

The Oregon Death With Dignity Act: Review and Proposals for Improvement

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I. INTRODUCTION

Proponents of physician-assisted-suicide (PAS) have been trying for over a decade to legalize some type of PAS at the state level. They first attempted to use the traditional state legislative process.¹ Although they managed to get some bills introduced and considered, none of them were approved.² Consequently, in 1991 PAS proponents tried a new method, going directly to voters in Washington through the state's voter initiative processes.³ When the measure was defeated in Washington, the legalization movement moved to California in 1992, where a measure again was defeated.⁴ The movement next moved to Oregon which houses the national headquarters of the Hemlock Society and is the home of Derek Humphry, a prominent right-to-die activist. The politically independent sentiments of many Oregonians, combined with the state's history of progressive initiatives and health reforms, were instrumental in the passing of the Death With Dignity Act. Furthermore, Oregon has progressive advance directive laws and a long history of citizens using the initiative power as an instrument of legal and social change. Regarding citizens' defiance toward organized religion and external political pressures, John Pridnoff, Executive Director of the Hemlock Society in Eugene, Oregon, said, "Oregonians tend to be more open-minded to a wide variety of opinions."⁵

Oregon also has a more conducive atmosphere for the passage of physician-assisted suicide because of the main characteristics of its population. About 90% of Oregonians

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1. See Patrick M. Curran, Jr., *Regulating Death: Oregon's Death With Dignity Act and the Legalization of Physician-Assisted Suicide*, 86 *GEO. L.J.* 725, 726 (1998).

2. See *id.* (citations omitted).

3. See Initiative for Death With Dignity, 1991 Wash. Legis. Serv. Init. Meas. 119 (West).

4. California Death With Dignity Act, 1992 Cal. Legis. Serv. Prop. 161 (West).

5. Tom Bates & Mark O'Keefe, *On Suicide Measure, Oregon Is a Maverick Again*, *PORTLAND OREGONIAN*, Nov. 13, 1994, at A1.

are white and research has shown that whites are more likely than minorities (particularly African-Americans and Hispanics) to support physician-assisted suicide.⁶ In addition, Oregon is a relatively secular state where religious sentiments are not strong. That factor allows Oregonians to espouse moral views that do not necessarily coincide with religious norms. Chet Orloff, Director of the Oregon Historical Society, explained, “This measure is in keeping with Oregon. Throughout history Oregon seems to be out there ahead of other states in testing things.”⁷

Interestingly, in order to gain the support of most Oregonians, the activists of the right-to-die campaign distanced themselves from Derek Humphry and the Hemlock Society. The initiators of Measure 16 saw Humphry as a political liability, fearing his controversial, fringe views might scare away voters worried that the measure was the beginning of a radical campaign to help people kill themselves. Spokeswoman Barbara Coombs Lee explained that Humphry always criticized the bill for being too moderate. Measure 16 was not designed to satisfy “the fringe element on either side of this issue, not Derek Humphry and not the archbishop. It was designed to find the common ground with a moderate, rational and safe solution to a problem facing Oregonians.”⁸ At the same time, the campaign had quietly used Humphry’s name to raise money across the country from right-to-die faithful. Humphry himself was very active in raising money for the campaign and contributed a large sum of money.⁹

In November 1994, the citizens of Oregon approved Ballot Measure 16—also called the Oregon Death With Dignity Act (hereinafter “the Oregon Act,” or “the Act”),¹⁰ making Oregon the first and only jurisdiction in the United States to legalize PAS.¹¹ The Act allows Oregon residents who are suffering from a terminal disease to receive prescriptions for self-administered lethal medications from their physicians.¹² The term “terminal disease” is defined as “an incurable and irreversible disease that has been

6. See U.S. BUREAU OF THE CENSUS, STATISTICAL ABSTRACT OF THE UNITED STATES (1997 ed.); P.V. Caralis, Bobbi Davis, Karen Wright & Eileen Marcial, *The Influence of Ethnicity and Race on Attitudes Toward Advance Directives, Life Prolonging Treatment, and Euthanasia*, 4 J. CLINICAL ETHICS 155, 157–59 (1993).

7. Tom Bates & Mark O’Keefe, *Suicide Law Reflects Oregon Politics: Voters Tend to Be Quirky But Consistent in Maverick State*, PLAIN DEALER (Clev.), Nov. 21, 1994, at 3E.

8. Mark O’Keefe, *Founding Father*, PORTLAND OREGONIAN, Nov. 1., 1994, at A01 (quoting Barbara Coombs Lee).

9. See *id.*

10. Oregon Death With Dignity Act § 2.01, OR. REV. STAT. § 127.805 (1999).

11. Measure 16 was approved by a vote of 618,751 to 586,702 (51% to 49%). See David A. Pratt, *Too Many Physicians: Physician-Assisted Suicide After Glucksburg/Quill*, 9 ALB. L.J. SCI. & TECH. 161, 185 n.121 (1999). Professor Pratt’s article references several sources that describe and discuss the statute. See *id.* (citing Melinda A. Lee & Susan W. Tolle, *Oregon’s Assisted Suicide Vote: The Silver Lining*, 124 ANNALS INTERNAL MEDICINE 267 (1996); Kathy T. Graham, *Last Rights: Oregon’s New Death With Dignity Act*, 31 WILLAMETTE L. REV. 601 (1995); David M. Smith & David Pollack, *A Psychiatric Defense of Aid in Dying*, 34 COMMUNITY MENTAL HEALTH J. 547 (1998)). For additional background, see Mark O’Keefe, *Assisted Suicide Measure Survives Heavy Opposition*, PORTLAND OREGONIAN, Nov. 10, 1994, at A1.

12. See Oregon Death With Dignity Act § 2.01, OR. REV. STAT. § 127.805 (1999).

medically confirmed and will, within reasonable medical judgment, produce death within six (6) months.” It does not permit euthanasia (good death), in which a physician or other person directly administers a medication to a patient in order to end his or her life.¹³ Implementation of the Act was barred for several years by a constitutional challenge.¹⁴ Passage of the Act in November 1997, for the second time, not only legalized PAS in Oregon but also placed Oregon at the center of a national debate regarding PAS.¹⁵

The Oregon Death With Dignity Act requires that the Oregon Health Division (OHD) monitor compliance with the law, collect information about the patients and physicians who participate in legal physician-assisted suicide, and publish an annual statistical report.¹⁶ This Article discusses the history of the Act from its passage in 1994 to the present, evaluates the strengths and weaknesses of the Act, and analyzes the Oregon Health Division’s reports on the consequences of the Act. It is acknowledged that the Act contains significant documentation and reporting requirements for every step of the procedure.¹⁷ These provisions are designed to ensure that the patient is making a voluntary and informed decision. The provisions help state agencies to monitor physicians’ compliance with the Act. This, in turn, helps safeguard patients’ interests and protects against the risk of involuntary euthanasia.

While the Act includes a number of safeguards that are intended to protect patients’ interests and guard against the abuses that have occurred in the Netherlands,¹⁸ there are still some flaws beyond the aforementioned weaknesses that do not necessarily advance the purpose of the Act, which is to give a dying patient the right to request lethal medication to end his or her life in a humane and dignified way. This Article proposes several improvements to the Act, including modification of the Act to contain self-administered lethal injections in situations where oral medications cannot be taken, additional reporting by pharmacists, mandatory psychiatric consultations for patients considering physician-assisted suicide, and enhanced control mechanisms. The meticulous set of guidelines will improve the working of the Act and make it less

13. Oregon Death With Dignity Act § 1.01, OR. REV. STAT. § 127.800 (1999).

14. See Oregon Death With Dignity Act § 3.14, OR. REV. STAT. § 127.880 (1999); see also *Lee v. Oregon*, 891 F. Supp. 1439 (D. Or. 1995), enforcing 891 F. Supp. 1421 (D. Or. 1995) (invalidating the Oregon Death With Dignity Act on equal protection grounds because it denied the terminally ill the same protection afforded to other Oregon residents found to be a danger to themselves).

15. See Kim Murphy, *Voters in Oregon Strongly Endorse Assisted Suicide*, L.A. TIMES, Nov. 5, 1997, at A1.

16. *Oregon’s Death With Dignity Act Annual Report* (updated Feb. 21, 2000) available at <<http://www.ohd.hr.state.or.us/chs/pas/pas.htm>>.

17. See Oregon Death With Dignity Act § 3.09, OR. REV. STAT. § 127.855 (1999) (listing medical record documentation requirements); Oregon Death With Dignity Act § 3.11, OR. REV. STAT. § 127.865 (1999) (listing reporting requirements under the Act).

18. For comprehensive critical discussions, see generally CARLOS F. GOMEZ, *REGULATING DEATH* (1991); HERBERT HENDIN, *SEDUCED BY DEATH* (1997); R. COHEN-ALMAGOR, *EUTHANASIA IN THE NETHERLANDS* (forthcoming).

susceptible to abuse.

The reasoning behind the Act recognizes that a person may face grave difficulties at the end of his or her life. The general argument of death-with-dignity advocates focuses on a special set of circumstances where (1) a person has a terminal disease, (2) is capable and (3) has made the request to end his or her life voluntarily. According to death-with-dignity advocates, a person in this situation should have the autonomy to make the decision to end his or her life and to be able to do so in the most humane manner. This does not negate the principle that a person's life is valuable at all times. Instead, the viewpoint is that although a person's life is always valuable, a patient's desire to control his or her manner of death and to die a more painless and/or dignified death should be given precedence over the value of his or her life.¹⁹ As said, the Oregon Act specifies that the time period for this judgment is after a reasonable medical prognosis has given the patient only six more months to live.²⁰ In order to protect the individual's freedom to act, two rights are recognized: the right to autonomy and the right to choice in end of life issues. Both of these rights were cited by family members as extremely important reasons why patients chose PAS in its second year of effect in Oregon.²¹

A. History of the Oregon Act

The Oregon Act passed in 1994 by a slight margin, with 51% in favor and 49% opposed.²² The Oregon Medical Association (OMA) officially remained neutral on the Act.²³ The Oregon Health Sciences University conducted an anonymous survey (OHSU survey) of all Oregon physicians eligible to participate in PAS in 1995. The findings show that 60% of the 2761 respondents believed that PAS is ethical and should be legal in some cases.²⁴ Forty-six percent stated that they might be willing to write a

19. See generally Raphael Cohen-Almagor, *Reflections on the Intriguing Issue of the Right to Die in Dignity*, 29 *ISR. L. REV.* 677 (1995); *Autonomy, Life as an Intrinsic Value, and Death With Dignity*, 1 *SCI. & ENGINEERING ETHICS* 271 (1995).

20. See *supra* notes 14-15 and accompanying text.

21. See Amy D. Sullivan, Katrina Hedberg & David W. Fleming, *Legalized Physician-Assisted Suicide in Oregon — the Second Year*, 342 *NEW ENG. J. MED.* 598, 603 (2000) [hereinafter *OHD REPORT 2*].

22. See Bill MacKenzie, *Whose Life Is It? Oregon Battles over Suicide Law*, *NEWSDAY* (New York, N.Y.), Dec. 5, 1994, at A17.

