

An Inside Look at the Right-to-Die Movement

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On November 7, 2000, Maine citizens were asked to approve the “Maine Death with Dignity Act.” The ballot question was, “Should a terminally ill adult who is of sound mind be allowed to ask for and receive a doctor’s help to die?”

Voters who took the time to wade through the measure’s small print found that what was called “a doctor’s help to die” was not a commitment to providing care, concern, and pain control as long as the patient lived, but a prescription for a fatal drug overdose. The measure failed.

After the vote, most opponents of assisted suicide breathed a sigh of relief and then promptly turned to other matters, but the reaction among those who favor assisted suicide was far different. They didn’t fold up their tents. They didn’t see the situation in Maine as a done deal. They looked at what had happened, saw it as a temporary setback, regrouped, and kept on working.

This pattern has been repeated over and over again in the battles that have taken place in recent years. “Out of sight, out of mind” seems to be the operative phrase among those who oppose euthanasia and assisted suicide. “If at first you don’t succeed, try, try again” depicts the response of proponents.

Those who seek to legalize euthanasia and assisted suicide¹ pursue their agenda with great dedication and zeal, coupled with savvy public relations instincts and a strategy that launches multidirectional attacks on state laws banning both practices.

¹ Although “euthanasia” and “assisted suicide” are often used interchangeably, they are not the same. One way to distinguish them is to look at the last act—the act without which an intended death would not occur. For example, if an intravenous needle has been inserted into a patient’s vein so that a lethal drug dose will flow through upon the flip of a switch, triggering the switch is the last act. If the patient activates the switch, assisted suicide occurs. If the doctor activates the switch, euthanasia takes place.

Voter Initiatives

Washington and California

Maine was not the first place where attempts were made to change the law by a direct vote of the people. Voter initiatives to legalize “aid-in-dying” measures failed in Washington (1991)² and in California (1992).³ Unlike more recent proposals, these “aid-in-dying” measures would have permitted both euthanasia and assisted suicide. Euthanasia activists attributed their defeats in Washington and California to the public’s natural aversion to doctors actively killing patients (euthanasia) and opponents’ ads depicting a syringe-wielding physician. So they went back to the drawing board and drafted a new “softer, gentler” bill.

Oregon

That new bill, which became Measure 16, the “Oregon Death with Dignity Act,” went through a number of drafts and, in its final version, it became the country’s first assisted suicide bill, explicitly prohibiting euthanasia in general and the lethal injection in particular. By limiting the proposal to assisted suicide only, the illusion of patient control was conveyed.

The measure’s supporters portrayed opponents as religious zealots who were trying to impose their views on everyone and depicted themselves as kind, compassionate individuals who wanted nothing but the right to end intolerable pain by gentle, legal means.

The campaign’s centerpiece was a 60-second television commercial that featured Patty A. Rosen, a former nurse who told a story of helping her daughter die. “So I broke the law and got her the pills necessary. And she slipped peacefully away,”⁴ Rosen said, as she pleaded with viewers to make such actions legal by approving Measure Sixteen.

The ad was powerful, compelling. Over and over, in interviews about the Oregon proposal, Rosen repeated the story of how she gave Jody the pills and “she slipped peacefully away.”⁵ There was only one problem. The story wasn’t true.

Two years earlier, during the California campaign to legalize both euthanasia and assisted suicide, Rosen told an audience she had given her daughter pills but they hadn’t worked. Explaining that it had been necessary to give her daughter a lethal injection, Rosen said, “So she went to sleep. I didn’t know about plastic bags. I wish I had. [I]t seemed to be backfiring. And I was fortunate enough at the very last to be able to hit a vein right and say, ‘Bye, Jody. See you later.’”⁶

² Washington state voters turned down the “Death with Dignity Act,” (Initiative 119) that would have legalized “aid-in-dying” on November 5, 1991 by a vote of 54–46 percent.

³ The campaign to place the “Humane and Dignified Death Act” which would have legalized euthanasia and assisted suicide under the name “aid-in-dying,” failed to gain enough signatures to be placed on the 1988 California ballot. California’s “Death with Dignity Act” (Proposition 161), which would have permitted “aid-in-dying,” did qualify for the ballot, but failed on November 3, 1992 by a vote of 54–46 percent.

⁴ Full text of ad from “Analyzing the ads,” *Portland Oregonian*, October 14, 1994.

⁵ *Ibid.*

⁶ Transcript of audio tape of panel discussion, “Grief, Guilt and Assisted Suicide,” at

Discrepancies between the pills-only and the lethal injection versions of Rosen's story went unchallenged until three days before the vote when an article in an inside section of the *Oregonian* carried Rosen's admission that the commercial was inaccurate.⁷

Based largely on the "peaceful pill" fabrication, Measure 16 passed, making Oregon the only state where, by law, a doctor can prescribe an intentional lethal dose of drugs. Soon the Oregon Medicaid program announced that it would pay for assisted suicide for poor residents as a means of "comfort care."⁸

Michigan

When Oregon's Death with Dignity Act went into effect in 1997, assisted-suicide activists thought other states would fall like dominoes. They selected Michigan as their next target, introducing the "Terminally Ill Patient's Right to End Unbearable Pain and Suffering Act"⁹ in 1998. Unlike the relatively short Oregon law, "Proposal B," as it was labeled on the Michigan ballot, was a 12,000-word disaster for assisted suicide backers. The proposal was so poorly written that even many who favored assisted suicide found it flawed.

There were other problems as well for its supporters. A broad based coalition against the measure prevented assisted-suicide activists from using the religion bashing that had been so effective in Oregon. Large minority populations in Detroit were very much opposed to assisted suicide. And the cost of gathering signatures to place the measure on the ballot had left little funding to wage an effective media campaign.

Although early public opinion polls had indicated that the majority of Michigan voters favored assisted suicide, the proposal was resoundingly defeated on November 3, 1998 by a vote of 71 to 29 percent.¹⁰ However, as with the losses prior to their

the Hemlock Society's 6th National Conference, Hyatt Regency Hotel, Long Beach, CA, Sept. 25, 1992. Tape and transcript on file with author.

In both the 1994 campaign ad and the 1992 Hemlock presentation, Ms. Rosen claimed that her daughter's pain was uncontrollable. However, according to the death certificate for 26-year-old Jody Grape (Patty Rosen's daughter), Ms. Grape's attending physician for the five months prior to her death was Dr. William Swartz, an obstetrician-gynecologist. Jody Grape had thyroid cancer that had metastasized. Swartz (who also signed her death certificate) would have been poorly equipped to provide adequate palliative care for her condition. Death certificate on file with author.

⁷ Mark O'Keefe, "TV ad on assisted suicide leaves out part of the story," *Portland Oregonian*, November 4, 1994.

⁸ Dan Postrel, "State could cover assisted suicide," *Statesman-Journal* (Oregon), December 1, 1994 and Erin Barnett, "Suicide coverage passes review," *Portland Oregonian*, April 26, 1999.

⁹ The full text of Michigan's "Terminally Ill Patient's Right to End Unbearable Pain and Suffering Act" (Proposal B) is available at the International Task Force web site at <http://www.iaetf/michin.htm>.

¹⁰ Jim Suhr, "Michigan voters turn back assisted suicide proposal," *AP News*, November 4, 1998; Brian Murphy, "Assisted suicide proposal opposed: Even its supports admit unpopularity," *Detroit Free Press*, November 4, 1998; Charlie Cain and Tim Kiska, "Voters overwhelmingly reject assisted suicide," *Detroit News*, November 4, 1998.

Oregon success, those who seek to make assisted suicide just another medical option used the abysmal failure in Michigan as a learning experience—and looked ahead, this time to Maine with a ballot initiative for 2000.

Maine

Conditions in Maine seemed favorable for passage of the “Maine Death with Dignity Act,” which appeared on the ballot as “Question 1.” The proposal was virtually identical to the Oregon law. Maine’s demographics were similar to those of Oregon. And, because the state is relatively small, the cost of the campaign would be only a fraction of that in Michigan.

The underlying theme used by the measure’s sponsor, Mainers for Death with Dignity (later called “Yes on One”), was that Maine should follow Oregon’s lead. During the course of the campaign, assisted-suicide supporters from Oregon pitched in to help. Dr. Katrina Hedberg (Oregon’s chief epidemiologist who co-authors Oregon’s official assisted suicide reports), Ann Jackson (executive director of the Oregon Hospice Association), Barbara Coombs Lee (a chief author of the Oregon law and executive director of the assisted suicide advocacy group Compassion in Dying), and former Oregon governor Barbara Roberts all traveled to Maine to assure voters that Oregon’s law was working well and was problem free.

However, the “No on One” campaign, made up of an impressive, broad-based coalition to oppose the measure, used effective research and carefully designed material to counter erroneous claims of a problem-free Oregon law. One television ad featured Oregon physician Thomas Reardon, immediate past president of the American Medical Association. In it, Reardon described Oregon’s problems and complications with assisted suicide. He related the story of a 911 call made by a panic-stricken family member when the lethal prescription caused complications. The ad concluded with Reardon saying, “And I don’t want Maine to make the same mistake we did.”¹¹

The No on One ads were so effective that the Yes on One camp tried to have them taken off the air. When they were unsuccessful, Yes on One enlisted the aid of Oregon’s current governor, John Kitzhaber, to appear in an ad to “set the record straight” about the Oregon law. “Here’s the truth,” Kitzhaber said. “It’s working well.”¹² He insisted that no assisted suicide under the Oregon law had ever resulted in complications warranting a 911 call. But the No on One campaign was able to produce documentation that the case had been the subject of a two-part article in the *Oregonian*.¹³

Support for Question 1, which had been at 71% in August, fell as Mainers learned more about the proposal, and it ultimately failed to pass by a vote of 51–49 percent. But, true to pattern, assisted suicide advocates have not given up. The Yes on 1 committee has reorganized as the “Maine Death with Dignity Center (MDDC),” a 501 (c)(3) corporation. Funded by the Hemlock Society, the MDDC staff and

¹¹ Transcript of “No on One” Ad, “Same Mistake,” on file with author.

¹² “Election politics: Kitzhaber joins Maine debate,” *Eugene City Register-Guard*, October 28, 2000.

¹³ See “Oregon Experience” below.

board—all activists from the Question One campaign—is “committed to continuing the movement” to legalize assisted suicide in Maine.¹⁴

It is unlikely that another initiative will be proposed in Maine at any time in the near future, however the legislative route is another avenue being taken to promote assisted suicide.

