated which violates the Fourteenth Amendment Equal Protection Clause²¹. In essence, the Court held that there is no difference between allowing a patient to die naturally by the withdrawal of life support and actively assisting a patient to kill himself.

C. The Supreme Court Decisions

The United States Supreme Court reversed both of these decision in June 1997.²² Although the decisions we comprised of a majority opinion and various concurring opinions, the Court was unanimous in holding that “neither the Fourteenth Amendment’s Liberty Clause nor the Equal Protection Clause provided a general constitutional right to physician-assisted suicide.”²³ Chief Justice Rehnquist wrote the majority opinions in both cases. It is important to note who actually instigated these two cases. According to its website,²⁴ the political activist organization “Compassion in Dying” which later became “Compassion & Choices” as it is known today, began developing the constitutional arguments in Washington and New York in 1994. These were not

²⁰ 80 F.3d 716 (2d Cir.), *cert. granted*, 117 S. Ct. 36 (1996).

²¹ The Equal Protection Clause of the Fourteenth Amendment to the United States Constitution provides that no State shall “deny to any person within its jurisdiction the equal protection of the laws.” U.S. Const. art. XIV, § 1.

²² *Washington*, 521 U.S. 702; *Vacco*, 521 U.S. 793.

²³ *Martyn & Bourguignon*, (hereafter *Wary Rejection*), *supra*, at 254.

²⁴ <http://www.compassionandchoices.org>.

cases brought by terminally-ill citizens who felt that their rights were being violated. Rather, these cases represented legal challenges developed over a period of years and ultimately filed by a political action organization in an attempt to impose its minority view upon the whole of American society.

1. *Washington v. Glucksberg*

Chief Justice Rehnquist delivered the opinion of the Court, in which Justices O'Connor, Scalia, Kennedy, and Thomas joined. The Chief Justice initiates his opinion by stating that all due process cases must begin “by examining our Nation’s history, legal traditions, and practices.”²⁵ He reminds us that “[i]n almost every state -- indeed, in almost every western democracy – it is a crime to assist a suicide.”²⁶ Citing *Stanford v. Kentucky*, he reiterates the Court’s position that “The primary and most reliable indication of [a national] consensus is...the pattern of enacted laws.”²⁷ The Chief Justice summarizes the historical journey by listing the numerous attempts in various states to legalize PAS, all of which have failed, with the exception of the Oregon statute²⁸ and by concluding that our “history, legal traditions and practices” must serve as the Court’s guide when issues of “freedom” and “due process” are presented for determination.²⁹

The constitutional issue in controversy is whether or not the right to commit suicide with the assistance of a physician is a liberty that has some reasonable relationship to a legitimate state interest. In holding that such a liberty does not exist, the Chief Justice asserted, “To hold for

²⁵ *Washington*, 521 U.S. at 710.

²⁶ *Id.*

²⁷ *Id.*, citing *Stanford v. Kentucky*, 492 U.S. 361, 373 (1989).

²⁸ *Id.* at 717.

²⁹ See *Id.* at 710-19; see Martyn & Bourguignon, *Wary Rejection*, *supra*, at 255.

respondent, we would have to reverse centuries of legal doctrine and practice, and strike down the considered policy choice of almost every state.”³⁰ Even if such an interest can be established, competing state interests can mandate the rejection of the current claim. In this case, those interests include (1) the preservation of human life; (2) prevention of suicide – especially in the young, the elderly and those with depression or other mental disorders; (3) protecting the integrity and ethics of the medical profession; and (4) protecting vulnerable groups such as the poor, the elderly and persons with disabilities from mistakes, abuse or neglect.³¹

The Court concludes by arguing that if suicide is protected as a matter of constitutional right, then “every man and woman in the United States must enjoy it.”³² The state may then fear that permitting assisted suicide “will start it down the path to voluntary and perhaps even involuntary euthanasia.”³³

2. *Vacco v. Quill*

Chief Justice Rehnquist also wrote the majority opinion in the Second Circuit case, in which Justices O’Connor, Scalia, Kennedy, and Thomas joined. The basis of the New York argument is that individuals similarly situated have the right to be treated equally. The Court of Appeals held that certain patients have the right to refuse or withdraw life support which will hasten death, but terminally ill competent patients do not have the right under law to have the assistance of a physician when they choose to hasten their death by suicide. This unequal treatment, the Court held, violates

³⁰ Id. at 723.

³¹ Id. at 731-33.

³² Id. at 733; see *Compassion in Dying*, 49 F.3d, at 591.

³³ Id. at 732-33.

constitutional rights under the Equal Protection Clause of the Fourteenth Amendment.³⁴

The Chief Justice distinguished between circumstances which require the Court to give a high level of scrutiny and those which are reviewed on the basis of minimum scrutiny.³⁵ The Court examined the facts in order to determine if the law being challenged is being applied unfairly to a suspect class. Quoting *Romer v. Evans*,³⁶ the Court states, “If a legislative classification or distinction ‘neither burdens a fundamental right nor targets a suspect class, we will uphold [it] so long as it bears a rational relation to some legitimate end.’”³⁷ In finding that “New York’s statutes outlawing assisted suicide affect and address matters of profound significance to all New Yorkers alike,”³⁸ the Court held that the statute in question neither infringed fundamental rights nor involved a suspect class. Accordingly, these laws are therefore entitled to a strong presumption of validity.³⁹ The central issue is whether or not there is a legal distinction between assisting in suicide and withdrawing life-sustaining treatment. The Second Circuit held that there was no distinction.⁴⁰ The Supreme Court disagreed, as it stated “Unlike the Court of Appeals, we think the distinction between assisted suicide and withdrawing life-sustaining treatment, a distinction widely recognized and endorsed in the medical profession and in our legal traditions, is both important and logical; it is

³⁴ See *Quill*, 80 F.3d, at 729.

³⁵ *Vacco*, 521 U.S. at 799.

³⁶ 515 U.S. ____ (slip op., at 10) (1996).

³⁷ *Vacco*, 521 U.S. at 799.

³⁸ *Id.*

³⁹ *Id.* at 799-800.