23. By contrast, both of the OMA's counterparts in Washington and California had voiced strong opposition to the assisted suicide initiatives in their respective states. In addition, the Oregon Hospice Association (OHA) refused to take a firm position on the Act and the Act was supported by the state's Democratic Party and a moderate wing of the Oregon Republican Party. See Patrick M. Curran, Jr., *Regulating Death: Oregon's Death With Dignity Act and the Legalization of Physician-Assisted Suicide*, 86 *GEO. L.J.* at 727-28 (1998).

24. See Erin Hoover and Patrick O'Neill, "The AMA is wary of legislation's effect on pain management but remains opposed to assisted death," *The Oregonian* (6 June 1998); Melinda A. Lee, *et al.*, *Legalizing Assisted Suicide—Views of Physicians in Oregon*, 334 *NEW ENG. J. OF MED.* 310, 312 (1996) [hereinafter *OHSU SURVEY*]. This is a higher percentage than the journal has found in studies of U.S. physicians nationwide, although results have varied, with anywhere from "20 to 70 percent of physicians favor[ing] the

prescription for a lethal dose of medication once the Act went into effect.²⁵ The survey also indicated that the Act may simply have legalized and expanded what was already being practiced by a small percentage of physicians: of the 21% of OHSU survey respondents who said that they had been asked for a prescription for a lethal dose of medication within the year preceding the Act, 7% admitted to writing such a prescription although doing so was illegal.²⁶ Eighty-six percent of physicians reported that legalization of PAS would have no effect on the way that they prescribe pain medication for terminally ill patients, and nearly half indicated that they might be willing to fulfill requests for lethal doses of prescriptions.²⁷ One interpretation of the statement that legalization of PAS would have no effect on the behavior of the majority of physicians is that providing a lethal prescription under the guise of pain management is often creating a “double effect” which most physicians agree is both ethical and legal.²⁸

Since the Act initially passed by such a narrow margin, it is not surprising that it elicited a storm of protest and public debate.²⁹ The Act was opposed by a coalition of religious groups including the Catholic Church, which perceive PAS as disrespectful of God’s gift of life, and the American Medical Association, which is afraid of altering physicians’ traditional role of protecting and preserving life.³⁰ The most influential response was a lawsuit filed in federal district court by a group of physicians, residential care facilities, and concerned Oregon residents challenging the Act on constitutional grounds.³¹ Citing the Fourteenth Amendment, the plaintiffs claimed that the Act violated due process and equal protection rights by failing to protect vulnerable patients who

legalization of physician-assisted suicide” in various U.S. studies. *See also* Kathleen M. Foley, *Competent Care for the Dying Instead of Physician-Assisted Suicide*, 336 NEW ENG. J. OF MED. 54 (1997).

25. *Cf.* OHSU SURVEY, *supra* note 24, at 312. It is important to note that the OHSU survey did not include all eligible physicians in Oregon, but approximately 69-70% (only those who returned the survey).

26. *See* OHSU SURVEY, *supra* note 24, at 313. The study also showed that religious beliefs strongly influenced physicians’ willingness to participate. In addition, physicians practicing in small towns or rural communities were less likely to be willing to participate. *Id.* at 312.

27. OHSU SURVEY, *supra* note 24, at 313.

28. For further deliberation on the double effect doctrine in medicine, *see* Joseph M. Boyle Jr., *Toward Understanding the Principle of Double Effect*, 90 ETHICS 527-38 (1980); Joseph M. Boyle, Jr., *Who Is Entitled to Double Effect?*, 16 J. OF MED. AND PHILOSOPHY 475-94 (1991); Timothy E. Quill, et. al., *The Rule of Double Effect—A Critique of Its Role in End-of-Life Decision Making*, 337 NEW ENGLAND J. OF MED. 1768-71 (1997); F.M. Kamm, *Physician-Assisted Suicide, the Doctrine of Double Effect, and the Ground of Value*, 109 ETHICS 586-91 (1999); Charles F. McKhann, *A TIME TO DIE: THE PLACE FOR PHYSICIAN ASSISTANCE* 102-106 (Yale University Press 1999); R. Cohen-Almagor, *Language and Reality at the End of Life*, 28 J.L. MED. & ETHICS 267 (2000). *See also* 338 NEW ENGLAND J. OF MED. 1389-90 (1998), pp. 1389-90.

29. *See e.g.*, George J. Annas, *Death By Prescription: The Oregon Initiative*, 331 NEW ENG. J. OF MED. 1240, 1243 (1994) (arguing that the Act will injure patients with terminal diseases); Timothy E. Quill, *The Oregon Death With Dignity Act [Letters]*, 332 NEW ENG. J. OF MED. 1174-75 (1995) (assorted responses to Annas’ article); Timothy Egan, *Suicide Law Placing Oregon on Several Uncharted Paths*, NEW YORK TIMES, Nov. 25, 1994, at A1 (quoting supporters and opponents of the Act).

30. *See* Patrick M. Curran, Jr., *Regulating Death: Oregon’s Death With Dignity Act and the Legalization of Physician-Assisted Suicide*, GEO. L.J. at 728 (1998).

31. *See* Lee v. Oregon, 869 F. Supp. 1491 (D. Or. 1994).

may resort to assisted suicide because of undiagnosed depression or coercion.³² In December 1994, the federal district court granted a temporary injunction saying that serious questions were presented as to whether the Act violated plaintiffs' freedom of association, freedom of religion, due process, and equal protection rights, and that the balance of hardships favored plaintiffs.³³ In August 1995, the district court struck down the Act on equal protection grounds.³⁴ Judge Hogan made three complimentary arguments: (1) provision of the Oregon Act was not rationally related to any legitimate state interest for equal protection purposes; (2) provision of the Act which established a subjective "good faith" standard of care for physicians and immunized them from liability for actions taken in good faith was not rationally related to any legitimate state interest for equal protection purposes; and (3) the Act was not rationally related to any state interest as it did nothing to ensure that the decision to commit suicide was rationally and voluntarily made at the time of death.³⁵

Although this decision was subsequently vacated for procedural reasons³⁶ execution of the Act was delayed yet again pending the Supreme Court decisions in *Washington v. Glucksberg*³⁷ and *Vacco v. Quill*.³⁸ In these decisions, the Supreme Court held that there is no constitutional right to PAS.³⁹ In addition, opponents of the Act attempted to have it repealed.

B. The Act's Last Hurdles Before Becoming Law

For the first time in Oregon's history, a ballot initiative was voted on twice. In November 1997, Measure 51 (to overturn the Act) was rejected by an even greater margin (60% to 40%) than had originally approved the Act.⁴⁰ A plausible explanation for this much larger margin in support of the Death With Dignity Act is that by this

32. *See id.* at 1495-96.

33. *Id.* at 1503.

34. *Lee v. Oregon*, 891 F. Supp. 1429 (D. Or. 1995). For criticism of this court ruling, *see* Charles H. Baron, et. al., *A Model State Act to Authorize and Regulate Physician-Assisted Suicide*, 33 HARV. J. ON LEGIS. 1, at 14-16 (1996).

35. *See Lee v. Oregon*, 891 F. Supp. 1429 (D. Or. 1995).

36. *See Lee v. Oregon*, 107 F.3d 1382, 1392 (9th Cir. 1997).

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

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

39. In *Glucksberg*, the Court rejected the plaintiffs' claim that individuals have a liberty interest in assisted suicide protected by the Due Process Clause. *See generally* 521 U.S. 702. In *Vacco*, the Court rejected the plaintiffs' claim that allowing terminally ill patients to be disconnected from life-support is, in effect, giving them a right to die, and therefore laws which deny the same right to terminally ill patients who are not on life-support violate the Equal Protection Clause. *See generally* 521 U.S. 793. For an overview of the legalization efforts of physician-assisted suicide in the United States, *see* Carol A. Pratt, *Efforts to Legalize Physician-Assisted Suicide in New York, Washington and Oregon: A Contrast Between Judicial and Initiative Approaches—Who Should Decide?*, 77 OR. L. REV. 1027 (1998).

40. *See* David J. Garrow, *The Oregon Trail*, NEW YORK TIMES Nov. 6, 1997, at A2. *See also* Tom L. Beauchamp, *The Autonomy Turn in Physician-Assisted Suicide*, in *MEDICAL ETHICS AT THE DAWN OF THE 21ST CENTURY* 111-126 (R. Cohen-Almagor ed., 2000).

decisive vote they expressed their anger over the fact that they were forced to vote on the issue for the second time. It was the first time in state history that the legislature tried to repeal an initiative by voting.⁴¹ That the citizens of Oregon took an active part in the legislation process and that the law reflects the wishes of the majority of Oregonians is praiseworthy. In that respect, Oregon serves as a model to be followed by other states and countries.

Some might object to this assertion, saying that legislation by referendum reduces complex public policy issues to TV sound-bites, making it impossible for parties with differing views to reach mutual consensus through legislative deliberation. We beg to differ. Discussions on issues decided by referendum are extensive, and the media provide ample opportunities to explore all relevant points of view. The statement that all citizens hear are “sound-bites” is over-simplified, exaggerated and remote from truth. The deliberation process allows more than enough time to reach accommodation and, more fundamentally, the participation of masses of people in public affairs is of great importance. Democracy has a vested interest in facilitating feedback between the citizens and public representatives, and in stimulating discussion and public debate. It is so important and fundamental that liberals call the existing form of democracy “participatory democracy.”⁴² Legislation by referendum on a public matter that concerns the lives of all citizens is preferable to a decision-making process in a room, where a small group decides for the people what they should do in an area that is intimate and personal: the right to die with dignity. The public has the right to decide on such an important private matter. Referendum is an excellent mechanism for the public to express its interests and goals.

The passage of the Act yet again created a flurry of controversy not only in Oregon but also across the United States. On April 30, 1997, President Clinton signed the Federal Assisted Suicide Funding Restriction Act of 1997.⁴³ The Act states that “Federal funds may not be used to pay for items and services (including assistance) the purpose of which is to cause (or assist in causing) the suicide, euthanasia, or mercy killing of any individual.”⁴⁴

Thomas Constantine, the administrator of the Drug Enforcement Administration (DEA), issued a letter stating that a physician who prescribed drugs under the Oregon Act would violate the federal Controlled Substances Act because the prescription would not promote a legitimate medical purpose. This letter was a reaction to pressure from Senator Orrin Hatch and Representative Henry Hyde, the chairmen of the Senate and House Judiciary Committees, respectively. Constantine threatened that physicians who

41. Yale Kamisar, *On the Meaning and Impact of the Physician-Assisted Suicide Cases*, 82 MINN. L. REV. 897 (1998).

42. Carole Pateman, *PARTICIPATION AND DEMOCRATIC THEORY* (Cambridge University Press 1979); Richard Dagger, *CIVIC VIRTUES* (Oxford University Press 1997).