Legislative Proposals

“In what states should proposals to legalize assisted suicide be expected?” is a fairly common question. The answer is simple. “Every state is likely to be faced with such a measure, sooner rather than later.”

Since passage of the Oregon’s assisted-suicide law in November 1994, at least 54 assisted suicide and/or euthanasia measures have been introduced in twenty-one states.¹⁵ Not one has passed. On the other hand, between 1995 and 1999, seven states passed laws prohibiting assisted suicide.¹⁶

However, passage is not always the goal of proposing a law to permit assisted suicide. Those who favor the practice acknowledge that the mere introduction of a legislative proposal is beneficial since, when a “death with dignity” bill is introduced, media coverage follows. This presents an opportunity to feature an emotional appeal from a patient who pleads for the “right” to assisted suicide.

Then, after the initial flurry of stories, most bills linger in committee until their demise at the end of a legislative session and coverage fades. But, the envelope has been moved. A step has been taken to build public support by creating the illusion that legalization of assisted suicide is a compassionate solution to a heart-wrenching situation.

Nonetheless, the constant barrage of proposals along with their accompanying attention-grabbing stories creates the illusion that assisted suicide is inevitable, that

¹⁴ “Maine Death with Dignity Center \$10,000,” *TimesLines* (Hemlock Society newsletter), Spring 2001, 5.

¹⁵ Alaska H.B. 371 (1996); Arizona S.B. 1007 (1996), H.B. 2167 (1999); California A.B. 1080 and A.B. 1310 (1995), A.B. 1592 (1999); Colorado H.B. 95-1308 (1995), H.B. 96-1185 (1996); Connecticut S.B. 334 (1995), H.B. 6083 (1997); Hawaii H.B. 418, H.B. 347, S.B. 981, S.B. 692, H.B. 1155, S.B. 1037 (1999), S. B. 709 (2001); Illinois H.B. 601 (1997); Louisiana S.B. 128 (1999); Maine H.B. 552 (1995), L.D.916 (1996), H.B. 663 (1997); Maryland H.B. 933, H.B. 474 (1995); Massachusetts H. 3173 (1995), H. 1543 (1997); Michigan H.B. 4134 (1994), S.B. 640 (1995), S.B. 653 (1997), H.B. 5474 (1998); Mississippi H.B. 1023 (1996); Nebraska L.B. 1259 (1996), L. B. 406 (1997), L.B. 70 (1999); New Hampshire H.B. 339 (1996), H.B. 1433-FN (1998), S.B. 44 (1999); New Mexico S.B. 446 (1995); New York S. 1683, S. 5024-A, A. 6333 (1995), S.B.4834 (1999), S.B. 677 (2001); Rhode Island S.B. 2985 (1995), S.B. 2869 (1998); Vermont H.B. 335 (1995), H.B. 109 (1997), H.B. 493 (1999); Washington S.B. 5596 (1995), S.B.6576 (1998); Wisconsin A.B. 174, S.B. 90 (1995), A.B. 32, S.B. 27 (1997), A.B. 297, S.B. 124 (1999), A.B. 417, S.B. 184 (2001).

¹⁶ Iowa Code § 707A.2 (1996); La. Rev. Stat. 14:32.12 (1995); Md. Ann. Code Art. 27, §416 (1999); Mich. 1931 PA 328, MCL 750.329a (1998); R.I. Gen. Stat. Tit. 11, ch. 60 (1996); S.C. Code Ann. §16-3-1090 (1998); Va. Code Ann., § 18.2-76.3, 18.2-76.4 (1998). All states except Nevada and Utah, prohibit assisted suicide by statute, common law or case law.

it's not going to go away, and that the rest of the country will eventually follow Oregon's lead.

It is true that attempts to legalize assisted suicide will continue. But it is not true that the rest of the country will inevitably fold under the pressure. Other states will not repeat Oregon's tragic mistake if those who seek to protect society from the dangers of assisted suicide develop coalitions to oppose such measures.

A 1999 California bill that seemed destined for passage provides an example of the strategies used to promote such a bill and the effectiveness of broad-based opposition.

Strong Grassroots Opposition Defeats California Bill

In 1999, the makeup of the California legislature was such that assisted suicide advocates believed that they had a good chance to get a measure passed. On February 29, 1999, Assemblywoman Dion Aroner introduced AB 1592, the "California Death with Dignity Act."

The proposal was virtually identical to the Oregon law. In fact, Aroner pointed to this as a benefit saying, "AB 1592 is based on the same law that was passed by voters in the state of Oregon a couple of years ago. The good news is that we're luckier than Oregon because we have their experience to consider."¹⁷

However, when the bill was introduced, opponents immediately began the task of contacting community leaders about its implications. Much to the surprise of assisted-suicide proponents, the points raised in opposition were not based on right-to-life or religious arguments. It didn't take long before Aroner and her bill encountered stormy waters in the form of strong grassroots opposition.

By the time hearings and committee votes on AB 1592 took place, people from across the state—those who were poor, individuals from diverse ethnic groups, disabled persons and the elderly—were present to stage protests outside the capitol and in front of Aroner's Berkeley office.

Petitions opposing the measure, circulated within the African-American community, were signed by thousands of people.¹⁸ The League of United Latin American Citizens (LULAC), which is the oldest and largest Latino civil rights organization in the United States, adopted a resolution condemning the legalization of doctor-assisted suicide. LULAC's resolution stated that "many Latinos do not have health care" and "the poor have a right to live and to receive proper medical care."¹⁹

It concluded, "We urge a 'NO' vote on AB 1592 because we believe it is unconscionable to talk about legalizing physician-assisted suicide when low-income people do not have access to comprehensive medical care including pain management and hospice care."²⁰

¹⁷ Presentation on July 12, 1999 by Dion Aroner at San Francisco's Commonwealth Club, published in *The Commonwealth*, September 27, 1999, 2.

¹⁸ Text of the petition is available at <http://www.iaetf.org/cabb.htm>.

¹⁹ LULAC resolution, on file with author.

²⁰ *Ibid.*

Aroner had failed to consider the day-to-day obstacles faced by minorities and the poor when they need health care. As disability rights leader Diane Coleman has observed, assisted suicide is primarily promoted by those who are white, well-off, worried and well. For many people, inequity in health care is a harsh reality, as illustrated by documented disparities in treatment and pain control:

- African-American patients with a broken arm or leg are less likely to be given pain medication in emergency rooms than white patients who have similar injuries and complaints of pain.²¹
- African-American cancer patients in nursing homes are severely undertreated for pain—some don't even get aspirin.²²
- Outpatients with cancer who went to clinics that served minority patients were three times more likely to be under-medicated for pain than were patients in other settings.²³
- Among minority groups, 35% of Hispanics lack health insurance, followed by 22% of African-Americans, and 21% of Asians. Those who lack insurance are three times more likely than those who are insured to be in poor health, have a higher mortality rate, and significantly reduced access to preventative medical care.²⁴
- African-Americans are 50% less likely to get heart by-pass surgery and 25% less likely to get pain medication than their counterparts in other races. And ten different studies in the U.S. have shown that the disparities cannot be explained away by the fact that, as a group, African-American patients tend to be poorer, sicker and have less health insurance than white patients.²⁵
- African-American academics who study bioethical issues have expressed concern that permitting assisted suicide, along with new limits on health care, presents new opportunities to victimize minorities: "People know they don't get the health care they need while they're living. So what makes them think anyone's going to be more sensitive when they're dying."²⁶

Even activists in Aroner's Berkeley and Oakland district actively opposed the bill. The Berkeley City Council, Californians for Disability Rights, and the Oakland-based Committee for the Black Panther Party were firmly against it, pointing out

²¹ "Ethnicity and Analgesic Practice," *Annals of Emergency Medicine*, 35 (January 2000): 11–16.

²² Sheryl Stolberg, "Study finds pain of oldest is ignored in nursing homes," *New York Times*, June 17, 1998 and "Management of Pain in Elderly Patients with Cancer," *Journal of the American Medical Association*, 279 (1998): 1877–1882.

²³ Charles Cleeland et al., "Pain and Treatment of Pain in Minority Patients with Cancer," *Annals of Internal Medicine* 127 (1997): 813–816.

²⁴ American College of Physicians & American Society of Internal Medicine, "Report: No Health Insurance? It's Enough to Make You Sick—Scientific Research Linking the Lack of Health Coverage to Poor Health," (November 30, 1999) Available at: <http://www.acponline.org/uninsured/lack-exec.htm>.

²⁵ "Health Care and Race," transcript of ABC *Nightline*, February 24, 1999.

²⁶ Lori Montgomery, "Blacks fearful of white doctors pulling the plug," *Detroit Free Press*, February 26, 1997.

that, at least in the current health system, no assisted suicide bill could be written that would safeguard its use against the poor and people with disabilities.²⁷

Opposition from those on whom Aroner had relied for support brought her to tears at one point in the debate over the measure.²⁸ But it did nothing to lessen her advocacy of her bill. She made it abundantly clear that she was committed to seeing assisted suicide legalized, no matter what the consequences. "It's a very personal issue," she told reporters. "It's not a question of what is good politics or good policy."²⁹

Although some last minute maneuvering and committee membership changes permitted its passage at the committee level,³⁰ it soon became clear that AB 1592 would not pass the full Assembly before the session ended. The bill was changed into what is known as a "two year bill," permitting it to be considered again in January 2000 and Aroner stepped up attempts to garner support for it by downplaying public fears.

Concerns that HMOs could view assisted suicide as a cost-cutting measure were declared groundless by Aroner who claimed that the measure would require the patient to initiate any discussion of assisted suicide:

The bill [AB 1592] says to the executives who run HMOs: "You don't get to talk about physician-assisted dying in your boardrooms, or in the back rooms of where you do business, or in your hallways. The only time you get to talk about physician-assisted dying is when a patient asks you about the procedure. That is the only time. Other than that, you are committing a felony."³¹

In saying this, Aroner was either uninformed about the content of her bill, or she was being deliberately deceptive. B 1592 did not allow anyone to "coerce" or use "undue influence" to obtain a request for assisted suicide.³² However, there was absolutely *nothing* in the measure that would have prevented HMOs, managed care companies, doctors or anyone else from suggesting, encouraging, offering, or bringing up assisted suicide with a patient who had not asked about it.