⁴⁰ *Quill*, 80 F.3d, at 729.

certainly rational.⁴¹

The primary distinctions lie in “intent” and “causation.” In both cases, the physician expects the patient to die; but only in the case of PAS does the physician intend for the patient to die. In PAS, the physician takes action by prescribing a lethal medication in order to help the patient cause her own death, whereas in withdrawing life-sustaining treatment, the cause of death is the underlying disease. Therefore, the patient’s death can be directly attributed to PAS, but it cannot be so attributed by the act of withdrawing life-sustaining treatment.⁴²

3. The Concurring Opinions⁴³

The chief concurring opinion was penned by Justice O’Connor. While she also joined in the Chief Justice’s majority opinions in both cases, she wrote a brief concurring opinion which “highlighted her own reservations about any absolute, definitive constitutional pronouncement on physician-assisted suicide.”⁴⁴ In reserving final judgment on the issue to different facts, she stated:

I join the Court’s opinion because I agree that there is no generalized right to ‘commit suicide.’ But respondents urge us to address the narrower question whether a mentally competent person who is experiencing great suffering has a constitutionally cognizable interest in controlling the circumstances of his or her imminent death. I see no need to reach that question in the context of the facial challenges to the New York and Washington laws at issue here.⁴⁵

⁴¹ *Vacco*, 521 U.S. at 800-01.

⁴² *Id.* at 801. See *Levy, supra*, at 705.

⁴³ The concurring opinions of Justices O’Connor, Stevens, Ginsburg and Breyer address both cases but only appear in *Washington*, 521 U.S. at 736-38.

⁴⁴ *Martyn & Bourguignon, Wary Rejection, supra*. at 258.

⁴⁵ *Washington*, 521 U.S. at 736.

Justice Ginsburg⁴⁶ and Justice Breyer⁴⁷ concurred with the result of the two cases, but for the reasons articulated by Justice O'Connor rather than by Chief Justice Rehnquist in the majority opinion.⁴⁸ In a detailed concurring opinion, Justice Souter concluded that state legislatures, rather than courts, should resolve the issues in the debate over physician-assisted suicide.⁴⁹

Justice Stevens, in a separate concurring opinion, goes farther than any other member of the Court toward potentially recognizing a constitutional right to PAS. He foresees a circumstance where a terminally ill patient may be suffering severe pain which cannot be adequately eliminated by palliative care. In such a case, the state may have an interest in revisiting the issue of whether an assisting physician should be subject to criminal prosecution.⁵⁰

D. The Attorney General Intervention

Oregon became the first state to have its voters approve a ballot measure legalizing PAS in 1994. The statute which was ultimately enacted by the Oregon legislature removed the criminal or civil liability for actions taken by a physician in accordance with the state statute in prescribing lethal doses of drugs to terminally ill patients who request them.⁵¹

In 2001, United States Attorney General John Ashcroft issued what became known as “The Ashcroft Directive” declaring that the Oregon statute was in conflict with the Controlled Substances

⁴⁶ Id. at 789.

⁴⁷ Id. at 790.

⁴⁸ Id. at 789.

⁴⁹ See id. at 788-89.

⁵⁰ See id. at 745-47.

⁵¹ Or. Rev. Stat. §§ 127.800 - .995 (2005).

Act (CSA) and therefore invalid.⁵² He based his directive upon two grounds:

1. A 1971 regulation which stated in part: “A prescription for a controlled substance to be effective must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice;”⁵³ and
2. A 1984 amendment to the CSA which authorized the Attorney General to revoke the a physician’s prescription privileges if it was determined that said physician’s actions were “inconsistent with the public interest.”⁵⁴

Upon challenge in an Oregon federal court, Judge Robert E. Jones entered a permanent injunction against enforcement of the Ashcroft Directive on April 17, 2002. When a divided panel of the Ninth Circuit Court of Appeals affirmed the injunction on May 26, 2004, the Attorney General appealed the decision to the United States Supreme Court.⁵⁵

On January 17, 2006, The Court affirmed the Court of Appeals decision. Justice Kennedy wrote the majority opinion for a divided court.⁵⁶ The majority held that the CSA does not apply to substances prescribed for the purposes of PAS. While stating that one reasonable interpretation of the purpose of medicine is to heal, Justice Kennedy implied that medicine may have other purposes as well. In his detailed analysis of the Gonzales case, Ken Levy summarizes the short-comings of the majority opinion as follows:

Justice Kennedy, then, conceded that one “reasonable” interpretation of the purpose of medicine is to heal, which includes preventing, curing, and curbing illness,

⁵² 66 Fed Reg. 56607-56608 (Nov. 9, 2001).

⁵³ 21 C.F.R. § 1306.04(a).

⁵⁴ 21 U.S.C. § 824(a)(4). For an excellent discussion of the Ashcroft Directive, see Levy, *supra*. at 710-11.

⁵⁵ John Ashcroft was succeeded as United States Attorney General by Alberto R. Gonzales on April 10, 2004.

⁵⁶ *Gonzales v. Oregon*, 546 U.S. 243 (2006).

disease, and injury. But implicit in Justice Kennedy’s expression “one reasonable understanding of medical practice” were the assumptions that, in addition to healing, medicine may serve another reasonable purpose, and physician-assisted suicide may be consistent with this other purpose. Unfortunately, Justice Kennedy failed to explain what this alternative legitimate medical purpose might be. Moreover, Justice Kennedy failed to explain how it might be the case that physician-assisted suicide does not threaten the public health and safety and is thereby consistent with the public interest.⁵⁷

Justice Scalia, joined by Chief Justice Roberts and Justice Thomas, wrote a dissent in which he gave detailed support for the proposition that the Attorney General’s interpretation of the CSA is entitled to deference. He followed his “deference” argument by detailed, historical definition of the purpose of medicine, which has, from the time of Hippocrates to the present, been solely to heal.⁵⁸

It seems ironic that the federal government would so blatantly ignore the clear intent of the Supreme Court as stated in *Washington* and *Vacco*⁵⁹ that the individual states are free to adopt whatever statutes they choose regarding PAS, so long as federal protections are not violated. Those of us who are proponents of state’s rights should support the result in *Gonzales*, irrespective of our personal feelings regarding the legitimacy of the underlying statute.⁶⁰

⁵⁷ Levy, *supra.*, at 711-12.

⁵⁸ *Gonzales*, 546 U.S. at 286 (Scalia, J., joined by Roberts, C.J. & Thomas, J., dissenting).

⁵⁹ *Washington v. Glucksberg*, 521 U.S. 702 (1997); *Vacco v. Quill*, 521 U.S. 793 (1997).