43. See Assisted Suicide Funding Restriction Act of 1997, Pub. L. No. 105-12, 111 Stat. 23 (1997).

44. 42 U.S.C.A. 14401(b) (West Supp. 2000).

ignored his directions would risk losing their license to prescribe controlled medications.⁴⁵ The Oregon Medical Association counseled physicians not to write prescriptions until this threat was removed.⁴⁶ Many people worried that the DEA's threat would have the nationwide effect of deterring physicians from providing responsible and humane treatment to dying patients.⁴⁷

Shortly after Constantine's letter, United States Attorney General Janet Reno stated that his letter was sent without her permission.⁴⁸ She further stated that the Justice Department was reviewing the Oregon statute, and that the DEA should have waited for the findings of the review before issuing any warnings to physicians.⁴⁹ Following its review of the statute, the Justice Department determined in June 1998 that the DEA does not have the authority to discipline physicians who write prescriptions in accordance with the Oregon Act.⁵⁰

In response to this announcement, a bill entitled the Lethal Drug Abuse Prevention Act⁵¹ was presented to the House and Senate in 1998. When this bill did not make much progress, the scope of the bill was narrowed to exclude drugs for sedation and only focused on analgesics (pain killers) and was introduced as the Pain Relief Promotion Act of 1999.⁵² The bill would authorize the DEA to enforce prohibitions on the use of controlled substances for assisted suicide in any state, regardless of state law. The bill also prohibits the Attorney General from giving force and effect to state laws permitting assisted suicide or euthanasia.⁵³ This would seriously impede Oregon's assisted suicide

45. See Timothy Egan, *Threat From Washington Has Chilling Effect on Oregon Law Allowing Assisted Suicide*, NEW YORK TIMES, Nov. 19, 1997, at A18.

46. See *id.*

47. See e.g., Rebecca Dresser, *Nervous Doctors*, NEW YORK TIMES, Nov. 24, 1997, at A22.

48. *Reno: Justice Reviewing Advice on Oregon's Assisted-Suicide Law*, ASSOCIATED PRESS, Nov. 14, 1997, available in WL 2562712.

49. *Id.* See also *Justice Dept. Bars Punishing Oregon Doctors Aiding Suicides*, NEW YORK TIMES, Jan. 24, 1998, at A6.

50. See *Reno Won't Fight Oregon Suicide Law*, ASSOCIATED PRESS ONLINE, June 6, 1998.

51. S 2151, 105th Cong. (1998); H.R. 4006, 105th Cong. (1998).

52. H.R. 2260, 106th Congress (1999). The actual text of H.R. 2260 (Title I) is, in relevant part:

For purposes of this Act and any regulations to implement this Act, alleviating pain or discomfort in the usual course of professional practice is a legitimate medical purpose for the dispensing, distributing, or administering of a controlled substance that is consistent with public health and safety, even if the use of such a substance may increase the risk of death. Nothing in this section authorizes intentionally dispensing, distributing, or administering of a controlled substance for the purpose of causing death or assisting another person in causing death.

(2) Notwithstanding any other provision of this Act, in determining whether a registration is consistent with the public interest under this Act, the Attorney General shall give no force and effect to State law authorizing or permitting assisted suicide or euthanasia.

(3) Paragraph (2) applies only to conduct occurring after the date of enactment of this subsection.

53. H.R. 2260, 106th Congress (1999). The measure was written in response to Attorney General Janet Reno's announcement that federal drug agents will not try to prosecute or revoke the drug licenses of doctors

law⁵⁴ and practically preclude states from passing new assisted suicide laws.

In addition, the bill defines a safe harbor for physicians to prescribe increased amounts of painkillers for palliative purposes, even if doing so increases the risk of death. The measure directs the Health and Human Services Department to create a program to study pain management and dispense that information to public and private health care programs and providers, medical schools, hospices and to the general public. The bill also authorizes \$5 million for grants to train health professionals in the care of patients with advanced illnesses. The DEA would have authority to interpret and enforce physicians' compliance with permissible uses of controlled substances.

Despite the national American Medical Association's (AMA) endorsement of the Pain Relief Promotion Act of 1999, twelve of its state chapters have opposed the bill.⁵⁵ Moreover, many physicians are uncomfortable with the AMA's support of the bill and are concerned that the bill may not carve out a clear and adequate safe harbor, but would instead expose them to the risk of DEA enforcement, creating the very chilling effect on the use of palliative measures that the bill is intended to avoid.⁵⁶

In addition to having the endorsement of the AMA, the bill is supported by other organizations including the National Legal Center for the Medically Dependent and Disabled, the National Hospice Organization, and Physicians for Compassionate Care.⁵⁷ The organizations opposing the bill include the American College of Physicians, the American Society of Internal Medicine, the American Society for Clinical Oncology, the Oregon Medical Association, the American Pain Foundation, the American Cancer Society, and the American Pharmaceutical Association.⁵⁸ These groups oppose the bill primarily because they believe it will reduce physicians' ability to prescribe sufficient pain medication and will reduce patients' privacy. The Oregon Medical Association said the law would do more harm than good for the treatment of patients suffering from a terminal disease and expose doctors to investigations and possible loss of their license to write prescriptions.⁵⁹ Although Clinton opposes PAS, he has not said whether he would

who help patients suffering from a terminal disease die under Oregon's law. See *Anti-Assisted Suicide Bill Approved*, ASSOCIATED PRESS, Sept. 14, 1999, available at WL 22043996.

54. The legislation would make it impossible for Oregon physicians to prescribe federally controlled substances, but there are other lethal medications which are not covered by the federal law, and Oregon physicians would remain free to prescribe them.

55. Patrick McMahon & Wendy Koch, *Assisted Suicide: A Right Or a Surrender?*, USA TODAY, Nov. 22, 1999, at 21A.

56. Interview with Thomas R. Bullock, III, Congressional Aide (Dec. 7, 1999) (discussing the Pain Relief Promotion Act of 1999 and issues surrounding the legislative debate).

57. See Brief of Henry J. Hyde, Chairman of the Committee on the Judiciary, available at <http://www.house.gov/judiciary/ib062399.htm>. See also the testimonies of Thomas J. Marzen and Physicians for Compassionate Care before the Committee on the Judiciary, June 24, 1999, available at <http://www.house.gov/judiciary/marz0624.htm>; <http://www.house.gov/judiciary/hami0624.htm>.

58. See David A. Pratt, *Too Many Physicians: Physician Assisted Suicide After Glucksberg/Quill*, 9 ALB. L.J. SCI. & TECH., Vol. 161, 189-90 (1999).

59. Brad Cain, *Oregon Medical Association Opposes Congressional PAS Bill*, ASSOCIATED PRESS, Aug. 3, 1999, available at 1999 WL 3051346.

veto the bill.⁶⁰ However, Justice Department spokeswoman Gretchen Michael stated that the administration, “ultimately opposes the bill as ‘an unwarranted expansion of federal authority.’”⁶¹

The bill passed the house on October 27, 1999, by a vote of 271 to 156, and is now in the Senate, where it was read and referred to the Committee on Judiciary on November 19, 1999.⁶² In December 1999, Oregon’s assisted suicide law suffered another blow when the American Medical Association voted to continue backing federal legislation intended to prevent doctors from prescribing lethal doses of drugs to patients suffering from terminal diseases who want to die.⁶³

C. Implementation of the Act

On February 26, 1998, the Oregon Health Services Commission voted (10-1) to add PAS to the list of medical care paid for entirely by the Oregon Health Plan for low-income people.⁶⁴ Complaints were heard that Oregon’s Medicaid scheme paid for physician-assisted suicide but not for caregivers to provide sufficient home care to enable elderly and disabled people to live independently.⁶⁵ Other commentators were bothered by the fact that the commission attempted to reduce coverage of anti-depressant drugs at the same time that it added coverage for PAS.⁶⁶

Several other bills that would restrict the Act are currently being considered by the Oregon legislature. The bills include proposals to increase restrictions on where and with whom a patient suffering from a terminal disease can have PAS, and increased methods for ensuring that all physicians participating in PAS follow the detailed guidelines.⁶⁷ One bill would permit health care facilities to forbid physicians from participating in PAS at their facilities and punish physicians who disobey. This bill would also restrict sites for PAS to health care facilities, physicians’ offices and private residences.⁶⁸ Another measure proposes that a patient must have reasons other than age or disability to participate in PAS and would require physicians to state the purpose of

60. *Legislating Pain and Death*, ST. LOUIS POST-DISPATCH, Oct. 31, 1999, at B2.

61. Patrick McMahon and Wendy Koch, *Assisted Suicide: A Right Or a Surrender?*, USA TODAY, Nov. 22, 1999, at 21A.

62. 145 CONG. REC. H10876 (daily ed. Oct. 27, 1999); 145 CONG. REC. S15086 (daily ed. Nov. 19, 1999); See also Thomas, *Legislative Information on the Internet*, available at <http://thomas.loc.gov>.

63. Ben Fox, *Assisted Suicide on Doctors’ Agenda*, THE ASSOCIATED PRESS, Dec. 8, 1999, available at 1999 WL 28147403.

64. See Steve Woodward, *Oregon Will Cover Assisted Suicide*, THE OREGONIAN, Feb. 27, 1998, at A1.

65. *Id.* at A1; Joseph P. Shapiro, *Assisted Suicide, Casting a Cold Eye On “Death With Dignity”*, U.S. NEWS AND WORLD REPORT, March. 1, 1999, available at 1999 WL 8432334.

66. See Diane M. Gianelli, *Suicide Opponents Rip Oregon Medicaid’s Pain Control Policy*, AM. MED. NEWS, Sept. 28, 1998, (available from author) (The commission sought to reduce coverage of antidepressants because it claimed that physicians were prescribing them too frequently).

67. See *Bills Aim to Curb Assisted-Suicide Law*, THE COLUMBIAN, Jan. 22, 1999, at B6, available at WL 6506869.

68. See *id.*

PAS on prescriptions for lethal doses of medication.⁶⁹ Although the Oregon legislature has yet to approve any of these measures, it did approve a bill making minor changes to the statute in May 1999.⁷⁰

In the next section we analyze the Oregon Act in detail. First, we explore what the Act allows by reviewing the terms and definitions. Second, we discuss the set of procedures that define how the Act would be implemented. We then discuss the documentation and reporting requirements that formalize the Act's safeguards, critiquing the current procedures and oversight rules and showing where improvements are needed.

II. ANALYSIS OF THE OREGON ACT

A. Terms and Definitions

The Oregon Death With Dignity Act allows Oregonian patients who suffer from a terminal disease and who have a life expectancy of no more than six months to receive prescriptions for self-administered lethal medications from their physicians. The Act legalizes only physician-assisted suicide, stating that "nothing in this Act shall be construed to authorize a physician or any other person to end a patient's life by lethal injection, mercy killing or active euthanasia."⁷¹ It permits a capable⁷² adult⁷³ Oregon resident⁷⁴ diagnosed with a terminal disease to "make a written request for medication for the purpose of ending his or her life in a humane and dignified manner"⁷⁵ Physicians who write such prescriptions in good-faith compliance with the Act are shielded from civil or criminal penalties and professional discipline.⁷⁶

69. *See id.*

70. *See* Erin Hoover Barnett, *Bill Clarifying Assisted-Suicide Law Passes House By a Wide Margin*, THE OREGONIAN, May, 25, 1999, at E1, available at WL 5327958.

71. The Oregon Death With Dignity Act § 3.14, OR. REV. STAT. § 127.880 (1999).

72. "Capable" is defined as having the ability to make and communicate health care decisions to a health care provider. *See* Oregon Death With Dignity Act § 1.01(3), OR. REV. STAT. § 127.800 (1999).

73. An "adult" is an individual who is at least eighteen years of age. *See* Oregon Death With Dignity Act § 1.01(1), OR. REV. STAT. § 127.800 (1999).