Yet, relying on Aroner's assertions, rather than on the bill's content, newspapers repeated the false assurances. The *San Francisco Bay Guardian* reported, "The bill would make it a felony for anyone—HMOs, family members, doctors—to encourage a patient to take the medication."³³ Similarly, an editorial in the *Sacramento Bee* stated, "In an effort to ensure that the action would be completely volun-

²⁷ Angele Rowan, "The death debate," *San Francisco Bay Guardian*, July 14, 1999, 27.

²⁸ Emelyn Rodriguez, "Aroner spearheads measure to legalize doctor-assisted dying," *Oakland Tribune*, May 23, 1999.

²⁹ "Jennifer Kerr, "Committee backs bill letting terminal patients end own lives," *San Francisco Chronicle*, April 20, 1999.

³⁰ For an extensive discussion of grassroots opposition to AB 1592, see: Wesley J. Smith, "Kill the Bill, Not the Ill: A report from the front lines of the assisted-suicide fight in California," *Weekly Standard*, June 21, 1999, 26–29.

³¹ *Supra* note 17, 4.

³² AB 1592, §7198.5(b).

³³ Angela Rowan, "The death debate: Making sense of California's proposed Death with Dignity bill," *San Francisco Bay Guardian*, July 14, 1999.

tary on the part of the patient, AB 1592 would make it a felony for any doctor or HMO or insurance company to suggest the idea. The request would have to be initiated by the patient.”³⁴

As late as December 1999, during a presentation at Berkeley’s Alta Bates Medical Center, Aroner was still claiming, “It is a felony if anyone else [but the patient] brings it up.”³⁵ A fact sheet about AB 1592, prepared by Americans for Death with Dignity and distributed by Aroner’s office at her Alta Bates presentation stated, “The patient must initiate the request for medication.”³⁶

Aroner persisted in misstating the content of her bill. However, her claims did not go unanswered. At each and every presentation, individuals who had carefully studied the proposal refuted her claims and stressed her bill’s danger to the community.

The strong grassroots opposition had an impact. AB 1592 died from lack of support. It was not brought to the floor of the Assembly by the deadline of January 31, 2000, and although Aroner later said she intended to introduce another assisted-suicide bill after the November 2000 election, she has not done so yet.

Court Cases

Although the political attempts to legalize assisted suicide will continue, right-to-die proponents have not confined their efforts to initiative campaigns and legislative proposals. They have long realized that victory in the courts could achieve their agenda and could eliminate the need to move incrementally toward what would essentially be assisted suicide on demand.

The court route goes beyond attempting to have assisted suicide legalized. Instead, it seeks to have hastened death constitutionalized. This presents a significant difference since it would be difficult to even attempt to place restrictions on a constitutionally protected right.³⁷

Since 1994, the Hemlock Society and its spin-off, Compassion in Dying, have been in the forefront of court challenges to the constitutionality of state laws prohibiting assisted suicide in Washington, New York, Florida and Alaska.³⁸

³⁴ “Physician-assisted suicide: Aroner bill sparks a thoughtful and needed debate,” *Sacramento Bee*, May 19, 1999.

³⁵ Audiotape of Dion Aroner’s presentation at Alta Bates Medical Center on file with author.

³⁶ Fact sheet on file with author. According to news reports, Aroner had filed her bill on behalf of Americans for Death with Dignity [Emelyn C. L. Rodriguez, “Senate committee votes 8–7 on doctor-assisted death bill,” *Pleasanton Tri-Valley Herald*, April 21, 1999; “State legislature takes on issue of assisted suicide,” *Alameda Times-Star*, April 21, 1999.] Americans for Death with Dignity (formerly known as Americans Against Human Suffering and Californians Against Human Suffering) began as a Hemlock spin-off and spearheaded the earlier, failed attempts to legalize both euthanasia and assisted suicide in California by ballot initiative.

³⁷ For a discussion of the implications of making assisted suicide a constitutionally protected right, see: Dan Brock, “A Critique of Three Objections to Physician-Assisted Suicide,” *Ethics* (April 1999): 519–521.

³⁸ Other failed court challenges to assisted suicide laws in Michigan, California and Colorado received far less attention. The Supreme Court of Michigan in *People v.*

The Hemlock Society, which was co-founded in 1980 in California by Derek Humphry (author of the 1991 suicide manual, *Final Exit*) and Ann Wickett Humphry, was deeply involved in drafting, promoting and funding the Washington, California, Oregon, Michigan and Maine ballot initiatives.³⁹

Compassion in Dying (CID) began after the 1991 defeat of the Washington State initiative to legalize euthanasia and assisted suicide. Unitarian minister Ralph Mero, the group's first executive director, described CID as "an outgrowth of the Washington State Hemlock Society chapter."⁴⁰ (Mero directed the Hemlock chapter until taking over the helm of CID.) According to Mero, "The Washington Hemlock chapter strongly wanted to expand its mission" to offer suicide assistance in "deserving cases" so it created a separate organization for that purpose.⁴¹

CID was officially organized in Seattle in April 1993 as a 501 (c) (3) organization⁴² and before long, the small band of activists, led by Mero, were making news across the country⁴³ as the "most controversial right-to-die venture" since Jack Kevorkian began plying his trade.⁴⁴ As the first U.S. group to publicly admit offering assistance in committing suicide, CID acknowledged involvement in twenty-four deaths during its first thirteen months of operation. It subsequently refused to di-

Kevorkian, 447 Mich. 436, 527 N.W.2d 714 (1994), *cert. denied*, 115 S. Ct. 1795 (1995) flatly rejected any claim that laws against assisted suicide violated the Due Process Clause of the federal constitution. The Michigan case involved five consolidated proceedings, including appeals in criminal prosecutions under Michigan's assisted suicide law and a group seeking a declaration that Michigan's assisted suicide statute was unconstitutional.

In a 1992 California case, the court found that California's right to privacy provision could not be expanded to include a right to assisted suicide (*Donaldson v. Lungren*, 2 Cal.App. 4th 1614, 4 Cal.Rptr. 2d 59 (1992)). In 1996, U.S. District Court Judge Consuela Marshall ruled that California's long-standing law banning assisted suicide did not violate the California constitution's right to privacy clause. (*Kevorkian & Doe v. Arnett, Medical Board of California and Lungren*, 939 F. Supp. 725; 1996 U.S. Dist. LEXIS 17720)

In Colorado, 82-year-old retired judge Robert Sanderson, with financial backing from the Hemlock Society, sought to have Colorado's law against assisted suicide declared unconstitutional, saying that the law violated his religious freedom. (12 P. 3d 851; 2000 Colo.App.LEXIS 1027)

³⁹ For background information on the Hemlock Society see: Rita Marker, *Deadly Compassion*, (New York: Wm. Morrow and Co. 1994).

⁴⁰ "Ralph Mero: An Omega Interview," *OMEGA—The Journal of Death and Dying*, 29 (1)(1994): 6.

⁴¹ *Ibid.*

⁴² "Changes and Developments in Washington Right to Die Organizations," *Hemlock NEWS*, (Newsletter of Hemlock Society of Washington State), 27 (Summer 1993): 1.

⁴³ See, for example: "Seattle group plans to help terminally ill people kill themselves," *Fort Worth Star-Telegram*, June 13, 1993; "Washington group says it assisted suicide," *Boston Globe*, August 21, 1993. Other failed court challenges to assisted suicide laws in Michigan, California and Colorado received far less attention. The Supreme Court of Michigan in *People v. Kevorkian*, (June 14, 1993).

⁴⁴ "New Washington group offers suicide 'assistance'," *American Medical News*, June 14, 1993.

vulge additional participation.⁴⁵ Mero and his Compassion in Dying activities even became the cover story in *The New York Times Magazine*.⁴⁶

Coverage of CID's activities caught the attention of Kathryn Tucker, an attorney with Perkins Coie,⁴⁷ the Pacific Northwest's largest law firm. Tucker, who had served as principal outside counsel to sponsors of the failed Washington "Death with Dignity Act,"⁴⁸ contacted Mero and suggested that, rather than exposing itself to possible prosecution, it may be better for CID to challenge the constitutionality of Washington State's law prohibiting assisted suicide.⁴⁹ That call launched two cases which would reach the U.S. Supreme Court and led to a major ongoing role for Tucker with CID.

Washington State

On January 24, 1994, *Compassion in Dying v. State of Washington* was filed in U.S. District Court in Seattle, claiming that Washington's law forbidding assisted suicide is unconstitutional. CID was not charged for Tucker's legal services.⁵⁰

From the outset, many expected the case to be a landmark for the right-to-die movement. "It would be the equivalent of *Roe v. Wade* for the right to die," said Kathryn Tucker. "If the Supreme Court rules on it, all state statutes which affect that conduct will be either upheld or struck down."⁵¹

⁴⁵ Dick Lehr, "Supporting those who want to die: A Seattle group including doctors and clergy, offers help and advice for suicide," *Boston Globe*, January 18, 1994 and William Cartsen, "When patients choose to die: Seattle group gives assisted suicide momentum in courts," *San Francisco Chronicle*, June 3, 1996.

⁴⁶ Lisa Belkin, "There's no simple suicide," *New York Times Magazine*, November 14, 1993.

⁴⁷ Perkins Coie is among the law firms that have received special thanks for their *pro bono* work with Tucker and CID. So acknowledged have been: Richard Abramson, Nicholas van Ackstyn and others at the California-based firm of Heller Ehrman White & McAuliffie who contributed to the choice of Alaska as the best state for CID's next legal challenge; Michael Isbell and colleagues at the New York firm Hughes, Hubbard & Reed, in part, for service as co-counsel in the New York litigation and for help in preparing the case before the Supreme Court; Rober Wagstaff of Alaska who is serving as co-counsel in the case pending before the Alaska Supreme Court; and Perkins Coie for continuing valuable support for Kathryn Tucker as she works as CID's legal director. ("Compassion Appreciates Pro Bono Counsel," *Compassion in Dying Newsletter*, 6 (1) (January 1999).

⁴⁸ Tucker's role in the failed campaign to legalize euthanasia and assisted suicide by a ballot initiative has been noted in faculty information for the conference, "The Right to Die: Legal and Ethical Issues in End-of-Life Decisions," held on September 30, 1994, sponsored by Law Seminars International and chaired by Kathryn Tucker and in *Compassion in Dying Newsletter* (Special Edition 1997): 3.

⁴⁹ David J. Garrow, "Nine Justices and a Funeral," *George*, 2(6) (July 1997): 59 and David J. Garrow, "The Right to Die: Death with Dignity in America," *Mississippi Law Journal*, 68 (1998): 413.