⁶⁰ I do not believe that the Attorney General should have attempted to interfere with the implementation of a statute legally adopted by a state, unless the statute clearly violates the federal constitutional rights of the citizens who will be affected by its administration. The Attorney General did not assert this position. Rather, he chose to enforce his interpretation of a provision of the Controlled Substances Act which he alleged would be violated if the Oregon Dignity Act was permitted to take effect. Once the case was filed, however, the judges and justices hearing the case were bound to follow existing constitution law. Justice Scalia’s reasoning in his application of mandatory deference under *Chevron U.S.A. Inc. V. Natural Resources Defense Council, Inc., et. al.*, 467 U.S. 837 (1984) and “legitimate medical purpose” was the most persuasive position and should have been the ruling of the Court. In *Chevron*, the Court held that the government’s interpretation of a federal statute must be given deference where the legislative history of the statute is silent as to the instant issue, if that interpretation is a “permissible construction” of the statute. Using historical legal foundation, plus the current position of the American Medical Association, both of

II. The Legislative History

A. Oregon

In November 1994, the voters of Oregon approved Measure 16, which became “The Death with Dignity Act.”⁶¹ Litigation to repeal the Act ensued, but was defeated. The law became effective in November 1997 and began operation in 1998. The first reported deaths under the Act took place in 2008.⁶²

The provisions of the statute require (or allow, as the case may be) the following:

1. An adult;
2. Who is capable;
3. Is a resident of Oregon;
4. Who has been determined by attending and consulting physician;
5. To be suffering;
6. From a terminal disease;
7. And who has expressed his or her wish to die;
8. Voluntarily;
9. May make a written request;
10. For medication;
11. For the purpose of ending his or her life.⁶³

As a former criminal prosecutor, I would argue that each of the foregoing elements, defined and applied separately, must be met in order to validly comply with the statute. However, most commentators apply a five-part test to assure a right to physician-assisted suicide; applicable only

which directly supported the government’s interpretation of the CSA provision in question, Justice Scalia argued convincingly that the Attorney General should prevail as a matter of constitutional construction.

⁶¹ Or. Rev. Stat. §§ 127.800 - .995 (2005).

⁶² See report of the Oregon Department of Human Resources issued in February 1999. For an excellent detailed analysis of the first documented case, see Susan Martyn & Henry J. Bourguignon, *Now is the Moment to Reflect: Two Years of Experience with Oregon’s Physician-Assisted Suicide Law*, 8 University of Illinois Elder Law Journal 1 (2000), at 4-7.

⁶³ The original statute was codified at Or. Rev. Stat. § 127.805 (1997).

for: (1) a competent or “capable” person, (2) who voluntarily seeks help in dying, (3) is terminally ill, (4) is suffering, and (5) receives assistance from a physician in dying.⁶⁴ Opponents take the position that a careful analysis of the five elements of the Oregon law “demonstrates that each is not a fixed line, but rather a continuum” which “calls for a subjective assessment by the physician.”⁶⁵

It has been more than ten years since the Oregon statute was first utilized as an authorization of death. While proponents of the law claim that the experiment has been a success,⁶⁶ opponents claim that the provisions of the laws are unenforceable and have been abused without adequate government oversight and reporting.⁶⁷

B. Washington

The voters of the state of Washington approved Measure 1000 (I-1000) on November 4, 2008. This law was “modeled on a virtually identical measure approved by Oregon voters in 1994.”⁶⁸ The similarities in the statutes should come as no surprise since the same organization has been responsible for not only spearheading the legislation in each separate state, but has also filed the lawsuits in each case discussed thus far in this paper.⁶⁹ The same organization filed suit in Montana and was ultimately successful in by-passing that state’s democratic legislative process, as will be discussed later. The Washington statute is codified as *Revised Code of Washington (RCW)*, Title

⁶⁴ Martyn & Bourguignon, *Two Years of Experience*, *supra*, at 8.

⁶⁵ *Id.*

⁶⁶ Kathryn L. Tucker, *U.S. Supreme Court Ruling Preserves Oregon’s Landmark Death with Dignity Law*, 2 NAELA Journal 291, 294-97 (2006); see Dieterle, *supra*, at 139.

⁶⁷ Martyn & Bourguignon, *Two Years of Experience*, *supra*. at 8; Campbell, *supra*, at 43-46.

⁶⁸ Kathryn L. Tucker, *The Washington State Death with Dignity Act*, 21 NAELA News (No. 1) 13 (2009).

⁶⁹ “Compassion in Dying” which later became “Compassion & Choices.” Their website appears at <http://www.compassionandchoices.org>.

70, Ch. 70.245.

C. Montana

In the same manner that Oregon and Washington should be commended for following the proper procedure to implement a law which is apparently the desire of the voters, the actions of the state court judge who approved PAS in Montana by unilateral edict expose one the worst, and certainly the most dangerous, abuses existing in our judicial system today. Over the past few years, examples having increasingly surfaced where rulings of activist judges impose their personal political agendas with little or no precedential support. These decisions are not limited to judges generally classified as “liberal” or “conservative” but have appeared in both extremist camps. While the rulings of liberal judges make more headlines, thanks in no little part to Bill O’Reilly and Rush Limbaugh, Republican judges have plundered long-standing legislation in furtherance of their personal views as well.

Two recent Texas cases illustrate the scourge of judicial activism:

1. In a 2007 federal bankruptcy case in Texas, a Houston Bush-appointee, Judge Jeff Bohm, ruled that the Texas statute which protects all IRA’s from creditor claims did not actually mean IRA’s inherited by parties other than the employee’s spouse.⁷⁰ Federal judges are required to follow the laws of the state where they are sitting, unless a federal law preempts the particular law of the state in question. The Texas statute⁷¹ in question is unquestionably clear in its language. In his opinion, the Court admits, “The plain language of § 42.0021 of the Texas Property Code appears

⁷⁰ *In re Jarboe*, 365 B.R. 717 (Bankr. S.D. Tex. 2007).

⁷¹ Tex. Prop. Code, § 42.0021(a).

to demonstrate that any IRA is presumptively exempt.”⁷² Citing the Fifth Circuit⁷³ He further concedes, “Texas has a longstanding rule of liberal construction of exemption statutes in favor of the debtor.”⁷⁴ Irrespective of the unambiguous statutory language supported by decades of historical interpretation, this federal judge ruled that “inherited individual retirement accounts” are not really retirement accounts, in his opinion, and thus overturned all previous Texas rulings to the contrary.

2. In October 2009, Judge Tena Callahan of the 302nd Family District Court of Dallas County, Texas ruled that she would hear the “divorce” case of two men married in the state of Massachusetts. By agreeing to hear this case, Judge Callahan decided to hold as unconstitutional the Texas’ ban on same-sex marriage. By more than a 75% margin, Texas voters had recently adopted a state constitutional amendment which define marriage as an institution involving one man and one woman.⁷⁵ The Texas Attorney General and Governor of Texas blasted the ruling and began the process to appeal the decision. Callahan defended her actions by stating, “My dad always used to tell me that a billion people can believe in a bad idea and it’s still a bad idea.”⁷⁶ This judge made her decision based solely upon her own person feelings and political agenda.