74. *See* Oregon Death With Dignity Act § 3.10, OR. REV. STAT. § 127.860 (1999). The residency requirement was intended to prevent individuals from other states from rushing to Oregon to take advantage of the Act. *See* Annette E. Clark, *Autonomy and Death*, 71 TUL. L. REV. 45, n. 43 (1996).

75. Oregon Death With Dignity Act § 2.01, OR. REV. STAT. § 127.805 (1999). Voluntary euthanasia occurs when an individual, usually a physician, administers a lethal drug at a patient's request, thus producing the patient's death. *See* David Orentlicher, *Physician Participation in Assisted Suicide*, 262 JAMA 1844, 1844 (1989).

76. *See* Oregon Death With Dignity Act § 4.01(1), OR. REV. STAT. 127.885 (1999). Without this provision, physicians who assisted a suicide would be civilly and criminally liable under OR. REV. STAT. § 163.125 (1995), which makes it a crime to intentionally cause or aid another in committing suicide.

B. Procedures

In response to concerns about inadequate safeguards, the authors of the Oregon Death With Dignity Act provided detailed procedures that patients and physicians must follow.⁷⁷ The patient who is suffering from a terminal disease must first make an oral request, then a written request⁷⁸ and lastly an additional oral request before the “attending physician”⁷⁹ may assist. The written request must be signed and dated by the patient, and witnessed by at least two individuals “one of whom must not be a relative, an heir, or the owner or operator of a health care facility where the patient is receiving treatment or is in residence.”⁸⁰ Neither of the witnesses shall be the patient’s attending physician.⁸¹ The requirement of both oral and written requests encourages the patient to consider his or her condition and the significance of the decision, thus serving the best interests of the patient. It also provides physicians with a record of the patient’s wishes, to safeguard them from liability. In order to ensure that the patient’s request is not a result of familial pressure, we suggest that the doctor or another member of the medical team will be obliged to conduct conversations with the patient and the relative to see that their motives are genuine, aiming to serve the patient’s best interests.

Physicians must also allow the patient to withdraw his or her request at any point, and are required to explicitly offer the patient the opportunity to change his or her mind before prescribing a lethal dose of medication.⁸² Like the requirement for both oral and written requests, these requirements provide additional safeguards to ensure that the patient is making a voluntary, informed, and cautious decision. They likewise protect the best interests of patients by encouraging them to reconsider their choice and provide prescribing physicians another indication that the patient is not making a rash or coerced decision.

Once the patient makes the first oral request, the physician must inform the patient of the diagnosis, prognosis, potential risks and probable result of taking the prescription, as well as alternatives including pain management and comfort and hospice care.⁸³ This

77. See Oregon Death With Dignity Act § 3, OR. REV. STAT. §§ 127.815-127.880 (1999), entitled “Safeguards”.

78. The statute contains a form for the written request, and requires that two witnesses affirm that the patient is capable and is acting voluntarily in making the request. See Oregon Death With Dignity Act §§ 2.02, 6.01, OR. REV. STAT. §§ 127.810, 127.897 (1999).

79. The “attending physician” is the doctor with primary responsibility for the care of the patient. See Oregon Death With Dignity Act § 1.01, OR. REV. STAT. § 127.800 (1999).

80. Herbert Hendin, et al., *Physicians-Assisted Suicide: Reflections on Oregon’s First Case*, 14 ISSUES IN L. & MED. 243, 254 (Winter 1998). The rationale might be to keep a close member of the family in the decision making process, thinking that he or she would, in the majority of cases, seek to protect the best interests of the patient. Hendin and colleagues criticized this, saying that the law should insist that no one of the two witnesses could be a beneficiary. Herbert Hendin, et al., *Physicians-Assisted Suicide: Reflections on Oregon’s First Case*, 14 ISSUES IN L. & MED. 254 (1998).

81. See Oregon Death With Dignity Act § 2.02, OR. REV. STAT. § 127.810 (1999).

82. See Oregon Death With Dignity Act § 3.07, OR. REV. STAT. § 127.845 (1999).

83. See Oregon Death With Dignity Act § 3.01(2)(a)-(e), OR. REV. STAT. § 127.815 (1999).

ensures that the patient is being given the pertinent information with which to make a reasoned and informed decision. It gives the patient an opportunity to consider his or her decision in view of the available choices.

The physician must wait at least fifteen days after the patient's first oral request before writing the prescription,⁸⁴ arguably too long for a patient who is on the verge of death. Although it is important to allow sufficient time for the patient to contemplate his or her decision and for physicians to assess the patient, establishing a fixed waiting period may prevent a patient closest to death from utilizing PAS before his or her natural death. In comparison, the annulled Northern Territory law in Australia required a "cooling off" period of only nine days.⁸⁵ It was argued that a substantial fraction of the Oregonian patients have died during the mandatory fifteen-day waiting period between their initial request and the date that they would have received medication to end their life.⁸⁶ According to author Linda Ganzini, 20% of the patients who requested assistance with suicide died during the fifteen-day waiting period.⁸⁷

During the waiting period, the attending physician must refer the patient to a "consulting physician"⁸⁸ for confirmation that the patient is suffering from a terminal disease, mentally capable, and acting voluntarily⁸⁹ and ask the patient to notify next of kin regarding the decision.⁹⁰ The referral to a consulting physician prevents one physician from making a unilateral decision to prescribe lethal medication. It also allows an important additional evaluation of the patient's illness, prognosis, and mental soundness. These precautions help prevent instances of involuntary euthanasia, which

84. See Oregon Death With Dignity Act § 3.08, OR. REV. STAT. § 127.850 (1999).

85. Rights of the Terminally Ill Act, 1995, § 7 (Austral.); See also Andrew L. Plattner, *Australia's Northern Territory: The First Jurisdiction to Legislate Voluntary Euthanasia, and the First to Repeal It*, 1 DEPAUL J. OF HEALTH CARE L. 647 (1997).

86. See Darien S. Fenn & Linda Ganzini, *Attitudes of Oregon Psychologists Toward Physician-Assisted Suicide and the Oregon Death With Dignity Act*, 30 PROF. PSYCHOL.: RES. & PRAC. 235, n.3 (1999).

87. Interview with Linda Ganzini (9 July 2000); Linda Ganzini, et al., *Physicians' Experiences With the Oregon Death With Dignity Act*, 342 NEW ENG. J. MED. 557, 561, n.8 (2000). See also Howard Wineberg, *Oregon's Death With Dignity Act: Fourteen Months and Counting*, 160 ARCH. INTERN. MED. (2000) (available from author) (The report of the first year's experience said, without explanation, that six of the 23 patients who received prescriptions for lethal medications died from underlying illness. The report of the second year said that five of the 33 patients who received such prescriptions died from underlying illnesses); Arthur E. Chin, et al., *Legalized Physician-Assisted Suicide in Oregon: The First Year's Experience*, 340 NEW ENG. J. MED. 577, n.3 (1999) [hereinafter OHD REPORT]; OHD REPORT 2, *supra* note 21, at 598-600. Interestingly, Katrina Hedberg said "We don't have any information on people who have started the request process, but didn't complete it, either because they were not eligible, they changed their minds, or because they died during the waiting period. We have heard anecdotally that many people die during the 15 day waiting period, but we only get the forms for those who have completed the process." Interview with Katrina Hedberg by R. Cohen-Almagor (June 7, 2000).

88. The "consulting physician" is the doctor qualified by specialty or experience to render a professional diagnosis and prognosis about the patient's condition. See Oregon Death With Dignity Act § 1.01, OR. REV. STAT. § 127.800 (1999).

89. See Oregon Death With Dignity Act § 3.01(1)(d), OR. REV. STAT. § 127.815 (1999).

90. See Oregon Death With Dignity Act § 3.01(1)(f), OR. REV. STAT. § 127.815 (1999). However, the physician may not require notification as a condition of assistance.

are reported to be a problem in the Netherlands.⁹¹

We would like to advise that the second opinion should be provided by a specialist who is not dependent on the first doctor, either professionally or otherwise. It is important that the consultant can form his or her judgment without being pressured in any way by the attending physician, the patient or the patient's family. The consultant should not work in the same practice, be a trainee, relative, friend or have any other compromising relationship with the attending physician, and should not be or have been a co-attending physician of the patient.⁹² To avoid the possibility of arranging deals between doctors (e.g., "you will consult for me regarding Mr. Jones, approving my decision, and I will consult for you regarding Ms. Smith, approving your decision"), it is advisable that the identity of the consultant will be determined by a small committee of specialists nominated by the State of Oregon that reviews the requests for physician-assisted suicide. In this regard, Oregon may learn from the lessons of the "Support and Consultation of Euthanasia in Amsterdam" project that was launched in 1997. All general practitioners (GPs) from Amsterdam can turn to a group of about twenty especially trained GPs for consultation or advice on euthanasia and PAS. The Royal Dutch Medical Association (RDMA) and the Amsterdam Association of GPs initiated the project because of their interest in quality improvement through consultation and the fact that GPs felt a need for information and advice on euthanasia. The project aims not only at making it easier for GPs to find an independent and knowledgeable consultant but also at professionalizing consultation.⁹³

If either the attending or the consulting physician believes that the patient is suffering from a psychiatric or psychological disorder, she or he must refer the patient to

91. According to the Rimmink Report, a 1990 nationwide survey of the Netherlands by a Dutch government commission, approximately 1,000 cases of the average 25,306 cases of euthanasia that occur annually in the Netherlands involved involuntary euthanasia, where the patients' lives were terminated by their physicians without the patients' knowledge or consent. The 1995 report spoke of 900 such cases. Cf. Paul J. van der Maas, et al., *Euthanasia and Other Medical Decisions Concerning the End of Life*, HEALTH POLICY MONOGRAPHS (Amsterdam: Elsevier, 1992); Richard Fenigsen, *The Report of the Dutch Governmental Committee on Euthanasia*, 7 ISSUES IN LAW AND MEDICINE 339, n.3 (1991); Paul J. van der Maas, et al., *Euthanasia, Physician-Assisted Suicide, and Other Medical Practices Involving the End of Life in the Netherlands, 1990-1995*, 335 NEW ENG. J. MED. 1699 (1996); Jacqueline M. Cuperus-Bosma, et al., *Physician-Assisted Death: Policy-Making By the Assembly of Prosecutors General in the Netherlands*, 4 EUROPEAN J. OF HEALTH L. 225 (1997); Gerrit van der Wal & Paul J. van der Maas, *Empirical Research on Euthanasia and Other Medical End-of-Life Decisions and the Euthanasia Notification Procedure*, in ASKING TO DIE 149, 171 (David C. Thomasma, et al., eds., 1998).

92. See also Darien S. Fenn & Linda Ganzini, *Attitudes of Oregon Psychologists Toward Physician-Assisted Suicide and the Oregon Death With Dignity Act*, 30 PSYCHOLOGY: RESEARCH AND PRACTICE (1999), available in 1999 WL 22443108; Franklin G. Miller, et al., *Can Physician-Assisted Suicide Be Regulated Effectively?*, 24 J.L. MED. & ETHICS 226 (1996); Herbert Hendin, et al., *Physicians-Assisted Suicide: Reflections on Oregon's First Case*, 14 ISSUES IN L. & MED. 250 (1998).