⁵⁰ Rob Carson, "Suit disputes state's ban on assisted suicides," *Tacoma (Washington) News Tribune*, January 25, 1994.

⁵¹ *Ibid.*

Five months later, Federal District Court Judge Barbara Rothstein ruled that the Washington statute prohibiting assisted suicide was unconstitutional. Rothstein based her decision heavily on the U.S. Supreme Court's decision in *Planned Parenthood v. Casey*,⁵² writing that "the suffering of a terminally ill person cannot be deemed any less intimate or personal, or less deserving of protection from unwarranted governmental interference, than that of a pregnant woman. Thus, consonant with the reasoning in *Casey*, such an intimate personal decision falls within the realm of the liberties constitutionally protected under the Fourteenth Amendment."⁵³

The following year Rothstein's ruling was reversed by a three-judge panel of the United States Circuit Court of Appeals for the Ninth Circuit.⁵⁴ But CID petitioned for a hearing before a larger panel and, on March 6, 1996, an *en banc* panel of the Court of Appeals, in an eight to three decision, reinstated Rothstein's finding that Washington's law violated the Due Process Clause of the Fourteenth Amendment.⁵⁵

In a letter to CID supporters, Ralph Mero wrote, "With your support, we have just won the greatest civil rights victory for terminally ill patients in American history." He noted that a decision in CID's "companion case" (see New York, below) would be made shortly and he told readers that "Compassion in Dying is the only organization sponsoring this effort to change the law to permit death with dignity through the courts."⁵⁶

Within months of CID's success in the Ninth Circuit, Barbara Coombs Lee replaced Ralph Mero as CID's executive director and president. Coombs Lee, who had helped draft Oregon's assisted suicide law and had been chief petitioner and a major spokesperson for the "Death with Dignity Act," left her position as vice president of a large Oregon managed care company to take over the helm of CID.⁵⁷

⁵² *Planned Parenthood v. Casey*, 505 U.S. 833 (1992).

⁵³ *Compassion in Dying v. Washington*, 850 F. Supp. 1454, 1460 (W.D. Wash. 1994).

⁵⁴ *Compassion in Dying v. Washington*, 49 F.3d 586 (9th Cir. 1995).

⁵⁵ *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir. 1996) (en banc).

⁵⁶ April 1996 "Dear Friends of Compassion" appeal letter from Ralph Mero to supporters of CID. (On file with author)

⁵⁷ Tom Bates, "Chief petitioner answers questions on Measure 16," *Sunday Portland Oregonian*, November 26, 1994; Elise Chidley, "PA Heads Right to Die Group," *PA Today* (Profession journal for physician's assistants), March 21, 1997, 8; Linda Rockey, "A call for compassion: Nurse leads fight for physician-assisted suicide," *Chicago Tribune*, February 8, 1998.

Coombs Lee's promotion of both assisted suicide and euthanasia began prior to her involvement with Measure 16. She had worked as a legislative aid to Oregon Senator Frank Roberts in 1991 when he introduced SB 114, a measure that would have permitted euthanasia on request of a patient and, if the patient was not competent, a designated representative would have been authorized to request the patient's death. (Diane Gianelli, "Oregon bill would allow euthanasia," *American Medical News*, April 1, 1991, Tom Bates, "Chief petitioner answers questions on Measure 16," *Sunday Portland Oregonian*, November 26, 1994; Linda Rockey, "A call for compassion: Nurse leads fight for physician-assisted suicide," *Chicago Tribune*, February 8, 1998.)

Under Coombs Lee's leadership, the organization has grown into a well-funded national organization⁵⁸ that has pressed forward with court challenges, and has "guided" approximately two-thirds⁵⁹ of patients whose assisted suicide deaths have been reported since the Oregon law went into effect.

New York

While the Washington State case was under consideration, Tucker was also working on a similar CID challenge to state law, this time in New York. For the New York case, Tucker recruited Dr. Timothy Quill as the lead plaintiff⁶⁰ who, until then, had been best known for his emotionally charged defense of doctor-assisted suicide that appeared in the *New England Journal of Medicine*.⁶¹

Tucker, with the assistance of the Manhattan law firm, Hughes Hubbard and Reed, where her father serves as chairman,⁶² filed suit on July 20, 1994 in U.S. District Court in Manhattan. The suit used virtually the same argumentation and wording employed in the Washington State suit. It alleged that the anti-assisted suicide statute violated both the liberty guarantees and the equal protection provisions of the Fourteenth Amendment. Five months later, New York District Court Judge Thomas P. Griesa rejected Tucker's claims, ruling unequivocally that there is no fundamental right to assisted suicide under the U.S. Constitution.⁶³

However, on April 2, 1996 (just a month after Tucker's Ninth Circuit victory), a three-judge panel of the U.S. Court of Appeals for the Second Circuit overturned Griesa's decision when it ruled unanimously that New York's statutes criminalizing assisted suicide violated the Equal Protection Clause.⁶⁴

Within the span of four weeks, the cases originally brought by Tucker on behalf of CID in 1994 had effectively overturned laws banning assisted suicide in Washington and New York. The rulings, however, affected other states as well in

⁵⁸ Among foundations providing support for CID are George Soros's Open Society Institute, the Gerbode Foundation, the Columbia Foundation and the Donald Pels Charitable Trust. [Rita Marker, "Dying for the Cause: Foundation funding for the 'right-to-die' movement," *Philanthropy*, 27 (January/February, 2001).]

⁵⁹ "Compassion in Dying of Oregon Releases Its Report on the Third Year of Helping Patients Use Oregon's Assisted Dying Law," Compassion in Dying Press Release, *U.S. Newswire*, February 20, 2001.

⁶⁰ *George*, *supra* note 49, p. 58.

⁶¹ Timothy E. Quill, "Death and Dignity: A Case of Individualized Decision-Making," *New England Journal of Medicine*, 324(10) (March 7, 1991): 691–694. In the article Quill recounted the story of his patient, Patricia Diane Trumbull, known then only as "Diane," who had leukemia. Diane's fears—that she would die and "would suffer unspeakably in the process" (p. 692)—were confirmed by Quill who referred her to the Hemlock Society. A week later he wrote a prescription for her, knowing that the medication "was an essential ingredient in a Hemlock Society suicide" (p. 693). A grand jury failed to indict Quill.

⁶² *George*, *supra* note 49, 58.

⁶³ *Quill v. Koppell*, 870 F. Supp. 78 (S.D.N.Y. 1994).

⁶⁴ *Quill v. Vacco*, 80 F.3d 716 (1996).

the Ninth Circuit (Alaska, Arizona, California, Hawaii, Idaho, Montana, Nevada, and Oregon) and the Second Circuit (Connecticut and Vermont).

Although both rulings had found that state laws against assisted suicide violated the Fourteenth Amendment, they did so for different reasons. The Ninth Circuit had based its decision on a perceived violation of the Due Process Clause, while the Second Circuit had rejected the Due Process basis and found, instead, that anti-assisted suicide laws violated the Equal Protection Clause. Both cases were appealed to the U.S. Supreme Court.

U.S. Supreme Court

On October 1, 1996, the U.S. Supreme Court agreed to hear the cases and to decide if state laws against assisted suicide are unconstitutional. The question before the Court was a narrow one: Do states have the right to prohibit assisted suicide?

Given their victories in lower courts and the passage of Oregon's "Death with Dignity Act," assisted suicide supporters were confident they would prevail—until oral arguments began on the morning of January 8, 1997.

As hundreds of members of the disability rights organization Not Dead Yet demonstrated outside, Tucker (arguing the Washington State case) and Laurence Tribe (arguing the New York case) met a chilly reception inside the court. Questions and comments from the justices made it clear that they were more than skeptical that assisted suicide is a constitutionally guaranteed right. And, although conventional wisdom has always held that oral arguments cannot predict the direction the Court will take, virtually everyone present to hear these was convinced that the Court would overturn the Second and Ninth Circuits' decisions.⁶⁵

In CID's newsletter, Coombs Lee acknowledged that "the standard wisdom coming from Court watchers is that the Court will not rule in our favor."⁶⁶ Emory University Law School Professor David J. Garrow, an assisted suicide advocate, noted that the justices seemed "downright annoyed at having to rule on the pair of controversial landmark cases Tucker had brought before them."⁶⁷

On June 26, 1997, the Supreme Court unanimously upheld the right of states to prohibit assisted suicide. The decisions in *Washington v. Glucksberg*⁶⁸ and *Vacco v. Quill*⁶⁹ dealt a crushing nine to zero blow to proponents of assisted suicide.

⁶⁵ For more information about the oral arguments, see: "IAETF Report: Supreme Court hears oral arguments in right-to-die cases," *IAETF Update*, 11(1) (January/February, 1997): 1. (Available at <http://www.iaetf.org/iaua7.htm#2>).

Also see transcript of oral arguments: "Justices hear arguments on laws barring physician-assisted suicide," *Chicago Daily Law Bulletin*, January 10, 1997.

⁶⁶ Barbara Coombs Lee, "Our Day in Court," *Compassion in Dying Newsletter*, 7: 1.

⁶⁷ George, *supra* note 49, 57.

⁶⁸ *Washington v. Glucksberg* 117 S. Ct. 2258 (1997).

⁶⁹ *Vacco v. Quill*, 117 S. Ct. 2293 (1997).

But, having seen the handwriting on the wall, right-to-die spokespersons had had months to prepare their “spin.” Even in the face total defeat, they claimed victory.

Post-decision talking points declared the decision a win for those seeking to legalize assisted suicide. Coombs Lee claimed that one of the chief goals of the cases had been to increase public awareness and discussion of options at the end of life and said, “We have succeeded in lifting the veils of secrecy around the ways that death is commonly and legally hastened.”⁷⁰ Tribe called the court’s decision “far more encouraging than anyone expected.”⁷¹ And Quill saw the decision as permitting the “underground practice” of assisted suicide to continue since, “the court didn’t suggest that the laws [against assisted suicide] should be more vigorously enforced.”⁷²

By far, at the top of the list of talking points was the claim that a new opportunity had been created by the Court, giving assisted suicide advocates the go ahead to do battle on the state level. Tucker said, “All of the justices are hoping this issue can be resolved legislatively, and the states have a green light.”⁷³ Coombs Lee also used the green light imagery. “It gives us a green light,” she said. “We’re really thrilled.”⁷⁴ This disingenuous claim ignored the fact that states had always had the “green light” to pursue such a course of action. But assisted-suicide advocates did not let the truth get in the way of a means to appear victorious.