Justice Antonin Scalia has characterized judicial activism as courts getting involved in the

⁷² *Jarboe*, 365 B.R. at 718.

⁷³ *Walden v. Mcginnes*, 12 F. 3d 445 (5th Cir. 1994), quoting *Hickman v. Hickman*, 149 Tex. 439, 443-44, 234 S.W. 2d 410 (1950).

⁷⁴ *Jarboe*, 365 B.R. at 719.

⁷⁵ Texas Constitutional Proposition 2 (2005).

⁷⁶ Dallas Divorce Law Blog, Dallas Judge Tena Callahan Speaks Publicly For The First Time Since Her Controversial Ruling, <http://www.dallastxdivorce.com> (Posted Oct. 23, 2009).

“culture war” and states that the Court should take no part in such debates.⁷⁷ In *Washington, Vacco* and *Gonzales*, the Supreme Court sent the clear message that there is currently no federally protected constitutional right to PAS and it is up to the legislatures of the various states to accept or reject the practice for the citizens within its borders. Oregon and Washington did so. Montana did not.

On December 5, 2008, Montana State District Judge Dorothy McCarter issued a summary judgment declaring that the citizens of Montana have a constitutional right to PAS.⁷⁸ This holding, which had no prior basis in Montana law and was opposed by the state attorney general, is an example of a judge implementing her own political agenda. Any doubt regarding her motives disappeared when she denied the attorney general’s request for stay pending appeal to the Montana Supreme Court. The AG’s concern is that the Court’s ruling is unenforceable, since it fails to define what the terms “mentally competent” and “terminal illness” actually mean under the law.⁷⁹

Whose rights were being violated by Montana’s law against PAS? Who was pushing this fight to establish the constitutional right for the people of Montana? The citizens of Montana? The physicians of Montana? According to Kathryn L. Tucker⁸⁰ of Compassion & Choices in Portland, Oregon, her group filed the suit.⁸¹ Do the people and physicians of Montana even want such a law? Not according to the Montana Medical Association. Dr. Kirk Stoner, president of the Montana

⁷⁷ See Justice Scalia’s dissent in *Romer v. Evans*, 517 U.S. 620 (1996), joined by Chief Justice Rehnquist and Justice Thomas. Justice Scalia concludes, “Today’s opinion has no foundation in American constitutional law, and barely pretends to.”

⁷⁸ *Baxter v. State*, No. ADV-2007-787, 2008 Mont. Dist. LEXIS 482, December 5, 2008.

⁷⁹ Amednews.com, Montana judge rejects stay of physician-assisted suicide ruling, <http://www.amednews.com> (Posted Jan. 29, 2009).

⁸⁰ Director of Legal Affairs, Compassion & Choices, Portland, Oregon.

⁸¹ Tucker, *Washington State DDA*, *supra*, at 15.

Medical Association states that PAS goes against the group’s code of ethics.⁸² Dr. Stoner explained further: “The Montana Medical Association does not condone the deliberate act of precipitating the death of a patient, and does not accept the position that death with dignity may be achieved only through physician-assisted suicide.”⁸³ Montana bioethicist Wesley J. Smith praised the Montana Medical Association for “refusing to cooperate with the suicide agenda,” stating his belief that PAS proponents have twisted the meaning of the Hippocratic Oath to defend their position.⁸⁴

The Baxter case was argued before the Montana Supreme Court on September 2, 2009. Lead counsel before the Court was Kathryn L. Tucker of Compassion & Choices. If the state of Montana has chosen to outlaw PAS; and if the state’s elected law enforcement officials are appealing the Court’s ruling; and if the doctors of Montana do not want this law implemented, then whose political agenda is being pushed upon the citizens of Montana? Which state is next?

III. The Extremists

It is the intention of this article to follow in the sacred tradition of Bill O’Reilly – to be “fair and balanced.” Therefore, it is recognized that there are individuals and organizations with extremist viewpoints on both sides of the PAS controversy. While some discussion will be devoted to the positions of the “far right,” this article stands for the proposition that proponents of extreme minority political views should not be allowed control and reshape law and public policy by imposing their agenda on the majority of citizens. The legal history of cases thus far discussed demonstrates that one organization is the driving force behind attempts to change long-standing legal policy at both

⁸² LifeSiteNews.com, Montana Doctors Refuse to Participate in Assisted Suicide, <http://www.lifesitenews.com> (Posted April 7, 2009).

⁸³ Id.

⁸⁴ Id.

the state and federal levels.

It is important to recognize and appreciate the difference between organizations which *instigate* change and those which *oppose* change. If not for the force with which the instigators attempt to impose their far left political agenda, those responding to such actions might remain in a more dormant state. It does not matter to PAS proponents that few people actually share their view of the issue.⁸⁵ Irrespective of this minority opinion, some promote the position that those who “oppose expansion of patient self determination at the end of life” should have no voice in matters involving public policy.⁸⁶

A. The Extreme Right

There are organizations who believe that it is wrong to take any action which will hasten or allow natural death whenever any means are available which will preserve life. This became evident during the Terry Schiavo case in Florida. Many people expressing their views in support of Ms. Schiavo continuing struggle seemed to have little understanding of the facts or the issues. Any group whose agenda includes the continuation of life irrespective of the circumstances is supporting an extreme minority viewpoint. As a result of the prime time Fox News coverage of the Schiavo case, there was a renewed interest in the public to obtain “living wills.”⁸⁷ I have been counseling clients and implementing living wills since the mid-1980's. It is not unusual for me to write 500 during the course of a year. During the past 25 years, I have had exactly one client choose to be kept alive by

⁸⁵ See Tucker, *Medical Right, supra*.

⁸⁶ *Id.*

⁸⁷ The term “living will” is a generic reference to an Advanced Medical Directive which addresses end-of-life wishes should the need arise. In Texas, this document, as amended in 1999, is entitled “Directive to Physicians and Family or Surrogates.” Every state has now adopted a format for the advanced medical planning of its citizens.

any means available.⁸⁸ Clients routinely inquire about obtaining advanced medical directives during the course of estate planning conferences.⁸⁹ The Schiavo case is discussed at my office in most every client meeting. That case illustrated exactly what clients do *not* want to happen at the end of their lives. Any political agenda opposing the option to withhold or withdraw life sustaining treatment is minority view shared by very few, in my experience.⁹⁰

The role of these groups appears to be more defensive than offensive. Rarely do we see the Family Research Council, National Right to Life Committee or the Christian Medical and Dental Society instigate litigation for the purpose of imposing its views on the general population. Such groups appear in opposition to actions initially taken by groups who seek to alter the status quo in their favor through the filing of lawsuits and voter initiatives.