93. Bregje Onwuteaka-Philipsen, *Consultation of Another Physician in Cases of Euthanasia and Physician-assisted Suicide* 104-18 (1999) (unpublished Ph.D. dissertation, Vrije Universiteit (Amsterdam)) (on file with author).

a counselor.⁹⁴ Although this requirement is in the patient's best interest, it provides insufficient protection because attending and consulting physicians are not trained to identify and treat patients with psychiatric or psychological disorders, and therefore may not be competent to do so. Twenty-eight percent of the 2761 physicians in the OHSU survey reported that they were not confident that they could recognize depression in a patient who requested a prescription for a lethal dose of medication.⁹⁵ Ganzini and colleagues report that 20% of the patients had symptoms of depression.⁹⁶ In light of this information, it is even more important that attending or consulting physicians be required to refer patients to a psychiatrist or psychologist for further assessment. Since the Act prohibits the dispensing of lethal medication to an "incapable" person, the Act should be revised to include a mandatory referral to a psychiatrist to assess individuals' mental capabilities and to determine that the patients do not suffer from depression. Indeed, Emanuel and his colleagues found that patients who had seriously considered and prepared for euthanasia or PAS were significantly more likely to be depressed.⁹⁷ It should be noted in this context that the Northern Territory Rights of Terminally Ill Act required that the patient meet with a qualified psychiatrist to confirm that he or she is not clinically depressed.⁹⁸

III. THE OREGON HEALTH DIVISION REPORTS

The following discussion reviews the first and second reports on the results of the Act since it came into effect. First, we will cover the findings of the reports in detail. Second, we will discuss several implications and conclusions that can be drawn from the reports' results. The analysis uncovers several weaknesses in the Act, and proposes further ways to amend the Act to eliminate those weaknesses.

A. The First Report's Findings

On February 18, 1999, the Oregon Health Division issued its report on the effects of the Death With Dignity Act during its first year.⁹⁹ Since no prescriptions were written under the Act for most of 1997, the report only contains data about the number and characteristics of Oregonians who received medication to end their lives between November 1997 and December 1998. The study was conducted as part of the required surveillance and public health activities of the Oregon Health Division and was

94. See Oregon Death With Dignity Act § 3.03, OR. REV. STAT. § 127.825 (1999). No physician may write a prescription until the counselor determines that the patient is not suffering from any mental illness.

95. See OHSU SURVEY, *supra* note 24, at 313.

96. Linda Ganzini, et al., *Physicians' Experiences With the Oregon Death With Dignity Act*, 342 NEW ENG. J. MED. 557, 559 (2000).

97. Ezekiel J. Emanuel, et al., *Euthanasia and Physician-Assisted Suicide: Attitudes and Experiences of Oncology Patients, Oncologists, and the Public*, 347 LANCET 1809 (1996).

98. Rights of the Terminally Ill Act, 1995, § 7 (Austl.).

99. See OHD REPORT, *supra* note 87, at 577-83.

supported by Division funds. It is important to note that, in formulating its report, the Division relied exclusively on physicians' perceptions of care in the end of life and physicians' perceptions of patients' experiences.¹⁰⁰ Patients and their families were not interviewed.¹⁰¹ Because the report is not a firsthand account, one may be hesitant in drawing definitive conclusions about the first year's experience with legalized PAS in Oregon.¹⁰²

Another important consideration in assessing the data is that, although physicians are required to report the writing of all prescriptions for lethal medications to the Oregon Health Division, the Division could not know whether physicians provided assistance with PAS without reporting it.¹⁰³ The Division's report contains no data on the percentage of doctors suspected or known to have participated in PAS without reporting to the state.

Despite these methodological weaknesses, the findings do suggest some interesting preliminary conclusions. The Division matched each "case patient" (a patient receiving a prescription for a lethal dose of medication) to up to three "control patients" (forty-three control patients in all) who died from similar illnesses but did not receive prescriptions for lethal medications.¹⁰⁴ In addition to the similarity of the underlying illness, the control patients were matched according to age (within ten years of the case patient's age) and date of death (within 30 days of the case patient's death). Only control patients who would have met the requirements of the Death With Dignity Act were included in the study. The data on control patients and case patients was obtained by the same methods, that is, by studying death certificates and interviewing physicians.¹⁰⁵

The first annual report on assisted suicide indicates that only twenty-three patients had invoked the Oregon Act. They received legal drugs to end their lives under the provisions of the law. Of these twenty-three, fifteen had actually used the drugs and died; six others had died from their illnesses, and two were still alive as of January 1, 1999. Most of the patients who applied for the drugs had cancer.¹⁰⁶ Physician-assisted

100. *Id.* at 578.

101. Families were interviewed in the second year OHD report.

102. The report has been criticized for providing:

Nothing approaching a full picture of the extent to which physicians (and others) both have and have not complied with the law . . . A report, like Oregon's, that relies heavily on physician self-reporting will tend to show that the law is operating well and its provisions are regularly being followed. And that is what the Oregon report shows . . . A report that makes no serious efforts to uncover the extent of "covert" assisted suicide does not inspire much faith that legalizing assisted suicide brings the practice into the open, as some proponents told us it would.

Marc Spindelman, *Flaws Mar Oregon Report On Dying Law*, DETROIT NEWS, Mar. 7, 1999 (available from author).

103. See OHD REPORT, *supra* note 87, at 582.

104. *Id.* at 578-79.

105. *Id.*

106. James D. Moore, *One Year Down: Oregon's Assisted-Suicide Law*, COMMONWEAL, Mar. 12, 1999, at 10.

suicide accounted for five of every 10,000 deaths in Oregon. The median age of the fifteen patients who died after taking lethal medication was sixty-nine years; eight were male, and all fifteen were white. Thirteen of the 15 patients had cancer.¹⁰⁷ The report holds that finances and fear of pain did not appear to be critical considerations in the choice of physician-assisted suicide. Instead, persons who chose physician-assisted suicide were primarily concerned about personal autonomy and control over the manner in which they died.¹⁰⁸ The fact that a significant number of Oregonians die under hospice care may provide a possible explanation for the relatively few patients who requested physician-assisted suicide.

The report was quickly hailed by advocates of PAS as evidence that the law had not led to abuses, botched suicides or a widespread rush among the sick or suffering to move to Oregon for the right to be put to death, as many critics of the law had contended. For example:

Dr. Peter Rasmussen, a cancer specialist in Salem, Ore., who said he has been present for at least two occasions “of physician-assisted suicide,” said that it was a very positive experience to have people gather around and say their final goodbyes and reminisce: “One of the potential advantages is you can plan it - people who have relatives far away can gather everybody together.”¹⁰⁹

On the other hand, a group opposed to assisted suicide criticized Oregon’s report on the Death With Dignity Act, saying that the study’s conclusions were unfounded.¹¹⁰

B. The Second Report’s Findings

Recently information on patients who received prescriptions for lethal medications in 1999 was reported to the Oregon Health Division. The report compiles the data of the second year experience with legalized physician-suicide in Oregon. The patients who received prescriptions for lethal medication were identified through the regulation that requires doctors to report. Health Division epidemiologists collected additional information using physician interviews and death certificates. Unlike the first report, here family members were also interviewed to better understand why some patients requested physician-assisted suicide. According to the report, thirty-three prescriptions were written in 1999 for lethal doses of medication, and twenty-seven died after using this medication; twenty-six of these patients obtained their prescription in 1999 (nine per 10,000 deaths in Oregon) and one in 1998. Five of the 1999 prescription recipients died

107. See OHD REPORT, *supra* note 87, at 577-79.

108. See *id.* at 577-83.

109. Sam Howe Verhovek, *Oregon Reporting 15 Deaths in Year Under Suicide Law; Officials See No Abuses*, N.Y. TIMES, Feb. 18, 1999, at A1; see *Assisted Suicide in Practice*, N.Y. TIMES, Feb. 27, 1999, at A14; see also *Mercy in Oregon*, ALB. TIMES UNION, Feb. 22, 1999, at A6.

110. See John Hughes, *New Doctors’ Group Criticizes Oregon Death With Dignity Report*, THE ASSOCIATED PRESS, Feb. 26, 1999 (available from author).

of their underlying illness and two were alive at the end of 1999. The median age of the twenty-seven patients who took the lethal medication was seventy-one years. Sixteen were male, twenty-six were white, and twelve (44%) were married. Seventeen patients had end-stage cancer, most commonly lung cancer. Four had chronic lung disease and four had amyotrophic lateral sclerosis (Lou Gehrig's Disease). All patients had health insurance and twenty-one were in hospice care before death.¹¹¹

C. Implications of the Reports' Findings and Suggestions for Improvement

The two published studies provide a clearer picture of the workings of the Oregon Death With Dignity Act, through which forty-three people have ended their lives in the last two years. Twenty-two physicians prescribed lethal medication to thirty-three patients in 1999. Six of the physicians had also prescribed such medication in 1998. Fourteen of the twenty-two physicians were in family practice or internal medicine, five were oncologists, and three were in other specialties. More doctors were present when patients took the lethal medication and when they actually died than in the previous year. In 1999, physicians were present in sixteen of the twenty-seven cases (59%) when the patient took lethal medicine (compared to eight of the sixteen cases in 1998, 50%). Doctors were present in thirteen of the twenty-seven cases (48%) when the patient died (compared to six of the sixteen cases, 38%, in 1998).¹¹² We think the presence of physicians at the patient's bedside is important for three reasons: first, it could enhance the trust between patients and physicians, welcoming physicians to the patient's private homes during the intimate moments of dying,¹¹³ sharing with them, as well as with the patients' loved ones, the last moments of the patient's lives.¹¹⁴ Patients are thus reassured that their physicians will stand by them until the very last moment.

Second, the wide variations in patients' time to death support the assertions that physicians should be required to be present when patients die. According to the 1998 report, the median time from ingestion of the lethal medication to unconsciousness was five minutes (range, three to twenty minutes) and the median time from ingestion to death was twenty-six minutes (range, fifteen minutes to 11.5 hours).¹¹⁵ In comparison, according to the 1999 report the median interval between ingestion to unconsciousness was ten minutes (range, one to thirty minutes) and the mean interval between ingestion

111. See OHD REPORT 2, *supra* note 21, at 598-600.

112. Reported by the Euthanasia Research and Guidance Organization, Mar. 2, 2000 (on file with author).

113. Ninety-three percent (25 patients) died at home in 1999. Eighty-one percent (15 patients) died at home in 1998. Cf. OHD REPORT 2, *supra* note 21, at 601.

114. "We prefer to speak of the patient's beloved people rather than of the patient's family. Blood relatives are not necessarily those at the patient's bedside during the last days of his or her life." R. Cohen-Almagor, *The Patients' Right to Die in Dignity and the Role of Their Beloved People*, 4 ANN. REV. L. & ETHICS 213, 232 (1996).

115. See OHD REPORT, *supra* note 87, at 578.

and death was thirty minutes (range, four minutes to twenty-six hours).¹¹⁶ During prolonged process of dying, the physician may provide much needed counsel and explanation to the patient's loved ones.