In keeping with the assertion that a new path had opened, Coombs Lee announced the formation of CID’s legal arm to be headed by Kathryn Tucker. Thus, with the door closed on federal constitutional claims, the search was on to find the state jurisdiction which might prove open to a claim that assisted suicide is a right under the *state* constitution. (State supreme courts must examine claims that are based on state constitutions solely on state grounds without regard to the interpretation of a counterpart provision in the Federal Constitution.)

In fact, such a case was already pending in Florida, this one spearheaded by the Hemlock Society.

Florida

At the same time court watchers were anticipating the U.S. Supreme Court decisions, they were also waiting for the Florida Supreme Court ruling in *Krischer v. McIver*.

⁷⁰ “US Supreme Court Overturns Two Lower Courts on Physician Aid in Dying,” Compassion in Dying press release, June 26, 1997.

⁷¹ Aaron Epstein, “Court backs law that ban aided suicide,” *Philadelphia Inquirer*, June 27, 1997.

⁷² Janny Scott, “Analysis: High Court Ruling Leaves Unresolved Questions,” *New York Times*, June 27, 1997.

⁷³ Tony Mauro, “Assisted suicide ban upheld but states can enact new laws,” *USA Today*, June 27, 1997.

⁷⁴ Richard Price and Tony Mauro, “Advocates promise to press the fight,” *USA Today*, June 27, 1997.

In the wake of the CID's 1994 federal court filing in Washington, the Florida chapter of Hemlock began efforts to "explore Florida's constitutional privacy provision" as a means to overturn that state's anti-assisted suicide law. Hemlock, along with the Florida ACLU, worked on "constructing a legal process patterned after the Washington State case" and actively recruited potential plaintiffs.⁷⁵ According to Florida Hemlock's Mary Bennett Hudson, lawsuit organizers traveled statewide, auditioning about fifty patients and more than twelve physicians in hopes of finding the ideal plaintiffs for the case. "We needed people who were articulate, who would make good witnesses," Hudson said. It took two years and several false starts before the right test case plaintiffs, AIDS patient Charles Hall and Dr. Charles McIver, were identified. Hall and McIver had never met before their match up for the court case.⁷⁶

On January 31, 1997, Florida Circuit Judge S. Joseph Davis ruled that, under the Privacy Amendment of the Florida Constitution, Hall had the right to end his life with McIver's help.⁷⁷ The case was immediately appealed to the Fourth District Court of Appeals which refused to review Davis' ruling and, instead, forwarded the case directly to the Florida Supreme Court.

Exactly three weeks after the U.S. Supreme Court ruled that there is no right to assisted suicide guaranteed in the U.S. Constitution, the Florida State Supreme Court ruled five to one to uphold the constitutionality of Florida's law prohibiting assisted suicide.⁷⁸ Chief Justice Gerald Kogan, who was the only dissenter, still holds out hope that there will eventually be another case challenging the Florida law and that, using his dissent, new justices will see fit to find a right to assisted suicide in the Florida Constitution. Speaking at the World Federation of Right to Die Societies Conference in September 2000, Kogan, who is now retired, said, "As a matter of fact, the Court in a few years time may be of such a mind and nature that, when they read my dissenting opinion, they will say that the decision was wrong and, as a result, they would set it [*Krischer v. McIver*] aside and uphold the trial judge's ruling in that particular case."⁷⁹

However, activists are not waiting for a possible replay of the Florida case. They directed their attention to the north.

Alaska

Assisted by a California-based law firm, CID selected Alaska for its next court challenge. Carrying forward the notion that the U.S. Supreme Court had opened

⁷⁵ "Hemlock of Florida Legal Plans Update," *Hemlock Beacon*, (Summer 1994) and "The Search is on," *Hemlock Beacon*, (Fall 1995).

⁷⁶ Diane C. Lade, "Group carefully orchestrated doctor-patient right-to-die test," *Ft. Lauderdale Sun-Sentinel*, January 12, 1997.

⁷⁷ *McIver v. Krischer*, No. CL 96-1504-AF, (Fla. 15th Cir. Ct. Jan 31, 1997).

⁷⁸ *Krischer v. McIver*, 697 So.2d 97 (Fla. 1997).

⁷⁹ Transcript of tape of "Why Charles Hall Should Have Had Help in Dying," presentation by Gerald Kogan, Sept. 1, 2000, World Conference on Assisted Dying, Boston, Mass., Sept. 1-3, 2000.

new avenues for it, CID announced the December 15, 1998, filing in Alaska Superior Court at Anchorage as the launch of “the second phase” of its Litigation Project and said:

Energized by the Supreme Court Justices call for national dialogue, Compassion in Dying now proceeds to the next phase of its campaign for recognition of this basic human right—the right to a humane death. We intend to present the compelling needs and arguments for constitutional protection of assisted dying to the state courts where the state constitution bestows broader and more specific guarantees of privacy and liberty than the federal constitution does.

Alaska is one such state. Compassion staff, outside counsel and experts on our legal advisory team chose it after a lengthy and deliberate examination of the constitutions and case law in each of the fifty states.⁸⁰

Plaintiffs in the case were 43-year-old Kevin Sampson, who was diagnosed with AIDs in 1992, and “Jane Doe,” a woman physician in her sixties who has breast cancer. Sampson committed suicide before arguments in the case were heard.

When Alaska Superior Court Judge Eric Sanders ruled that the state’s law banning assisted suicide does not violate the liberty, equal protection, or right to privacy clauses contained in Alaska’s Constitution,⁸¹ CID’s Tucker and her co-counsel, Anchorage attorney Bob Wagstaff, took the rejection in stride, calling it a “temporary setback”⁸² and appealed the ruling to the Alaska Supreme Court. As this article is being written in June 2001 the decision from Alaska’s Supreme Court is pending.

According to Tucker, the Alaskan ruling will determine whether CID will take another bite of the state court apple:

If the Alaska Supreme Court enters a favorable decision it does make sense to consider looking at another state that also has a very favorable constitution and body of case law. And, at the same time, I believe if the decision from the Alaska Supreme Court is adverse to this question then restraint should be exercised and other cases should not be brought.

I think that while, state by state, states are not bound by what a particular state supreme court does, I think a trend of authority by a number of states concluding that this is not protected would be very problematic. And I would certainly recommend against bringing another state challenge if the Alaska decision is not favorable.⁸³

⁸⁰ “Compassion Brings Court Challenge in Alaska and Seeks Recognition of Right under State’s Constitution,” *Compassion in Dying Newsletter*, 11: 1. (Accessed on May 11, 1999 at <http://www.compassionindying.org/news/newsletter11.htm>).

⁸¹ *Sampson and Doe v. State of Alaska*, No. 3AN-98-11288 CIV, Super. Ct., (3d D, Anchorage 1999).

⁸² “Larry Campbell, “Court rejects suit seeking right to die,” *Anchorage Daily News*, September 10, 1999.

⁸³ Transcript of tape of “Legal Developments in the Right-to-Die Movement,” presentation by Kathryn Tucker, Sept. 1, 2000 at World Conference on Assisted dying held in Boston, Mass., Sept. 1–3, 2000.

Whether a loss in Alaska would really curtail CID's challenges to state laws remains to be seen. However, regardless of where future assisted suicide efforts are directed, two predominant themes are certain to be a large part of the continuing debate over assisted suicide. The first is an assertion that what is called "terminal sedation" is a commonly practiced, ethically acceptable form of intentionally hastening death. The second is the claim that Oregon's experience with assisted suicide proves the safety and benign nature of legally permitted assisted suicide. Because both themes will undoubtedly be in the forefront of efforts to push the assisted suicide agenda in the future, they bear close examination.

Terminal Sedation

"Terminal sedation" is a phrase that is relatively new. It did not even appear in medical literature until the 1990s. Even today, there is not a clear definition of the term.⁸⁴

It has long been recognized that, in the very rare case when symptoms cannot be relieved in any other way, sedation can be administered even if it renders a patient unconscious. The use of such sedation is not limited to dying patients, but is sometimes used temporarily in trauma or burn cases. And it has been traditionally understood that, even if such an intervention carries the risk of death, it is appropriate and ethical under the principle of double effect. (It should be noted that, contrary to widespread belief, medication—morphine, for example—gradually increased to even extremely high doses to control pain, does not hasten death.⁸⁵ And sedation to the point of unconsciousness may even slightly prolong the life of a dying patient.)⁸⁶

Medical professionals have found the principle of double effect immensely useful as a guide for ethical decisionmaking.

Principle of Double Effect

The principle of double effect is based in Catholic tradition,⁸⁷ but it has long figured prominently as a guide to ethical decision making in secular settings.⁸⁸ Ac-

⁸⁴ Susan Carter, Raymond Viola, Judi Peterson and Virginia Jarvis, "Sedation for intractable distress in the dying—a survey of experts," *Palliative Medicine* 12 (1998): 255–269.

⁸⁵ See, for example: Andrew Thorns and Nigel Sykes, "Opioid use in the last week of life and implications for end-of-life decision-making," *The Lancet*, 356(9227) (July 29, 2000): 398–399 and Gina Kolata, "When Morphine Fails to Kill," *New York Times*, July 23, 1997.

⁸⁶ Joanna Lynn, Letter to the Editor, *New England Journal of Medicine*, 338 (17) (April 23, 1998): 1230.

⁸⁷ Articulation of the principle of double effect can be found in St. Thomas, *Summa Theologica*, II–II, q. 68.

⁸⁸ See, for example: American Medical Association, Council on Ethical and Judicial Affairs of the American Medical Association Opinion 2.20. "... Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing palliative treatment even though it may foreseeably hasten death ... " (*Amici Curiae* Brief of the American Medical Association, American Nurses Association and American Psychiatric Association, *et al*, in Support of Petitioners, in *Vacco v. Quill*, 13a.)

According to the principle of double effect, it is morally permissible to perform an act that has both a good effect and a bad effect if all of the following conditions are met:

1. The act to be done must be good in itself or at least indifferent.
2. The good effect must not be obtained by means of the bad effect.
3. The bad effect must not be intended for itself, but only permitted.
4. There must be a proportionately grave reason for permitting the bad effect.⁸⁹

It is the third requirement—the intent aspect—that assisted suicide proponents have seized on as the Achilles heel in the principle, claiming that a physician who intended to kill a patient could escape scrutiny by claiming the death was unintended.