A serious departure from this conclusion occurred when the United States Attorney General wrote, and subsequently attempted to enforce, the Ashcroft Directive.⁹¹ The Supreme Court's opinions in *Washington* and *Vacco* had foreclosed the federal issue of a constitutional right to PAS and had clearly left further action within the prerogative of the state legislatures to accept or reject the practice. The voters of Oregon had passed their Dignity Act several years before and had reject a referendum to overturn it. Accordingly, the state of Oregon had followed the lead of the Court.

⁸⁸ This particular client did not get along well with her spouse and stated her concern that he would take the first available opportunity to "pull the plug." I suggested that she not name her husband as her financial power of attorney agent and immediately review her life insurance beneficiary designations.

⁸⁹ I discuss advanced medical directives at virtually every estate planning and elder law office conference. Since the subject of medical directives is the last of my three basic topics (Wills, Powers of Attorney and Advanced Medical Directives), clients often inquire about them earlier in the meeting.

⁹⁰ For an excellent, scholarly discussion of the Schiavo case and related issues, see D. Dixon Sutherland, *From Terri Schiavo Toward a Theology of Dying*, in *Resurrection & Responsibility* 225 (Keith D. Dyer and David J. Neville ed., 2009).

⁹¹ See *supra*. pp. 10-13.

Whether or not a valid, legally supportable argument in support of the Ashcroft Directive can be made, the move was ill-advised. This action constituted an irresponsible and unwelcome intrusion into the business of a sovereign state by a federal administration attempting to impose its value-based agenda where the citizens had already spoken. The role of the federal government is to follow and implement the will of the people and not *visé versa*.

B. The Extreme Left

In the months following its passage in 1994, many believed that there would be “a demographic migration of near-death patients to Oregon” and that Oregon would become the “suicide center” for the terminally ill.⁹² The Oregon Death with Dignity Act was believed to be the national model for other states which would certainly rush to pass similar statutes in order to properly deal with the needs of terminally-ill patients. It didn’t happen. Proponents attempted to legalize PAS in California, Hawaii, Maine, Vermont, Connecticut, Wisconsin, Arizona and Pennsylvania. All efforts failed as one state after the next refused to adopt this practice. These are the bluest of the “blue states” and yet even their liberal populations did not buy into the PAS agenda.⁹³

Within a few years after the Supreme Court holdings in *Washington* and *Vacco*,⁹⁴ the volume of academic literature being published on PAS began to decline sharply. Authors who had been passionate about the issue turned to other topics, obviously believing that the Supreme Court had

⁹² Campbell, *supra*, at 36.

⁹³ See Raphael Cohen-Almagor, *The Right to Die with Dignity: An Argument in Ethics and Law*, Health Law & Policy, Spring 2008, available at: <http://ssrn.com/abstract=1292302>, where he states at 3: “Most if not all 50 states in the United States had, at some point or another, initiatives to legislate end-of-life mechanisms. All such laws, with the exception of one, have failed.”

⁹⁴ Both cases were decided in 1997.

given the last word, at least for the time being.⁹⁵ Ironically, even PAS proponents who published after 1997 did not necessarily endorse the Oregon model.⁹⁶ Reports of PAS abuses began to surface from the Netherlands and caused some to re-evaluate their position.⁹⁷ In 2008, ten years after the Oregon statute was implemented, Professor Campbell concluded: “For one reason or another, an act like Oregon’s may not be necessary or feasible for many states.”⁹⁸ As a professor at Oregon State University, Ms. Campbell was in a unique position to observe academic sentiment in the years following the passage of the Oregon statute. She states that interest in the subject declined so dramatically that her law students no longer favored PAS as a term paper, with selection of the topic dropping from 30 percent to 3 percent. What was once considered to be a “burning issue” and a “hot topic” for debate, gradually reached the point of eliciting a “ho-hum” in the newspaper.⁹⁹

While most were losing interest, Compassion in Dying based in Portland, continued to aggressively push for the legalization of PAS. According to its website, Compassion in Dying was founded in 1993 “to provide support and advocacy programs for the terminally ill in Washington state.”¹⁰⁰ In 1997, the Compassion in Dying Federation was formed for the purpose of “expanding

⁹⁵ Susan Martyn, Stoepler Professor of Law and Values at the University of Toledo College of Law, published four scholarly works, previously cited herein, analyzing in depth the Second and Ninth Circuit PAS decisions, the Supreme Court decisions in *Washington* and *Vacco*, and capacity issues in the Oregon Dignity Act. I recently contacted Professor Martyn to inquire if she had written further on the issue since 2000. She responded that she had not, but that she had turned her attention to issues in legal ethics. Professors Rebecca Morgan and D. Dixon Sutherland of Stetson University College of Law wrote a comprehensive article on PAS in 1996 which included a potential “Model Statute” for consideration by states wishing to legalize the practice. They did not write further on the subject. But see reference to Sutherland *Schiavo* article *supra*, at n. 88.

⁹⁶ Levy, *supra*, at 728.

⁹⁷ Cohen-Almagor, *supra*, at 5.

⁹⁸ Campbell, *supra*, at 37.

⁹⁹ *Id.* at 46.

¹⁰⁰ <http://www.compassionandchoices.org>.

to launch national advocacy and support programs. The Hemlock Society was founded in 1980. In 2003, the Hemlock Society changed its name to End-of-Life Choices. In 2005, Compassion in Dying and End-of-Life Choices merged to become Compassion & Choices (hereafter “C/C”) with headquarters in both Denver and Portland, Oregon.¹⁰¹

C/C is an advocacy group who champions the cause of PAS. According to Kathryn Tucker, its Director of Legal Affairs, this group began developing the legal cases which ultimately became *Washington* and *Vacco* in 1994. C/C (under its predecessor name) was both a named plaintiff and lead counsel. When it failed in its goal of establishing a constitutional right to PAS at the federal level, C/C took to the states.¹⁰² It was 14 years after the passage of the Oregon Dignity Act before the voters of a second state approved a similar measure. C/C was instrumental in the passage of I-1000 in Washington which was virtually identical to the Oregon Dignity Act. C/C then developed, filed and prosecuted the case of *Baxter v. State of Montana* which resulted in the unilateral proclamation by a Montana state judge that PAS is now legal in Montana.¹⁰³

The most unfortunate part of this debate is the manner in which C/C consistently attack the credibility of those who oppose its views. Legal counsel for C/C has written extensively in support of her organization’s position on PAS. At least a dozen of her articles and commentaries are cited in this article. The extent of the scholarship demonstrated by her publications is commendable and should be encouraged from all of those who seek to influence public policy. However, as years have

¹⁰¹ Id.