Third, the physician's presence may be required to finalize an agonizing process of death. Restricting the Act to include only self-administered oral medication is problematic because such medication may not end the patient's life and/or may prolong the patient's suffering needlessly. Oral medication may be difficult or impossible for many patients to ingest because of nausea or other side effects of their illnesses. Studies of lethal oral medications have found that death may take hours or may never occur. In the Netherlands, physicians who intend to provide assistance with suicide sometimes end up administering a lethal medication themselves because of the patient's inability to take the medication or because of problems with the completion of physician-assisted suicide.¹¹⁷ It was argued that lethal prescriptions of oral medications are ineffective 25% of the time.¹¹⁸ Fifty percent of physicians in the OHSU survey reported that they were not sure what they would prescribe if they decided to comply with a patient's request for a lethal prescription of oral medication.¹¹⁹ This widespread uncertainty on the effectiveness of drugs and dosages when used orally raises serious concerns that family members might face a situation in which their beloved is forced to endure an unsuccessful suicide attempt or a protracted death. To date, there are no known failed suicides in Oregon, but families should be counseled on the possibility, which is not slim, of a protracted death. Possible alternatives for patients who are incapable of taking oral medication are lethal injection, which is proscribed in the Oregon Death With Dignity Act, and self-administered, lethal intravenous infusion, which may not be prohibited.¹²⁰

Thus, our suggestion is: for those patients who are unable to ingest oral medication, a mechanism can be introduced by which all that patients are required to do is to activate a lethal injection administered by a qualified physician. Alternatively, patients may administer lethal intravenous infusion. When patients who took the oral medication are

116. See OHD REPORT 2, *supra* note 21, at 599.

117. Johanna H. Groenewoud, et al., *Clinical Problems With the Performance of Euthanasia and Physician-Assisted Suicide in the Netherlands*, 342 NEW ENG. J. OF MED., 551, 556 (2000).

118. *Oregon State Ballot Measure 51: Repeal of 1994 Assisted Suicide Ballot Measure*, 79 *City Club of Portland Bulletin* (Oct. 17, 1997), available at <http://www.pdxcityclub.org/ballot51.html>; International Anti-Euthanasia Task Force, *Special Report: Oregon Takes a Closer Look At Assisted Suicide*, available at <http://www.iaetf.org> (citing Barbara Coombs Lee, et al., *Physician Assisted Suicide*, 2 OREGON HEALTH L. MANUAL 8 (1997)); see also Mark O'Keefe & Gail Kinsey Hill, *Suicide Methods Come Into Question*, THE OREGONIAN, Aug. 15, 1997, at A01, available at WL 13111490.

119. See OHSU SURVEY, *supra* note 24, at 313.

120. Legislative attempts to legalize PAS that were introduced during 1997 in Connecticut, Illinois and Massachusetts stated that the physician may assist the patient in making use of the means to hasten death, so long as the actual use is a voluntary physical act of the patient. The Maine bill requires the responsible physician to be present when the patient self-administer the lethal medication. See Russell Korobkin, *Physician-Assisted Suicide Legislation: Issues and Preliminary Responses*, 12 NOTRE DAME J.L. ETHICS & PUB. POL'Y 464 (1998).

lingering for an unusually long period, such as 11.5 hours, the physician should be allowed to administer a lethal injection.¹²¹

In the second year, the number of patients who died after ingesting lethal medication increased, something that could be expected because of the growing awareness of the public to the availability of PAS. Having said that, the number of PAS remained small in relation to the total number of persons in Oregon who died during the year. According to the physicians' reports, eight of twenty-six patients for whom data were available received a prescription from the first physician they asked. Of the other eighteen patients, ten asked one other doctor, and eight asked two or three other physicians. Information on one patient was not available.¹²² This data shows that many physicians in Oregon are still reluctant to provide assistance with suicide.

Particularly troubling findings in the first report were that persons who were divorced were 6.8 times more likely to choose PAS than married persons, and persons who had never married were 23.7 times more likely to choose PAS than married persons. Although these findings do not necessarily lead to the conclusion that patients choosing PAS are more socially isolated than the norm, there is often a direct correlation between marital status and level of familial support and care. At a minimum, these findings indicate that the psychological makeup and life circumstances of the patients choosing PAS should be studied further because they may be facing an even more difficult process because of weak family support.

It should be noted that the low proportion of married persons in 1998 was not found in the second report. In 1999, twelve of the patients who died by PAS were married, six were widowed, eight were divorced, and one never married. This issue should continue to be observed in the coming annual researches. Reduced family support may exacerbate patients' fears of loss of autonomy and loss of bodily control that were reported as important motivating factors for choosing PAS. The higher risks associated with the marital status of patients and the fact that only five of the sixteen patients had undergone psychological consultations in 1998 indicate the need for increased psychiatric and/or psychological assessments of patients. In addition, these factors support the recommendation that the Act could be improved by requiring psychiatric consultations of patients, as did the Northern Territory Right of Terminally-Ill Act.¹²³ The second-year report says that ten of the patients who died by PAS in 1999 (37%) were referred for psychiatric evaluation. This is a slight increase compared to 1998 (31% of the patients who died by PAS).¹²⁴ The report does not state the time spent on the consultations. This point should be explored and pondered.

Most patients in both reports said that they chose death because of a fear of loss of

121. One such case was reported in 1998. See OHD REPORT, *supra* note 87, at 582. In 1999, 24 patients died within 4 hours, and three patients died after 11 hours or more. See OHD REPORT 2, *supra* note 21, at 599.

122. See OHD REPORT 2, *supra* note 21, at 599.

123. Rights of the Terminally Ill Act, 1995, § 7 (Austral.).

124. See OHD REPORT 2, *supra* note 21, at 601.

autonomy and control over their lives. Controlling the time of death was important to them. Similarly, in the Netherlands fear of loss of dignity and of being a burden, rather than pain, drive most requests for assistance in dying.¹²⁵ In Oregon, two patients in 1998 and seven patients in 1999 expressed concern about inadequate pain control. These findings may reflect advances in palliative care in Oregon, which ranks among the top five states in per capita use of morphine for medical purposes.¹²⁶ Other studies have shown that pain is not prominent in oncology patients' attitudes toward PAS. Emanuel and colleagues found that "patients actually experiencing pain were more likely to find euthanasia or physician-assisted suicide unacceptable."¹²⁷

On the other hand, the findings that only two patients in 1998 and a more significant number of patients in 1999 expressed concern about inadequate pain control may indicate only physicians' opinions that they are capable of managing pain. It might also be the result of poor communication between cancer patients (the majority of patients who asked for lethal drugs) and physicians. This hypothesis is strengthened when one looks at interviews with family members, conducted only in 1999. The most frequently cited reasons by family members for the patient's decision to request assistance with death were concern about loss of control of bodily functions (68%), loss of autonomy (63%), and physical suffering (53%)¹²⁸ Ganzini and colleagues report that pain was an important consideration for 43% of patients who requested prescription for a lethal medication.¹²⁹

Moreover, studies showed that pain control for cancer patients is often inadequate, and that the norm for physicians is to underestimate pain. Patients with significant pain caused by cancer visit their physicians and frequently leave with as much pain as they came with because their pain was never discussed or treated. Impediments to adequate pain treatment include health care providers' fear of inducing physical or psychological addiction, misconceptions about pain tolerance and assessment biases.¹³⁰ Furthermore, communication about pain often depends on the patient complaining of it. Patients, however, are often reluctant to report pain for a variety of reasons, including wanting to be a "good" (non-complaining) patient, concern about having to take strong pain killers or worries that talking about pain might take too much time and distract the physician

125. Paul van der Maas & Linda L. Emanuel, *Factual Findings, REGULATING HOW WE DIE* 151 (Linda L. Emanuel, ed., 1998).

126. See OHD REPORT, *supra* note 87, at 582. It should be noted that it was argued that more than one patient feared pain. See Joseph P. Shapiro, *Casting a Cold Eye on 'Death With Dignity' Oregon Studies Year 1 of a Benchmark Law*, U.S. NEWS & WORLD REPORT, Mar. 1, 1999, at 56.

127. Ezekiel J. Emanuel, et al., *Euthanasia and Physician-Assisted Suicide: Attitudes and Experiences of Oncology Patients, Oncologists, and the Public*, 347 *Lancet* 1805, 1809 (1996).

128. See OHD REPORT 2, *supra* note 21, at 601.

129. Linda Ganzini, et al., *Physicians' Experiences With the Oregon Death With Dignity Act*, 342 *NEW ENG. J. MED.* 557, 559 (2000).

130. Kathleen Foley, *Dismantling the Barriers: Providing Palliative and Pain Care*, 283 *MEDICAL STUDENTS JAMA* 115 (2000).

from dealing with the disease itself.¹³¹ Moreover, many patients seek pain relief from complementary therapies. “Often they feel that these methods offer a holistic approach that is lacking in the traditional allopathic model.”¹³² It is advisable that doctors examine whether the prescribed pain control is adequate. Palliative care is able to prevent or at least to ease most manifestations of physical pain.¹³³

In addition to the dearth of data regarding patient perspectives on PAS, insufficient data exists on the level of underreporting by physicians.¹³⁴ The Oregon Health Division is not only responsible for collecting information under the Death With Dignity Act; it is also obligated to report any cases of noncompliance with the law to the Oregon Board of Medical Examiners. According to the Division’s report, its responsibility to report noncompliance makes it difficult, if not impossible, to detect accurately and comment on underreporting. Furthermore, the reporting requirements, as written in the Oregon Act, can only ensure that the process for obtaining lethal prescriptions complies with the law. “[The Division] cannot determine whether PAS is being practiced outside the framework of the Death With Dignity Act.”¹³⁵

One way to decrease the chances of underreporting, which is a major problem in the Netherlands,¹³⁶ is to require reporting by pharmacists who dispense lethal prescriptions in addition to requiring reporting by physicians. Indeed, recent changes in the Act now require pharmacists to report separately all prescriptions. If physicians knew that pharmacists were also required to report all prescriptions for lethal medication, thus providing a check on physicians’ reporting, they would be more likely to comply with the Act’s reporting requirement. Although some pharmacists may be less willing to fill prescriptions for lethal medication knowing that their names will be associated with the procedure, additional reporting requirements would help protect the state and public’s compelling interest in monitoring PAS and ensure that safety procedures are followed. The confidentiality of pharmacists could be guaranteed by the Health Division, as the

131. See S. Ward, et al., *Patient-Related Barriers to Management of Cancer Pain*, 53 PAIN 319 (1993); Charles S. Cleeland, et al., *Pain and Its Treatment in Outpatients With Metastatic Cancer*, 330 NEW ENG. J. MED. 592, 596 (1994); Charles S. Cleeland, *Controlling Cancer Pain: Many Missed Opportunities*, MSJAMA REPORT (Jan. 5, 2000), available at http://www.ama-assn.org/sci-pubs/msjama/articles/vol_283/no_1/cleeland.htm.

132. Catherine S. Magid, *Pain, Suffering, and Meaning*, 283 MSJAMA 114, 114 (2000).

133. In order to institute effective pain control, new programs for the training and certification of palliative care consultants need to be developed and implemented. See generally Franklin G. Miller, et al., *Regulating Physician-Assisted Death*, 331 NEW ENG. J. MED. 119 (1994); Timothy E. Quill, et al., *Palliative Options of Last Resort*, 278 JAMA 2099 (1997); TEXTBOOK OF PALLIATIVE MEDICINE (P. D. Doyle, G. W. Hanks and N. MacDonald, eds. 1998); Anne Scott, *Autonomy, Power, and Control in Palliative Care*, 8 CAMBRIDGE Q. OF HEALTHCARE ETHICS 139 (1999); Janet L. Abrahm, *The Role of the Clinician in Palliative Medicine*, 283 MEDICAL STUDENTS JAMA 116 (2000).