Distorting the Principle of Double Effect

In its later-overtaken *Compassion in Dying* ruling, the Ninth Circuit sided with this viewpoint, saying that the “euphemistic use of ‘possible’ and ‘may’ [as in may cause death] may salve the conscience of the AMA, but it does not change the realities of the practice of medicine”⁹⁰ The Court claimed that “in the case of ‘double effect’ we excuse the act,” not by sugarcoating the act itself but by hiding the intent behind the facade of the double effect.⁹¹ As an example, the Court referred to providing a morphine drip for a patient and erroneously stated that such an intervention “will indubitably hasten his death.”⁹²

Dr. Thomas Preston agreed with the Court’s statements,⁹³ but his stance was not surprising. Two years earlier, while the case was wending its way to the Ninth Circuit, Preston had written an opinion piece for the *New York Times* that became the first widely circulated attack on double effect as it pertains to palliative care. In it, he referred to use of double effect as “medical jargon” and said “the morphine drip is undeniably euthanasia, hidden by the cosmetics of professional tradition and language.”⁹⁴ Preston called on society to come to grips with the fact that euthanasia is widespread now and, therefore, efforts should turn to establishing appropriate guidelines for its practice.

However, Preston who is a Seattle cardiologist and professor of medicine at the University of Washington was not an objective commentator on the state of

⁸⁹ Austin Fagothey, S.J., *Right and Reason: Ethics in Theory and Practice*, 2d ed., (St. Louis: C.V. Mosby Co., 1959), 152–160. For a further discussion of the application of the principle of double effect as it applies in the medical setting, see: Daniel P. Sulmasy, “The Rule of Double Effect: Clearing Up the Double Talk,” *Archives of Internal Medicine*, 159 (March 22, 1999): 545–550.

⁹⁰ *Supra* note 55, n. 95.

⁹¹ *Ibid.*

⁹² *Ibid.*, 823.

⁹³ Diane Gianelli, “Assisted suicide or pain relief?” *American Medical News*, July 1, 1996.

⁹⁴ Thomas A. Preston, “Killing pain, ending lives,” *New York Times*, November 1, 1994.

medical ethics. He was, in fact, one of four physician-plaintiffs in the Washington case seeking to overturn assisted-suicide laws, as well as a board member and a medical advisor for CID. He was involved in assisted suicides being facilitated by CID.⁹⁵

The claims made in Preston's article made their way into the U.S. Supreme Court briefs and arguments. Terminal sedation was said to be the same as assisted suicide, only a more "gruesome"⁹⁶ method of doing so than a quick lethal dose of drugs. Tribe called sedation a means to "chemically kill someone."⁹⁷ However the Court rejected attempts to equate an intended death with the risk of an unintended death that may accompany sedation.⁹⁸

Nonetheless, assisted suicide leaders continue to blur the lines between killing patients and killing pain. They persist in declaring that sedation is "slow euthanasia."⁹⁹

By distorting both the practice of sedating patients and the principle of double effect, assisted suicide advocates are attempting to persuade the public that it is unreasonable to continue to prohibit such deaths. As Dion Aroner said in a public presentation to gather support for her "Death with Dignity" bill, "I don't see the difference between terminal sedation and physician assisted dying except that the patient has control of one and not the other."¹⁰⁰

It is likely that assisted suicide proponents will use this obfuscation as they continue in their attempts to gain public support.

Appealing to the Public

Among the most effective ways to influence public opinion are declarations issued in conjunction with major events and guest columns in newspapers where the terminal-sedation-as-a-cruel-hypocritical-practice theme has recently been found.

⁹⁵ Preston announced CID's first assisted suicide in 1993 "Washington group announces first assisted-suicide death," *Boston Globe*, August 21 1993. Preston, along with Ralph Mero, later published guidelines and drug dosage information that had been used for forty-six CID assisted deaths. See: Thomas Preston and Ralph Mero, "Observations Concerning Terminally Ill Patients Who Choose Suicide," *Drug Use in Assisted Suicide and Euthanasia*, (Haworth Press 1996.)

⁹⁶ *Vacco v. Quill*, Brief for Respondents, 49.

⁹⁷ Ed Bradley referring to Laurence Tribe's depiction of terminal sedation on *60 Minutes*, CBS, January 5, 1997.

⁹⁸ Justice Rehnquist wrote, "The law has long used actors' intent or purpose to distinguish between two acts that may have the same result." Citing the dissent in the Ninth Circuit decision (*Compassion in Dying v. Washington* 79 F.3d 790, 858, Kleinfeld, J. dissenting), he wrote, "When General Eisenhower ordered American soldiers onto the beaches of Normandy, he knew that he was sending many American soldiers to certain death His purpose, though, was to ... liberate Europe from the Nazis." (*Vacco v. Quill*, 521 U.S. 793, 802-803.)

⁹⁹ Supreme Court Overturns Lower Courts," *Compassion in Dying Newsletter*, Special Edition 1997, 4 and "Terminal Sedation," World Federation of Right-to-Die Societies. Available at: <http://www.worldrtd.org/tersedate.htm>.

¹⁰⁰ *Supra* note 35.

At an international right-to-die conference held in Boston last year, health-care professionals issued the following declaration:

We are health-care professionals attending the biennial Conference of the World Federation of Right to Die Societies being held in Boston from 1–3 September 2000. We support the right of competent adults who are suffering severe and enduring distress from terminal illnesses to seek medical assistance to hasten dying if this is their voluntary, rational and persistent request, after other relevant options offered by palliative medicine have been fully explored.

On this occasion, we wish to draw public attention to the practice of “terminal sedation” or “slow euthanasia” which is performed extensively today throughout the world in hospitals, nursing homes, hospices and in private homes. This is carried out under the doctrine known as “double effect” by which a physician may lawfully administer increasing dosages of regular analgesic and sedative drugs that can hasten someone’s death as long as the declared intention is to ease pain and suffering. Of course, the key word is “intention.” Compassionate physicians without publicly declaring the true intention of their actions, often speed up the dying process in this way.

Many thousands of terminally ill patients are so helped globally every year. We feel that the only real difference between “terminal sedation” and a rapidly effective lethal dose is one of time—a slow death, over a few days, with life-shortening palliative drugs, versus a more dignified and peaceful death, because it is not prolonged, and is determined by the patient. We urge other medical professionals worldwide to be more open about this form of physician-assisted dying.¹⁰¹

Herb Berkowitz, president of Compassion in Dying of Alaska, expressed similar sentiments in a guest column for the *Anchorage Daily News* when he wrote:

[T]here is a medical solution known as “terminal sedation.” This involves putting the patient into a drug-induced coma that is maintained until the patient withers away and dies. This can take weeks. Religious spokesmen consider this a ‘natural’ death, and therefore do not oppose it.¹⁰²

Within the span of a few years, a rarely used treatment to alleviate uncontrollable pain has come to be depicted as an optional method of intentionally causing death. If such erroneous impressions are not refuted effectively, the confusion that will exist in the mind of legislators, judges and the general public could be devastating. Along with their representation of terminal sedation as “slow euthanasia,” right-to-die leaders are depending on what they call the “Oregon experience” to further their cause.

The Oregon Experience

Oregon’s experience with assisted suicide is, by far, the foundation on which activists hope to build support for their agenda. It has already figured prominently in

¹⁰¹ “Health-Care Professionals Attending the Biennial Conference on Assisted Dying in Boston Approved the Following Declaration,” *World Right-to-Die Newsletter*, No. 37, November 2000.

¹⁰² Herb Berkowitz, “Dying Alaskans should have control of their destinies,” *Anchorage Daily News*, March 8, 2001.

initiative campaigns and in cases before the courts. Speaking to international right-to-die conference attendees, Tucker called official Oregon data “enormously useful.” She said, “[W]hat that data shows quite convincingly is that speculative fears that the state has conjured in these cases have not come to pass.”¹⁰³

As discussed earlier, supporters of Maine’s Death with Dignity Act were unsuccessful, in large part, because their claims about Oregon’s assisted suicide law were countered with accurate, documented information about what is happening in Oregon. But that did not deter Tucker from using official Oregon statistics to bolster her arguments before the Alaskan Supreme Court. Tucker assured the Court that official statistics prove that permitting assisted suicide in Alaska would not result in abuses, but would, instead, present an opportunity for people to make careful, reasoned choices about how their lives will end.¹⁰⁴

Regardless of the outcome of the Alaskan case, Oregon will continue to be used as the “poster state.” Therefore, it is extremely important to carefully examine the Oregon law itself and the official reports about its implementation.

Oregon’s Law

Its advocates give solemn assurances that Oregon’s Death with Dignity law is tightly written; is limited to specifically qualified, terminally ill patients; has stringent safeguards; and is carefully monitored to prevent any possibility of abuse. But, under close scrutiny, the actual content of the law raises a number of concerns:

1. Oregon’s assisted suicide law does not require that family members be notified when a doctor is going to help a loved one commit suicide. Family notification is *not required*, only recommended.¹⁰⁵ The patient’s family doesn’t need to be notified until after the patient is dead.

2. Oregon’s assisted suicide law permits doctors to help mentally ill or depressed patients commit suicide. A referral for counseling is only necessary if, in the “opinion” of the attending physician, the patient requesting death has a “psychiatric or psychological disorder, including depression, *causing impaired judgment.*”¹⁰⁶

Even then, the law does not preclude people who are depressed or who have psychiatric or psychological disorders from obtaining a prescription for lethal drugs as long as a mental health professional determines that the person’s judgment is not impaired.

Neither early dementia nor other cognitive problems automatically prevent a patient from being “qualified” for assisted suicide.¹⁰⁷ Practice guidelines on imple-

¹⁰³ *Supra* note 83.

¹⁰⁴ Molly Brown, “Law, emotion mix in assisted suicide debate,” *Anchorage Daily News*, November 15, 2000.

¹⁰⁵ ORS 127.835 §3.05.

¹⁰⁶ ORS 127.825 §3.03 (emphasis added).

¹⁰⁷ Erin Barnett, “A family struggle: Is Mom capable of choosing to die?” *Portland Oregonian*, October, 17, 1999.

mentation of the Oregon law indicate that a person for whom the court has appointed a guardian or conservator can still qualify for assisted suicide. The guidelines merely suggest that doctors notify (not obtain permission from) the guardian or conservator regarding the request for lethal drugs.¹⁰⁸

3. Oregon's assisted suicide law permits "shopping" for health professionals who will find that a patient is qualified for assisted suicide. Even if a patient is found to have "impaired judgment," Oregon's law does not prohibit a health provider, family member or others from arranging for the patient to be evaluated by other health professionals until one is found who declares that the patient is capable of choosing assisted suicide. Such was the case with an elderly woman who died under the Oregon law.