¹⁰² Kathryn L. Tucker, *The Chicken and the Egg: The Pursuit of Choice for a Human Hastened-Death as a Catalyst for Improved End-of-Life Care; Improved End-of-Life Care as a Precondition for Legalization of Assisted Dying*, 60 NYU Annual Survey of American Law 355, 369-70 (2004).

¹⁰³ See discussion *supra*, at IIC.

gone by without significant success in state legislatures and the courts, C/C articles have become more conclusory and emotional, including personal attacks against the Catholic Church, Evangelical Churches, disability groups, conservative foundations, conservative lawmakers, Catholic medical groups, Christian medical and dental groups and a list of individuals described as “[e]xperts [who] are critical to the Medical Right’s propagation of its ideology.”¹⁰⁴ Several articles and “Letters to the Editor” to various professional journals are critical of anyone who uses the term “physician-assisted suicide” claiming that those who do so are failing to use “accurate, value-neutral terminology.”¹⁰⁵

Of particular concern is the consistent self-proclaimed position that C/C represents the interests of the terminally-ill, as though terminally-ill patients are a class of individuals who all share the same viewpoint.¹⁰⁶ Such a claim might have some validity if C/C was an organization of which the terminally-ill were voluntary members by individual application, but this is not the case. Scholarly articles analyzing the first several years of the Oregon statute concede that [d]eath with dignity is the death of choice for relatively few persons.”¹⁰⁷

IV. Maintaining the Status Quo

A. What is Status Quo?

At this point in time, the status quo seems to be relatively clearly defined. In *Washington* and

¹⁰⁴ Tucker, *Medical Right*, *supra*, at 6-13; Kathryn L. Tucker, *The Chicken and the Egg: The Pursuit of Choice for a Humane Hastened-Death as a Catalyst for Improved End-of-Life Care - Improved End-of-Life Care as a Precondition for Legalization of Assisted Dying* (September, 23 2008). NYU Annual Survey of American Law, Vol. 60, No. 355, 2004. Available at SSRN: <http://ssrn.com/abstract=1272827>.

¹⁰⁵ See *supra*, n. 4 at 1-2.

¹⁰⁶ Kathryn L. Tucker, *Ensuring Informed End-of-Life Decisions*, 12 *Journal of Palliative Medicine* 119, 119 (2009).

¹⁰⁷ Campbell, *supra*, at 36.

Vacco, the Supreme Court refused to recognize a constitutional right to PAS under the Due Process Clause or the Equal Protection Clause of the Fourteenth Amendment. In the 13 years since those cases were decided, no serious attempt has been made to reverse that position or establish such a right under any other constitutional theory. In *Gonzales*, the Supreme Court reaffirmed the rights of a state to adopt a statute implementing PAS.

Only two of 50 states have voted to adopt PAS. While efforts have been made to legalize the practice in most of the other states, these efforts have failed. In Montana, where PAS has been “approved” only by judicial order, the state government is challenging the validity of the Court’s ruling and that case is currently on appeal in the Montana Supreme Court.

B. What Defines the Status Quo?

The status quo is defined by current laws, established upon the history, traditions and values which formed the basis for the laws. In *Washington*, Chief Justice Rehnquist examines “our Nation’s history, legal traditions, and practices” with regard to assisted suicide.¹⁰⁸ He then goes back “over 700 years” to examine “the Anglo-American common-law tradition” disapproving of both suicide and assisted suicide.¹⁰⁹ He concludes that “[t]hough deeply rooted, the States’ assisted-suicide bans have in recent years been reexamined and, generally, reaffirmed.”¹¹⁰

C. The Difference Between Killing and Letting Die

¹⁰⁸ *Washington*, 521 U.S. at 710.

¹⁰⁹ *Id.* at 711. Over the course of several pages, the Chief Justice actually goes back as far as the year 673 and outlines relevant laws and traditions throughout the centuries.

¹¹⁰ *Id.* at 716. In his final pronouncement before moving to the specific constitutional challenge before the Court, the Chief Justice states: “Despite changes in medical technology and notwithstanding an increased emphasis on the importance of end-of-life decisionmaking, we have not retreated from this prohibition.”

The right to refuse life sustaining treatment was established in *Cruzan*.¹¹¹ Practically every work day of the year, a client executes a “living will” in my office, exercising her rights to refuse such treatment under the *Texas Natural Death Act*.¹¹² Given the validity of this universally accepted right, it would follow that PAS proponents could move much closer to their goal if they could eliminate the difference between hastening natural death by refusing or removing life sustaining treatment and assisting a patient with the specific means to cause immediate death. This was the argument urged by PAS proponents in *Vacco*.¹¹³ The Court began by distinguishing the rights of citizens with regard to the two practices: “*Everyone*, regardless of physical condition, is entitled, if competent, to refuse unwanted lifesaving medical treatment; *no one* is permitted to assist a suicide.”¹¹⁴ The gist of the Court’s holding on the issue is as follows:

The distinction comports with the fundamental legal principles of causation and intent. First, when a patient refuses life-sustaining medical treatment, he dies from an underlying fatal disease or pathology; but if a patient ingests lethal medication prescribed by a physician, he is killed by that medication.¹¹⁵

Both proponents and opponents of PAS alike have written extensively on whether there is a distinguishable difference between killing and letting die.¹¹⁶ Indeed, the Second and Ninth Circuits have held that there is no such difference. But as federal courts of appeals, they are bound by the U.S. Constitution and the ultimate interpretation of such laws by the Supreme Court. With the

¹¹¹ *Cruzan*, 497 U.S. at 269.

¹¹² *Texas Health & Safety Code*, § 166.031 ff (2009).

¹¹³ *Vacco*, 521 U.S. at 800.

¹¹⁴ *Id.* at 841.

¹¹⁵ *Id.* at 842.

¹¹⁶ Martyn & Bourguignon, *Lethal Flaws*, *supra*, at 385-90; Morgan & Sutherland, *supra*, at 515-16; Levy, *supra*. at 717-18.

reversals in *Washington* and *Vacco*, the legal positions held by the Second and Ninth Circuit Courts of Appeals in the underlying cases before the Court were invalidated.

D. Who Bears the Burden of Proof When Seeking Change?

Perhaps the most fundamental difference in the PAS controversy is the reasoning behind the call for change. Who bears the “burden of proof?” This is certainly not a new concept. The push for change seems to have escalated since the 1960's. Some changes were necessary and reaped a positive reward. Some changes have caused serious problems. In the political arena, change is often about increased freedom. For better or for worse, with increased freedom comes less restraint. It goes without saying that those classified as “conservatives” usually favor tradition and the status quo, while “liberals” favor expanding individual freedoms which quite often requires changes in the law.