134. OHD REPORT, *supra* note 87, at 583; see also OHD REPORT 2, *supra* note 21, at 603.

135. OHD REPORT, *supra* note 87, at 583.

136. See Gerrit van der Wal, et al., *Evaluation of the Notification Procedure for Physician-Assisted Death in the Netherlands*, 335 NEW ENG. J. MED. 1706, 1710 (1996); John Griffiths, et al., *EUTHANASIA AND LAW IN THE NETHERLANDS* 259-98 (Amsterdam University Press 1998).

Division currently guarantees the confidentiality of the reporting physicians.¹³⁷ Furthermore, the Oregon Medical Association should establish a committee that will investigate the underlying facts accounted for in the reports as well as whether there were “mercy” cases which were not reported and/or which did not comply with the Act. Licensing sanctions will be taken to punish those healthcare professionals who violated the required procedure.

Many patients who sought assistance with suicide had to ask more than one physician for a prescription for lethal medication. The Act states that no health care provider is under any duty to participate in the dispensing of medication to a patient who desires to end his or her life. Any health care provider who is unable or unwilling to assist the patient with his or her request is required to send the patient and the patient’s records to a new health care provider.¹³⁸ Only eight of the twenty-seven patients in 1999, and eight of sixteen patients in 1998¹³⁹ were able to initiate the prescription process with the first physician they approached. The other patients had to request a prescription from a second or third physician. These findings are supported by the findings of Ganzini and colleagues who report that “physicians grant about one-in-six requests for a prescription for a lethal medication and that one-in-ten requests actually results in suicide.”¹⁴⁰ Furthermore, a recent study shows that fourth-year medical students in Oregon are significantly less willing than other medical students in the United States to provide a patient with a lethal prescription.¹⁴¹ In the OHSU survey, less than half of physicians stated that they would be willing to write a prescription for a lethal dose of medication once the Act went into effect.¹⁴² Moreover, the study indicated that physicians practicing in rural communities were less likely to be willing to participate in PAS because of greater threats to confidentiality, lack of anonymity and social disapproval. Considering that 62% of Oregon’s population resides in rural

137. Van der Maas and colleagues decided not to include pharmacists in their comprehensive study about the Dutch practice of euthanasia. They explained:

While, in several instances, pharmacists are aware of the preparation or carrying out of euthanasia, they often are not. Therefore it did not appear necessary to interview pharmacists, either for reliable quantification or to obtain an insight into the background for this type of decision, although they might be able to provide interesting additional information in a number of cases.

Paul J. van der Maas, et al., *Euthanasia and Other Medical Decisions Concerning the End of Life*, HEALTH POLICY MONOGRAPHS 12 (Amsterdam: Elsevier, 1992).

138. See Oregon Death With Dignity Act § 4.01, OR. REV. STAT. § 127.855 (1999).

139. See OHD REPORT 2, *supra* note 21, at 601. See also OHD REPORT, *supra* note 87, at 582.

140. Linda Ganzini, et al., *Physicians’ Experiences With the Oregon Death With Dignity Act*, 342 NEW ENG. J. MED. 557, 557-63 (2000).

141. Richard S. Mangus, et al., *Medical Students’ Attitudes Toward Physician-Assisted Suicide*, 282 MSJAMA 2080 (1999).

142. OHSU SURVEY, *supra* note 24, at 312. See also Section IV(B), *infra*, discussing the Oregon Health Division Report’s finding that six of twenty-three Oregon patients who received lethal prescriptions in 1998 requested lethal medications from one or two physicians before finding a physician who would begin the prescription process.

communities, many patients are likely to be transferred at least once.¹⁴³ Patients may have a difficult time finding assistance. Each transfer to another health care provider creates a delay in which the patient may deteriorate further and continue to suffer.

Obviously it is not proposed that physicians should be forced or pressured to participate in PAS. Physicians should not be compelled by the state to take part in a medical activity, especially an activity that many find morally repugnant or religiously offensive, unless the state has a compelling interest, which is not the case here. Granted that PAS should be a voluntary act by both the patient and the physician, we also think that physicians should be open and candid about their views on PAS and should express their reservations about the Act, if they have any, so patients would know what they could expect from them near the time of their death. Physicians should be required to alert patients of their blanket opposition before subjecting them to the time and expense of assessments, which may have to be repeated by other physicians.

Despite its flaws, the Oregon Act is a significant step toward establishing a patient's right to autonomy and choice in deciding end of life issues. Strengthening its weak areas will ensure that the Act achieves its laudable purpose: guaranteeing that competent, adult Oregonian patients have the right to exercise control and autonomy in end of life decision making, including the right to die in a humane and dignified manner.¹⁴⁴ On the positive side, many of the Oregon Health Division's findings refute arguments commonly voiced by the public and by opposition groups on the dangers of PAS. For instance, the Division's studies provide no evidence to support the common fears that PAS will be disproportionately chosen by, or forced, on patients who are poor, uneducated, uninsured or afraid of the financial costs or pain of their illness. The 1998 case patients and the larger group of 5604 Oregon residents who died from similar underlying illnesses in 1996 did not differ statistically with respect to age or education. Moreover, the case patients did not differ from the matched control patients in age, race, sex, level of education, and rural or urban residence. Lastly, neither the case patients nor the control patients expressed concern about the economic costs of their illness.¹⁴⁵ Similarly, the 1999 report indicates that "poverty, lack of education or health insurance, and poor care at the end of life were not important factors in patients' requests for assistance with suicide."¹⁴⁶ Although these results are based on a relatively small number of patients and ongoing supervision is needed, these findings suggest the conclusion that PAS will not be disproportionately chosen by or forced on unwilling, uneducated and/or socially and economically disadvantaged individuals. Based on the motivations of the patients examined in the two reports, PAS seems to be associated more with the desire for autonomy

143. OHSU SURVEY, *supra* note 24, at 312.

144. See also R. Cohen-Almagor, *A Circumscribed Plea for Voluntary Physician-Assisted Suicide*, in *MEDICAL ETHICS AT THE DAWN OF THE 21ST CENTURY* 127 (R. Cohen-Almagor ed., 2000).

145. OHD REPORT, *supra* note 87, at 579.

146. OHD REPORT 2, *supra* note 21, at 602. See also Linda Ganzini, et al., *Physicians' Experiences With the Oregon Death With Dignity Act*, 342 *NEW ENG. J. MED.* 557, 563 (2000).

and control rather than fear of intolerable suffering or devastating financial consequences.

IV. CONCLUSION

The studies from Oregon portray the individuals opting for assisted suicide as well-educated, well-insured, often in hospice care and very concerned about loss of independence. The most frequently cited reasons for PAS in both years were loss of autonomy (cited by 81% of patients in 1999 and by 75% in 1998) and an inability to participate in activities that make life enjoyable (81% in 1999 and 69% in 1998). Worries about money played essentially no role in the patients' decision. There is no evidence that the poor, uneducated, mentally ill or socially isolated are disproportionately seeking or getting lethal prescriptions of drugs under the Oregon Death With Dignity Act.¹⁴⁷

Although polls have consistently shown for over a decade that a majority of Americans, from 60% to 70%, support making assisted suicide legal for patients who are mentally competent and have less than six months to live Oregon remains the only state to legalize assisted suicide, and the future of the Act is uncertain.¹⁴⁸ Physical and mental pain and suffering as well as the loss of dignity and autonomy resulting from a patient's lack of bodily control due to a degenerative disease are strong arguments supporting Oregon's Death With Dignity Act. While it is important to allow a patient the right to decide when to end his or her pain and suffering, it is also important to protect the patient's best interests and ensure that a patient's life is not being ended involuntarily. While the Oregon Act already includes many safeguards that serve the best interests of patients, incorporating greater protections in the particular areas discussed earlier will help ensure that all patients receiving lethal medications are truly making an informed and voluntary choice.

Building on the experiences of the Act, as well as on the experiences of the Dutch and the Australian Northern Territory, we would suggest the following guidelines in conducting physician-assisted suicide.

Guideline 1. The physician should not suggest assisted-suicide to the patient. Instead, it is the patient who should have the option to ask for such assistance. Initiation by the physician might undermine trust between the patient and his/her physician, conveying to the patient that the doctor gave up on him/her, and values his/her life only to the extent of offering assistance to die. Such an offer might undermine the will to live and to

147. See generally OHD REPORT 2, *supra* note 21, at 598-604. See also David Brown, *A Picture of Assisted Suicide: Most Who Use Oregon Law Are Educated, Insured; Some Change Their Minds*, WASH. POST, Feb. 24, 2000, at A3.

148. Mark O'Keefe, *Surveys: More Favor Assisted-Suicide Law*, THE OREGONIAN, Mar. 11, 1997 at D1; See also Roper Organization of New York City, *The 1988 Roper Poll on Attitudes Toward Active Voluntary Euthanasia* (National Hemlock Society 1988); Mark Gillespie, *Kevorkian to Face Murder Charges*, GALLUP NEWS SERVICE, Mar. 19, 1999, available at <http://www.gallup.com/poll/releases/pr990319.asp>; Charles F. McKhann, *A TIME TO DIE: THE PLACE FOR PHYSICIAN ASSISTANCE* (Yale University Press, 1999).

explore further avenues for coping with the illness. It is noted that the 1973 KNMG report on euthanasia said that doctors should not be the ones to suggest "active euthanasia."¹⁴⁹ By 1984 this proviso disappeared. There is nothing in today's KNMG protocols about doctors bringing up the option of euthanasia to patients or friends/relatives, since it is seen as "preceding" the euthanasia process. The issue is left at the discretion of the doctor.¹⁵⁰

Guideline 2. The request for physician-assisted suicide of an adult, competent patient who suffers from a terminal disease must be voluntary.¹⁵¹ The decision is that of the patient who asks to die without interference because life seems the worst alternative in the current situation. The patient should state her wish several times over a period of time. We must verify that the request for physician-assisted suicide does not stem from a momentary urge, an impulse, a product of passing depression. This emphasis of enduring request is one of the requirements of the Oregon Death With Dignity Act, and of the Dutch Guidelines,¹⁵² and it was one of the requirements of the abolished Northern Territory law in Australia.¹⁵³ We must also verify that the request is not the result of external influences. It should be ascertained with a signed document that the patient is ready to die now, rather than depending solely on directives from the past. Section 2 of the Oregon Act requires that the written request for medication to end one's life be "signed and dated by the patient and witnessed by at least two individuals who, in the presence of the patient, attest to the best of their knowledge and belief the patient is capable, acting voluntarily, and is not being coerced to sign the request"¹⁵⁴.

Guideline 3. At times, the patients' decision might be influenced by severe pain.¹⁵⁵ In this context, the role of palliative care can be crucial. Ganzini and colleagues report that as a result of palliative care, some patients changed their minds about assisted suicide.¹⁵⁶ The World Health Organization defines palliative care as the "active, total care of patients whose disease is not responsive to curative treatment," maintaining that control of pain, of other symptoms, and of psychological, social and spiritual problems is

149. Van debtor Koninklijke Maatschappij tot Bevordering der Geneeskuns, *Discussienota van debtor Weggroep Euthanasie*, 30 MEDISCH CONTACT 1, 7 (1975).