Kate Cheney, eighty-five years old, reportedly had been suffering from early dementia. After she was diagnosed with cancer, her own physician declined to provide a lethal prescription for her. Counseling was sought to determine if she was capable of making health care decisions.

A psychiatrist found that Mrs. Cheney was not eligible for assisted suicide since she was not explicitly pushing for it, her daughter seemed to be coaching her to do so, and she couldn't remember important names and details of even a recent hospital stay.

Mrs. Cheney was then taken to a psychologist who said she was competent but possibly under the influence of her daughter who was "somewhat coercive." Finally, a managed care ethicist who was overseeing her case determined that she was qualified for assisted suicide, and the lethal drugs were prescribed.¹⁰⁹

Doctor-shopping played a role, as well, in the case of another elderly woman whose assisted suicide death was showcased by CID. Two doctors—including her own physician who believed that her request was due to depression—refused to prescribe lethal drugs for this woman in her mid-80s who had been battling breast cancer for twenty-two years.

But then, CID became involved. Dr. Peter Goodwin, the group's medical director, determined that the woman was an "appropriate candidate" for death and referred her to a doctor who provided the lethal prescription. In an audiotaped statement, made two days before her death and played at a press conference called by CID, the woman said, "I will be relieved of all the stress I have."¹¹⁰ (CID later revealed that, of the fifteen reported deaths during the statute's first year, it had "helped" eleven (73.3%) of those who died.¹¹¹)

¹⁰⁸ Barbara Coombs Lee, Eli D. Stutsman, Kelly T. Hagen, "Physician-Assisted Suicide," *Oregon Health Law Manual, Vol. 2: Life and Death Decisions* (Oregon State Bar Association 1997), Chapter 8: 12.

¹⁰⁹ *Supra* note 107.

¹¹⁰ Erin Hoover and Gail Hill, "Two die using suicide law: Woman on tape says she looks forward to relief," *Portland Oregonian*, March 36, 1998 and Kim Murphy, "Death called First under Oregon's new suicide law," *Los Angeles Times*, March 26, 1998.

¹¹¹ Barry Siegel, "A legal way out," *Los Angeles Times*, November 14, 1999.

4. Oregon's assisted suicide law allows fatal dose of drugs to be mailed to patients. Nothing in the Oregon law requires that the patient obtain the lethal drugs in person. In one reported assisted suicide under the state's new law, the patient received them via Federal Express.¹¹²

5. Under Oregon's assisted suicide law, requests for assisted suicide do not need to be made in person. Oregon's law requires that a patient make two oral requests and one written request for assisted suicide within a time span of no less than fifteen days.¹¹³ However, there is no requirement that any of these be made in person. The two oral requests could be made by phone and the witnessed, written request could be sent by mail to the doctor, who could then prescribe the lethal drugs.

Furthermore, the waiting period may not withstand a court challenge. The required fifteen-day time lapse between the first and second oral requests was included in the Oregon law as a direct result of the failure of the Washington and California initiatives. Speaking at a 1997 conference in Seattle, Tucker explained that the waiting period was inserted into the Oregon proposal to make it palatable to voters, but she opined that the waiting period would be found unconstitutional if it is subjected to a court challenge.

In my view, the Oregon measure, in some sense, became overly restrictive. It has a fifteen-day waiting period. And my own view of the federal constitutional claim is that a fifteen-day waiting period would be struck down immediately as unduly burdensome. But in the legislative forum, to pass, you need to have measures *that convince people that it's suitably protective* so you see a fifteen-day waiting period."¹¹⁴

6. Oregon's assisted suicide law has no safeguards for the patient at the time the lethal drugs are taken. The Oregon law's safeguards, illusory though they may be, only cover behavior up through the time the doctor writes the prescription for lethal drugs. The law contains no provisions dealing with what happens after the patient receives the prescription. The prescribed drugs could be stored over time, with no concern for public safety or for protecting the vulnerable patient from those who might benefit from the patient's early demise.

Moreover, even the requirement that the patient's judgment not be impaired refers only to the time between the patient's first request for assisted suicide and the doctor's writing the prescription. Nothing in the law requires that the patient be competent at the time the deadly overdose is taken.

In a 1997 Oregon Bar Association publication about Oregon's "Death with Dignity" law, CID's Barbara Coombs Lee and her co-authors wrote, "The Act merely regulates the conduct of all parties *up to the point of the drug prescription.*"¹¹⁵

¹¹² Erin Barnett, "Dilemma of assisted suicide: When?" *Portland Oregonian*, January 17, 1999.

¹¹³ ORS 127.840 §3.06.

¹¹⁴ Kathryn Tucker, Seattle Pacific University's Discovery Institute Conference, July 12, 1997 (emphasis added). Videotaped by TVW, Seattle, WA. Tape on file with author.

¹¹⁵ *Supra* note 108, Chapter 8: 13. (emphasis added)

7. Oregon's assisted suicide law gives doctors greater legal protection when they prescribe assisted suicide than when they provide pain relief and other end-of-life care to their patients. Oregon exempts doctors who are prescribing assisted suicide from the standard of care that they are required to meet when providing other medical services. Under the assisted suicide law, a health provider would not be subject to criminal or civil liability or any other professional disciplinary action as long as the person is acting in "good faith."¹¹⁶ This subjective "good faith" standard is far less stringent than the objective "reasonable standard of care" which physicians are required to meet for compassionate medical care such as hospice, palliation and curative treatment.

Thus, a doctor who negligently "participates"¹¹⁷ in an assisted suicide cannot be held accountable so long as he or she claims to have acted in "good faith." On the other hand, a doctor who negligently provides other medical interventions can be held legally accountable in civil court regardless of his or her "good faith." This lessening of the standard of care for assisted suicide could serve as an inducement for doctors to recommend assisted suicide over palliative care at the end of life.

8. Oregon's assisted suicide law does not preclude use of Kevorkian-like devices to induce death. Even though it is generally assumed that Oregon only permits prescriptions for a lethal dose of pills or capsules, the law does not require that the drugs be taken orally.

After passage of Oregon's law, supporters said the new law would permit the types of activities carried out by Jack Kevorkian. In an appearance on *Nightline*, Geoffrey Fieger (Kevorkian's attorney) and Peter Goodwin (CID's medical director) both agreed that the new law would permit use of a death-inducing device such as that developed by Kevorkian.¹¹⁸

Speaking at the Ninth National Hemlock Conference on Physician Aid-in-Dying, Tucker said that assisted suicide under the Oregon law "can take many forms" beyond swallowing pills. "I think that technology can make self-administration possible for a very broad range of patients who would not have the wherewithal to self-administer otherwise," she said. "For example, there are certainly technologies that permit patients to do things by voice activation of a computer that could generate an infusion of medication. That can be self-administration."¹¹⁹

Like the law itself, the official reports deserve attention.

The Oregon Assisted-Suicide Reports

As previously discussed, passage of the Oregon law provided an extremely important tool for assisted suicide proponents to use in their quest to spread legalized

¹¹⁶ ORS 127.885 §4.01 (1).

¹¹⁷ "Participate" means to perform the duties of an attending physician, consulting physician, or counseling function described in the law (ORS 127.885. § 4.01 (5) (D)(b)).

¹¹⁸ "Oregon's Assisted Suicide Law," ABC *Nightline*, December 7, 1994. (Kevorkian's device, used in most of the known deaths in which he participated, resulted in the victim's death by carbon monoxide poisoning.)

¹¹⁹ Diane Gianelli, "Hemlock leaders reveal strategy in campaign for suicide aid," *American Medical News*, December 9, 1996, 25.

assisted suicide across the country. And they have used the official reports from Oregon to refute concerns that the law would result in deaths of vulnerable people who are depressed, under pressure from others, living in poverty, or lacking adequate health care.

If assessment of Oregon's experience with assisted suicide depended solely on official reports, those concerns have, indeed, been found to be without merit. However, reliance on those official reports for an accurate portrayal of assisted suicide in Oregon is impudent.

Physician Noncompliance

Although descriptions of the law have consistently stated that the law requires physicians to report involvement in assisted suicide, it actually requires only that prescribing doctors maintain documentation in patients' medical records.¹²⁰ The actual "reporting requirements" are directed only at the Oregon Health Division (OHD) which must make rules to facilitate information collection, review a *sample* of records and issue an annual statistical report.¹²¹ The OHD has the mandate of requiring health care providers to file a copy of dispensing records.¹²² However, the law contains no penalties for health care providers who fail to report prescribing lethal doses for the purpose of suicide. Moreover, according to Dr. Katrina Hedberg, co-author of Oregon's three official reports, the OHD has no regulatory authority or resources to ensure compliance with reporting requirements.¹²³

Questionable Data

The OHD acknowledges that information on which its official reports are based may be incomplete and inaccurate. The only physicians interviewed for either report were those who had acknowledged prescribing lethal drugs. The first report stated that among its limitations was the fact that "the possibility of physician bias must be considered."¹²⁴ In addition, the OHD conceded, "[W]e cannot detect or collect data on issues of noncompliance with any accuracy"¹²⁵ and "We do not know if covert physician-assisted continued to be practiced in Oregon in 1998."¹²⁶

This situation did not change for subsequent reports. The second official report noted, "Underreporting cannot be assessed, and noncompliance is difficult to assess

¹²⁰ ORS 127.855 § 3.09.

¹²¹ ORS 127.865 § 3.11.

¹²² ORS 127.865 § 3.11 (b).

¹²³ Linda Prager, "Details emerge on Oregon's first assisted suicides," *American Medical News*, September 7, 1998.

¹²⁴ "Oregon's Death with Dignity Act: The First Year's Experience," Department of Human Resources, Oregon Health Division, Center for Disease Prevention and Epidemiology (February 18, 1999): 9. Hereafter: "OHD Report 1." Available at: <http://www.ohd.hr.state.or.us/chs/pas/year1/ar-index.htm>.