Few would argue that the status of race in the 1960's called for change which has been implemented with generally positive results. Conversely, however, demands for acceptance of relatively unrestrained sexual freedom and federal protection of rights to control reproductive choices has led to the AIDS epidemic, abortion on demand, the fight over same-sex marriage and similar issues which have sharply divided the country. Just one year ago, a slight majority of the electorate adopted “Change we can believe in” as a slogan designed to reflect their desire for abandoning the status quo in favor of “change” offered by the Democrats. Now, 12 months into the new administration, the President has the lowest approval rating in history for the first year after taking office and the country is facing debt never before experienced in America.

History has shown that those demanding change often have little concept of what the results of implementing that change will be – they see the short-term benefits of what they want, but fail to comprehend what the long-term holds. It is not surprising, therefore, that Supreme Court Justices

regularly go to great length to explain the history and tradition behind the laws being challenged. Even on the Court, the philosophical differences are sharply divided between the so-called liberals and conservatives. One can usually know the outcome of a case by which Justice wrote the majority opinion. Quite often, the most publicized cases are where some group or legal organization is suing to have change in the law expanding the rights of a class of individuals.

In the case of PAS, there is sharp division on the issue of who bears the burden. This is not usually the case and should not be here. A proponent of changing a law should bear the burden of proving why the current law violates his rights, or how his rights are not adequately protected by existing law. To the proponents, PAS is simply a basic human right that everyone should enjoy, generally “seen as conceptually acceptable.”¹¹⁷ They charge that no actual controversy exists, but that the debate is fiction, kept alive by the “Medical Right,” the “Religious Right,” “some disability groups” and “the Catholic Church.”¹¹⁸ Accordingly, unless opponents can adequately demonstrate why the PAS should not be approved, then the law should be changed. As one writer argues, “Ultimately, I conclude that no anti-PAS argument has merit. Although I do not provide positive arguments for PAS, if none of the arguments against it are strong, we have no reason not to legalize it.”¹¹⁹

Our legal system does not work that way. The party asserting the right has the burden of proving all of the requisite elements. It should be no different with the PAS debate. While everyone has the right to assert their political beliefs, in order to change the status quo – that is, existing law

¹¹⁷ Morgan & Sutherland, *supra*. at 514.

¹¹⁸ Tucker, *Medical Right*, *supra*. at 13-14.

¹¹⁹ Dieterle, *supra*. at 139.

– proponents of the new position must prove how current law infringes upon an entitled right and how such right is not currently protected under existing law. There is no federally protected right to PAS under current law. Proponents must promote change at the state level. Thus far, 48 of 50 states do not agree that PAS is a basic right which should be universally protected. State lawmakers must require proponents to meet the proper burden of proof before considering a change in the status quo.

E. Concerns Regarding Implementation of PAS

There are three distinct arguments against PAS: (1) Concerns regarding potential future consequences; (2) Concerns regarding the adequacy of current protections under the Oregon Dignity Act; and (3) Concerns regarding reported abuses in The Netherlands. I will not discuss the first category since such concerns are speculative. As one writer states: “These arguments rely on empirical claims about the future and thus their strength depends on how likely it is that the predictions will be realized.”¹²⁰ Numerous scholarly works from both proponents and opponents alike discuss these concerns at length.¹²¹ These arguments should not be disregarded, but rather they should be studied and accorded proper weight, given the limited data currently available in their support.

1. Concerns regarding the adequacy of current protections under the Oregon Dignity Act

Not surprisingly, there is no agreement on the current status of the Oregon Dignity Act.

¹²⁰ Dieterle, *supra.* at 127.

¹²¹ Levy, *supra.* at 723-29; Campbell, *supra.* at 43-46; Dieterle, *supra.* at 128-36; Cantor, *supra.* at 9-13; See Morgan & Sutherland, *supra.*; See Daniel Gilman, *Thou Shalt Not Kill as a Defeasible Heuristic: Law and Economics and the Debate Over Physician-Assisted Suicide*, 83 Or. L. Rev. 1239 (2004).

Proponents claim great, overwhelming victory with no problems.¹²² Based upon this success, they argue that all states should line up and follow suit. Others do not share this view.¹²³ Primary objections point to (1) inadequate protections in the statute and (2) inadequate reporting of the administration of PAS as required under the law.

Two articles cited in this paper analyze administration of the Oregon statute. One was written two years after the new law went into effect¹²⁴ while the other, whose author is a law professor in Oregon, was published after 10 years of operation.¹²⁵ Although written eight years apart, both articles express similar concerns – ambiguity in the Oregon statute’s terminology which may lead to abuses. Professor Martyn discusses the first documented case of PAS under the Dignity Act.¹²⁶ She relates how the patient was initially determined by her physicians to be depressed and her decisionmaking impaired. One physician indicated that the patient was not bedridden, not suffering great pain and generally able to take care of herself. Since these fact would not qualify the patient under the terms of the statute, Compassion in Dying referred to her to a team of new physicians who declared that she was not, in fact, depressed and qualified for PAS under the Oregon statute. The patient was provided with lethal drugs and took her own life. Could this be construed

¹²² Tucker, *Death with Dignity Act, supra.* at 294-97; Cohen-Almagor, *supra.* at 7; Dieterle, *supra.* at 189; McLean, *supra.* at 178.

¹²³ Campbell, *supra.* at 43; Levy, *supra.* at 728; See Gilman, *supra.* at 57-58; Martyn & Bourguignon, *Moment to Reflect, supra.*

¹²⁴ Martyn & Bourguignon, *Moment to Reflect, supra.*

¹²⁵ Campbell, *supra.*

¹²⁶ Martyn & Bourguignon, *Moment to Reflect, supra.* at 4-8. See Herbert Hendin et al., *Physician-Assisted Suicide: Reflections on Oregon’s First Case*, 14 *Issues L. & Med.* 243-246.

as “Shopping for Suicide?”¹²⁷ Certainly this is not what the statute intends.

The study of elder law clear indicates that capacity is not fixed, but rather is a continuum.¹²⁸ Given the statutory requirements¹²⁹ which rely upon the mental capacity of the patient and the voluntariness of her actions, how can compliance at the moment of decisionmaking be assured? More recent arguments discussing these concerns were made in Montana’s *Baxter* case.¹³⁰ These are difficult questions. One physician may find the existence of sufficient capacity while another may not. The possibility that terminally ill patients may be pawns in the middle of an ideological struggle is unacceptable. Until reasonable safeguards are sufficiently guaranteed, serious concerns will remain.