150. Cf. Carlos F. Gomez, REGULATING DEATH: EUTHANASIA AND THE CASE OF THE NETHERLANDS 109 (The Free Press, 1991); P.J. van der Maas, et al., *Euthanasia and other Medical Decisions Concerning the End of Life*, HEALTH POLICY MONOGRAPHS 102 (Amsterdam: Elsevier, 1992); Herbert Hendin, et al., *Physician-Assisted Suicide and Euthanasia in the Netherlands*, 277 JAMA 1721 (1997); See also Ezekiel J. Emanuel, et al., *Euthanasia and Physician-Assisted Suicide: Attitudes and Experiences of Oncology Patients, Oncologists, and the Public*, 347 LANCET 1809 (1996).

151. See John Griffiths, et al., EUTHANASIA AND LAW IN THE NETHERLANDS 66 (Amsterdam Univ. Press 1998) (Describing the Dutch requirements of careful practice).

152. *Id.*

153. Rights of the Terminally Ill Act, 1995, § 7 (Austral.).

154. See Oregon Death With Dignity Act § 2.02, OR. REV. STAT. § 127.80 (1999).

155. See William Ruddick, *Do Doctors Undertreat Pain?*, 11 BIOETHICS 246-55 (1997) (Explaining physicians and patients different conceptions of pain).

156. Linda Ganzini, et al., *Physicians' Experiences With the Oregon Death With Dignity Act*, 342 NEW ENG. J. MED. 557, 563 (2000).

paramount.¹⁵⁷ The medical staff must examine whether, by means of medication and palliative care, it is possible to prevent or to ease the pain.¹⁵⁸ If it is, then we may not fulfill the patients' wish, but instead prescribe the necessary treatment. This is provided that the educated patient (i.e., patient who was advised by the medical staff about the available palliative care options) does not refuse to receive the painkillers, and that when the pain is eased the motive (or one of the main motives) that caused the patient to ask for assisted suicide is no longer present. If the patient insists on denying all medication, doctors must try to ascertain the reasons for this insistence before they comply.

At times, coping with pain and suffering can demand all the patient's emotional strength, exhausting his or her ability to deal with other issues. In cases of competent patients, it must be determined that the decision is based on the patient's soundness of mind. The assumption is that the patient understands the meaning of his or her decision. A psychiatric assessment of the patient could confirm whether the patient is able to make such a meaningful decision concerning his or her life. A meeting with a psychiatrist should confirm that the decision is truly that of the patient, expressed consistently and of her own free will. As mentioned above, the Northern Territory Rights of Terminally Ill Act required that the patient meet with a qualified psychiatrist to confirm that he or she is not clinically depressed.¹⁵⁹ It is worthwhile to hold several such conversations, separated by a few days. The patient's loved ones and the attending physician should be included in at least one of the conversations.

Guideline 4. The patient must be informed of his or her situation and the prognoses for both recovery and escalation of the disease, as well as the suffering it may involve. There must be an exchange of information between the doctors and the patient.¹⁶⁰

Guideline 5. It must be ensured that the patient's decision is not a result of familial and environmental pressures. At times, the patient may feel that he or she constitutes a burden to his or her loved ones. It is the task of social workers to examine the motives of the patient and to see to what extent they are affected by various external pressures (as opposed to a true free will to die). A situation could exist in which the patient is under no such pressure but still does not wish to be a burden to others. Obviously, we cannot say that the feelings of a patient toward her loved ones are not relevant to the decision making.

Guideline 6. Verification of diagnosis. To minimize misdiagnosis, and to allow the

157. World Health Organization, *CANCER PAIN RELIEF AND PALLIATIVE CARE: REPORT OF A WHO EXPERT COMMITTEE 11* (World Health Organization 1990).

158. Cf. Christine K. Cassel & Kathleen M. Foley, *Principles For Care of Patients at the End of Life: An Emerging Consensus Among the Specialties of Medicine*, MILBANK MEMORIAL FUND REPORT (New York, 1999), cited in Vida Foubister, *Medical Experts Agree On Guide For End-Of-Life Care*, AM. MED. NEWS, Feb. 7, 2000; Timothy E. Quill, et al., *Palliative Treatments of Last Resort: Choosing the Least Harmful Alternative*, 132 ANNALS OF INTERNAL MEDICINE 488 (2000).

159. Rights of the Terminally Ill Act, 1995, § 7 (Austral.).

160. See Oregon Death With Dignity Act § 3.01, OR. REV. STAT. § 127.815 (1999) (Attending physician responsibilities).

discovery of other medical options, the decision-making process should include a second opinion provided by a specialist who is not dependent on the first doctor, either professionally or otherwise. The patient's attending physician, who supposedly knows the patient's case better than any other expert, must be consulted. All reasonable alternative treatments must be explored. The Oregon Act requires that "a consulting physician shall examine the patient and his/her relevant medical records and confirm, in writing, the attending physician's diagnosis that 'the patient is suffering from a terminal disease,' and verify that the patient is capable, is acting voluntarily and has made an informed decision."¹⁶¹ The Dutch guidelines require that the physician consult a colleague.¹⁶² The Northern Territory Rights of Terminally Ill Act required that the patient be examined by a physician who specializes in treating terminal illness.¹⁶³

Guideline 7. To avoid the possibility of arranging deals between doctors, it is advisable that a small committee of specialists that will review the requests for physician-assisted suicide will determine the selection of the consultant.

Guideline 8. Some time prior to the performance of physician-assisted suicide, a doctor and a psychiatrist are required to visit the patient, examine him or her, and verify that this is the genuine wish of a person of sound mind who is not being coerced or influenced by a third party. A date for the procedure is then agreed upon.¹⁶⁴ The patient's loved ones will be notified so they can be present right until the performance of the act, making the day an intimate, family occasion.

Guideline 9. The patient could rescind at any time and in any manner. This was granted under the Australian Northern Territory Act¹⁶⁵ and is granted under the Oregon Act.¹⁶⁶

Guideline 10. Physician-assisted suicide may be performed only by a doctor and in the presence of another doctor. The decision-making team should include at least two doctors and a lawyer, who will examine the legal aspects involved. Insisting on this demand would serve as a safety valve against possible abuse. Perhaps a public representative should also be present during the entire procedure—the decision making process and the actual performance of the act. This extra precaution should ensure that the right to die with dignity does not become a duty. The doctor performing the assisted suicide should be the one who knows the patient best, has been involved in his or her treatment, has taken part in the consultations with the patient and with the patient's loved ones, and

161. Oregon Death With Dignity Act, § 3.02, OR. REV. STAT. § 127.820 (1999).

162. John Griffiths, et al., *EUTHANASIA AND LAW IN THE NETHERLANDS* 66 (Amsterdam Univ. Press 1998).

163. Rights of the Terminally Ill Act, 1995, § 7 (Austral.).

164. This Guideline is somewhat similar to the guidelines of the Swiss EXIT protocol. See *Assisted Suicide in Switzerland - SAVES Fact Sheet No. 20*, SOUTH AUSTRALIAN VOLUNTARY EUTHANASIA SOCIETY (1997), available at <http://www.on.net/clients/saves/fs20.htm>.

165. Andrew L. Plattner, *Australia's Northern Territory: The First Jurisdiction to Legislate Voluntary Euthanasia, and the First to Repeal It*, 1 DEPAUL J. OF HEALTH CARE L. 648 (1997).

166. Oregon Death With Dignity Act, § 3.07, OR. REV. STAT. § 127.845 (1999).

has verified, through the help of social workers and psychologists, that euthanasia is the wish of the patient.

Guideline 11. Physician-assisted suicide may be conducted in one of three ways, all of them discussed openly and decided upon by the physician and his/her patient: (1) Oral medication; (2) Self-administered, lethal intravenous infusion; (3) Self-administered lethal injection. As discussed, oral medication may be difficult or impossible for many patients to ingest because of nausea or other side effects of their illnesses. In the event that oral medication was provided and the dying process lingers on for long hours, the physician is allowed to administer a lethal injection by himself/herself.¹⁶⁷

Guideline 12. Doctors may not demand a *special fee* for the performance of assisted suicide. The motive for physician-assisted suicide is humane, so there must be no financial incentives and no special payment that might cause commercialization and promotion of PAS.

Guideline 13. There must be extensive documentation in the patient's medical file including the disease diagnosis and prognosis by the attending and the consulting physicians; attempted treatments; the patient's reasons for seeking physician-assisted suicide; the patient's request in writing or documented on a video recording; documentation of conversations with the patient; the physician's offer to the patient to rescind his or her request; documentation of discussions with his or her loved ones, and a psychological report confirming the patient's condition. This meticulous documentation is meant to prevent exploitation of any kind: personal, medical, or institutional.¹⁶⁸ Each physician-assisted suicide report should be examined by a coroner.

Guideline 14. Pharmacists should also be required to report all prescriptions for lethal medication, thus providing a further check on physicians' reporting.

Guideline 15. A doctor must not be coerced into taking actions that contradict his or her conscience and understanding of his or her role. This is the practice in Oregon and was provided under the Northern Territory Act.¹⁶⁹

Guideline 16. The local medical association should establish a committee whose role will be not only to investigate the underlying facts in the reports, but to investigate whether there are "mercy" cases that were not and/or that did not comply with the Guidelines.

Guideline 17. Licensing sanctions will be taken to punish those healthcare profes-

167. Cf. Johanna H. Groenewoud, et al., *Clinical Problems With the Performance of Euthanasia and Physician-Assisted Suicide in the Netherlands*, 342 N. ENG. J. MED. 551 (2000).

168. Most of these documents are required under Oregon Death With Dignity Act, § 3.09, OR. REV. STAT. § 127.855 (1999). For further deliberation, see the Dutch guidelines in Griffiths, *supra* note 136, at 66. Rebecca Cook pointed out that such a bureaucratic procedure might discriminate against minorities who will not find it easy to cope with the described demands. However, the demand for detailed documentation is meant to prevent abuse, not to discourage people from getting the help they want. We should be sensitive to cultural differences and strive to meet special needs that arise from cultural norms but not at the expense of opening the door wide for "eliminating" unwanted people.

169. Andrew L. Plattner, *Australia's Northern Territory: The First Jurisdiction to Legislate Voluntary Euthanasia, and the First to Repeal It*, 1 DEPAUL J. HEALTH CARE L. 645 (1997).

sionals who violated the guidelines, failed to consult and to file reports or who engaged in involuntary euthanasia without the patient's awareness or consent, or euthanized patients lacking decision-making capacity. Physicians who fail to comply with the above guidelines will be charged and procedures to sanction them will be opened by the Disciplinary Tribunal of the Medical Association. The maximum penalty for violation of guidelines should be the revoking of the medical license.¹⁷⁰

There is always the risk that patients and doctors might view a proposal for increased regulation as too paternalistic and unjustifiably intrusive. Although the proposals do create more regulations and will be viewed by some patients and physicians as unnecessary increases in bureaucratic "red tape," these regulations are necessary to protect the best interests of patients, and thus to ensure the effectiveness and longevity of the Act. Implementation of the proposals will strike a better balance between the need for information and monitoring and the need to protect the privacy and confidentiality of those involved.

170. See also Arthur L. Caplan, et al., *The Role of Guidelines in the Practice of Physician-Assisted Suicide*, 132 ANNALS OF INTERNAL MEDICINE 476 (2000).