Proponents point to the statutory requirements of reporting as protection from potential abuses.¹³¹ Reporting requirements and compliance is either strict and detailed¹³² or shrouded “behind a thick veil of secrecy.”¹³³ A group organized by Oregon Health Sciences University published a “guidebook” for caregivers shortly after the law went into effect.¹³⁴ Irrespective of the guidelines

¹²⁷ See *Shopping for Suicide*, Detroit News, Apr. 26, 1998, at B6.

¹²⁸ See Martyn & Bourguignon, *Trojan Horse*, *supra*. which is an analysis of capacity issues in end-of-life decisionmaking.

¹²⁹ See *supra*. at IIA.

¹³⁰ See Brief of Margaret Dore as Amicus Curiae Supporting Appellants, *Baxter v. State of Montana*, No. ADV-2007-787, 2008 Mont. Dist. LEXIS 482, December 5, 2008.

¹³¹ OR. Rev. Stat. § 127.865 (2003); Tucker, (*Death with Dignity Act*), *supra*. at 295-96.

¹³² Cohen-Almagor, *supra*. at 3; Tucker, *Washington State*, *supra*. at 12.

¹³³ See Martyn & Bourguignon, *Moment to Reflect*, *supra*. at 5, 11-14 for a discussion of the initial Oregon reports.

¹³⁴ See *The Oregon Death with Dignity Act: A Guidebook for Health Care Providers* (Kathleen Haley & Melinda Lee eds., 1998).

established for the protection of the patients, research showed that “only fifteen of the forty-three persons (about one-third) whom physicians in Oregon assisted to end their lives were given psychological consultations.”¹³⁵ Questions also remain regarding the extent of data required to be reported to the Oregon Department of Human Resources in order to ensure compliance with the statute.

2. Concerns regarding reported abuses in The Netherlands

Perhaps the most widely discussed controversy involving PAS by serious scholars on both sides of the debate is the experience in The Netherlands. As discussed briefly below, writers either believe that the brief history of the Dutch are sufficiently abhorrent to end the possibility of acceptance in the United States, are exaggerated reports based upon insufficient data, or are of little value in the discussion due to the disparity of health care systems in the two countries. Irrespective of which side of the debate one takes, the majority on both sides express concern about the disintegration of patient safeguards in The Netherlands.

The legal history of PAS began in the Netherlands courts in 1983 when a physician was exonerated for his part in assisting a patient suicide, an existing criminal offense. As a result, guidelines were negotiated between the chief prosecutor and the Royal Dutch Medical Society. Three initial conditions were required: (1) Suicide could only be assisted after repeated voluntary and competent requests from a patient; (2) The patient must be experiencing suffering that could only be relieved through death; and (3) An independent consulting physician had to assess the

¹³⁵ Martyn & Bourguignon, *Moment to Reflect, supra.* at 18.

patient's condition and voluntary request and concur that euthanasia was appropriate.¹³⁶ In 1990, a fourth requirement was added, mandating that each case of PAS be reported to authorities. In 1991, the Rummelink Committee was formed to determine if the guidelines previously approved by the courts should become actual Dutch law. In ascertaining that at least 2,700 cases of PAS or euthanasia were occurring each year, the committee concluded that "none of the initial lines drawn by Dutch law had held."¹³⁷ More than half of PAS cases were not reported and many physicians failed to obtain the required colleague consultation. Most shocking, however, was the admission by physicians of 1,000 cases where they had intentionally taken the life of a patient "involuntarily, without an explicit request from either the patient or family."¹³⁸ It appeared certain that "[i]n the short span of a decade, involuntary euthanasia had become a significant reality."¹³⁹

One of the most interesting discussions of the Netherlands experience is reported by Raphael Cohen-Almagor. Dr. Cohen-Almagor is a supporter of PAS and has written a book on the subject entitled, *The Right to Die with Dignity: An Argument in Ethics, Medicine, and Law*, published in 2001 (Rutgers University Press). While researching for his book, he became concerned about reports of abuse in the practice of PAS in the Netherlands. At that time, Dr. Cohen-Almagor was "very much in favor of euthanasia."¹⁴⁰ He felt compelled to travel to the Netherlands to determine the truth

¹³⁶ See Martyn & Bourguignon, *Legal Flaws*, *supra*. at 410-419 for a discussion of PAS in the Netherlands.

¹³⁷ *Id.*, citing Ezekiel J. Emanuel, *Euthanasia: Historical, Ethical and Empirical Perspectives*, 154 *Archives Internal Med.* 1890 (1994).

¹³⁸ *Id.*, citing John Keown, *The Law and Practice of Euthanasia in the Netherlands*, 108 *L.Q. Rev.* 51, 66-67 (1992); and Johannes J.M. van Delden et al., *The Rummelink Study Two Years Later*, *Hastings Center Rep.*, Nov.-Dec. 1993, at 24, 24.

¹³⁹ *Id.* at 412.

¹⁴⁰ Cohen-Almagor, *supra*. at 4.

of the reports first hand. After that experience, he concluded: “In the Netherlands, I heard of abuse – lots of abuse – and as a result, I had to change my view about the practice of euthanasia. At the same time, I do support PAS.¹⁴¹

The concept of involuntary euthanasia should offend the sensibilities of citizens living in a country defined by its freedoms under law. While no such incidents have been reported in Oregon (and hopefully never will), state lawmakers and individual citizens alike should consider the Dutch example of the escalation of a practice when tradition protections under the law begin to change.

CONCLUSION

The practice of physician-assisted suicide is a controversial, emotional and important political issue. Terminally ill patients deserve the best available treatment to alleviate their pain and suffering. At the same time, wholesale changes of established law protecting life should not be undertaken lightly.

While it has been determined that there presently exists no federal right to PAS, the Supreme Court has left it to the states to determine whether or not to adopt legislation approving the practice. This is as it should be. Accordingly, it is the responsibility of state lawmakers and each of us as citizens to understand both sides of the issue. Only then can reasonable choices be made.

Since current law is relatively stable at both the federal and state level, the burden of proving the necessity of change falls upon the proponents of such change. Responsible dialogue should be encouraged. Irresponsible political activism should not. Lawmakers should be aware of both and should have sufficient knowledge of the subject matter to distinguish between the two.

¹⁴¹ Id. at 5.

Current law was not written in a day. It evolved over hundreds of years. These laws should not be discarded lightly. Too many questions are still unanswered for state lawmakers to endorse adoption of PAS in the manner of Oregon and Washington. The citizens of those states have spoken and their decisions must be respected. However, until sufficient safeguards are in place to protect the most fragile of our citizens, the status quo should be maintained.