¹²⁵ *Ibid.*

¹²⁶ *Ibid.*

because of the possible repercussions for noncompliant physicians reporting data to the division.¹²⁷

The OHD has even admitted that reporting physicians may have fabricated their versions of the circumstances surrounding the prescriptions written for patients: “For that matter, the entire account could have been a cock-and-bull story. We assume, however that physicians were their usual careful and accurate selves.”¹²⁸

Over the course of the first three years of legal physician-assisted suicide in Oregon, seventy deaths were *reported*.¹²⁹ But there is no way to know how many such deaths actually took place. Nor is it possible to determine the circumstances surrounding those deaths.

Questions and More Questions

Nonetheless, some information that does appear in the Oregon reports raises as many questions as it answers. For example, one patient was reported to have taken the lethal dose more than eight months after receiving the prescription.¹³⁰ Lethal prescriptions under Oregon’s “Death with Dignity Act” are supposed to be limited to patients who have a life expectancy of six months or less. However, the OHD is not authorized to investigate how physicians determine their patients’ diagnoses or life expectancies.¹³¹ The actual life expectancy of those who died after taking prescriptions for assisted suicide is unknown.

Official reports from Oregon also indicate that at least fifty-nine percent of patients did not receive their lethal drug prescriptions from the first physician they asked.¹³² Since the refusing physicians were never interviewed by the OHD for the official reports there is no way to know why these doctors refused to prescribe or why they determined that the patient was not qualified for an assisted suicide death under the Oregon law.

Was it because the patient was not terminally ill? Was it because the physician was personally opposed to assisted suicide? Or was it because the doctor knew the

¹²⁷ Ann Sullivan, Katrina Hedberg, and David Fleming, “Legalized Physician-Assisted Suicide in Oregon—The Second Year,” *New England Journal of Medicine* 342 (February 24, 2000): 603; “Oregon’s Death with Dignity Act: The Second Year’s Experience,” Department of Human Services, Oregon Health Division, Center for Disease Prevention and Epidemiology (February 23, 2000): 12. Hereafter referred to as “OHD Report 2.” Available at: <http://www.ohd.hr.state.or.us/chs/pas/year2/ar-index.htm>.

¹²⁸ Oregon Health Division, *CD Summary*, (March 16, 1999): 2. The OHD’s CD Summary is available at: <http://www.ohd.hr.state.or.us/chs/pas/pascdsm2.htm>.

¹²⁹ “Oregon’s Death with Dignity Act: Three years of legalized physician-assisted suicide,” Department of Human Services, Oregon Health Division, Center for Disease Prevention and Epidemiology (February 22, 2001). Available at: <http://www.ohd.hr.state.or.us/chs/pas/ar-index.htm>.

¹³⁰ Sullivan, *supra* note 127, 599.

¹³¹ Katrina Hedberg *et al.*, Letter to the Editor, *Hastings Center Report* (January-February 2000): 4.

¹³² *Supra*, note 129, Table 3.

patient was subtly being pressured or encouraged by others to opt for an early death? The answers to these questions will never be known.

The OHD's figures also indicate that some patients knew their doctors for only two weeks before the lethal dose was prescribed.¹³³

Since at least two weeks must elapse between the first and last requests for the lethal dose, it appears that, in these cases, the physician-patient relationship was established for the specific purpose of obtaining the drugs for assisted suicide.

There are other omissions in the reports that raise even more questions. For example, the reporting doctors stated that none of the patients expressed financial concerns as a reason for wanting to die from assisted suicide. Yet 14.3% of those who died were on Medicaid,¹³⁴ Oregon's health program for the poor. In this population, financial difficulties are a fact of life. Is it possible that physicians did not probe these patients' reasons for choosing assisted suicide since the difficulties associated with poverty seemed insurmountable?

Among others whose deaths were reported, there remains a question about financial concerns that may not have been discussed with the prescribing physician (or may have been discussed, but not reported).

The Oregon law requires the doctor to inform the patient of the "feasible alternatives, including, but not limited to, comfort care, hospice care and pain control."¹³⁵

Since these would likely not be "feasible alternatives" for patients who do not have the financial resources to obtain such care, there is even some question as to whether the physician would have to inform a patient about such services.

In fact, in the absence of the ability to afford such services, being "informed" about them is useless, if not cruel. Even among Oregonians who are covered by private medical insurance, coverage for hospice services is often woefully inadequate. For example, QualMed Oregon Health Plan (created out of a merger of two HMOs) covers assisted suicide "as a prescription" while the plan's "value option" has a \$1000 limit on hospice care for terminally ill patients.¹³⁶

Complications Not Reported

Most notably absent from official reports are any references to problems occurring in conjunction with assisted suicide. According to assisted suicide provider

¹³³ Ibid., 601, Table 2 and OHD Report 2, *supra* note 127, Table 2.

¹³⁴ Ibid., 600. In the first two annual reports, specific figures were provided for the number of Medicaid patients. In the third annual report, figures were combined for Medicare and Medicaid patients, making it impossible to determine how many of the poorest Oregonians died of assisted suicide. In addition, the third annual report contains figures for "unknown" in a number of categories, including the category regarding insurance coverage for those whose deaths are included in the report.

¹³⁵ ORS 127.815 § 301 (2)(E).

¹³⁶ Mark O'Keefe, "Money's influence figures in debate on assisted suicide," *Portland Oregonian*, October 26, 1997.

Peter Rasmussen, “anybody can commit suicide,” but Oregon’s process is “predictably comfortable, painless.”¹³⁷ Of course, Patty Rosen’s commercials also declared, falsely, that her daughter had “slipped peacefully away” after taking pills.¹³⁸

Barbiturates are the most common substances used for assisted suicide in Oregon and in the Netherlands. Overdoses of barbiturates are known to cause distress. Extreme gasping and muscle spasms can occur. While losing consciousness, a person can vomit and then inhale the vomit. Panic, feelings of terror and assaultive behavior can take place from drug-induced confusion. Other problems can include difficulty in taking the drugs, failure of the drugs to induce unconsciousness and a number of days elapsing before death occurs.¹³⁹

Yet OHD’s first two annual reports contained no instances of problems or complications associated with the assisted-suicide deaths. The third year’s report cited only one case where the patient regurgitated a small amount of the drugs but died anyway. According to the OHD, “No other complications were reported.”¹⁴⁰

Hedberg has explicitly downplayed any complications. “Those things have not materialized,” she stated.¹⁴¹ However, she has acknowledged that OHD must rely on the word of the doctors who prescribed the drugs and that, since those doctors don’t need to be present when patients take the lethal drugs, they may not even know if there were problems.¹⁴² In addition, following release of the third report, she admitted to a reporter, “Dying is not pretty, and it takes a lot of preparation.” “We have not seen a botched suicide,” she said, “but we certainly have seen a wide spectrum, some of which you’d put in the category of not going as smoothly as might be hoped for.”¹⁴³

Problem Cases in the News

If it were not for occasional news reports and inadvertent disclosures, assisted suicides in Oregon would seem problem-free. Two particularly troubling reports have shattered that image. The first was on the death of Patrick Matheny.

After Patrick Matheny received his lethal dose of drugs from Oregon Health Sciences University via Federal Express, he delayed taking them for four months. On the day of his death, he experienced difficulty. His brother-in-law, Joe Hayes,

¹³⁷ Patrick McMahon and Wendy Koch, “Assisted suicide: A right or a surrender?” *USA Today*, November 21, 1999.

¹³⁸ *Supra* note 4.

¹³⁹ Johanna H. Groenwoud *et al.*, “Clinical Problems with the Performance of Euthanasia and Physician-Assisted Suicide in the Netherlands,” *New England Journal of Medicine* 342 (February 24, 2000): 553–555 and David Reinhard, “The pills don’t kill: The case,” *Portland Oregonian*, March 23, 2000.

¹⁴⁰ OHD press release, February 21, 2001.

¹⁴¹ Joe Rojas-Burke, “Suicide critics say lack of problems in Oregon is odd,” *Portland Oregonian*, February 24, 2000.

¹⁴² *Ibid.*

¹⁴³ Erin Hoover, “Assisted suicides hold steady,” *Portland Oregonian*, February 22, 2001.

said he had to “help” Matheny die. According to Hayes, “It doesn’t go smoothly for everyone. For Pat, it was a huge problem. It would not have worked without help.”¹⁴⁴

Another assisted suicide that went awry was inadvertently disclosed by Oregon attorney Cynthia Barrett during a “Physician-Assisted Suicide: Counseling Patients/Clients” presentation at Portland Community College in December 1999.

According to Barrett, “The man was at home. There was no doctor there,” she said. “After he took it [the drug overdose], he began to have some physical symptoms. The symptoms were hard for his wife to handle. Well, she [the wife] called 911. The guy ended up being taken by 911 to a local Portland hospital. Revived. In the middle of it. And taken to a local nursing facility. I don’t know if he went back home. He died shortly—some period of time after that time.”¹⁴⁵

George Eighmey who directs the Oregon chapter of CID was also present at the workshop. He told participants that the man “wasn’t one of our patients.”¹⁴⁶

Barrett’s remarks may have stayed within the confines of that room had it not been for Catherine Hamilton, a nurse who opposes assisted suicide. According to Hamilton, Eighmey approached her in the hallway following the workshop and cautioned her that the information was confidential and that no one should discuss it with the media. Since Barrett hadn’t given any identifying information, there was only one reason to keep the story “confidential,” and it wasn’t to protect the man or his family. It was to keep any news of a “botched suicide” away from the public. A short time later Hamilton’s account of the event appeared in *Brainstorm*, an Internet magazine.¹⁴⁷

Following the Internet article, during an interview on Portland’s KXL radio, Eighmey was asked if he was familiar with the case that Hamilton had described in her article. He accused Hamilton of “irresponsible, unsubstantiated reporting” and said that neither he nor two other workshop participants had heard Barrett say anything about such a case. “So whether Mrs. Hamilton is hearing things or not we don’t know,” he said.¹⁴⁸

His suggestion that Hamilton had been imagining things might have prevailed but for the fact that—apparently unnoticed by Eighmey—the workshop had been recorded and the talk show host was aware of this. He told Eighmey that not only were Barrett’s remarks on tape but that Eighmey’s statement that the patient wasn’t Compassion in Dying’s had also been recorded. Eighmey chose to end the interview early.¹⁴⁹

¹⁴⁴ Barnett, *supra* note 112 and Erin Barnett, “Man with ALS makes up his mind to die,” *Portland Oregonian*, March 11, 1999.

¹⁴⁵ Catherine Hamilton, “The Oregon Report: What’s Hiding behind the Numbers?” *Brainstorm*, March 2000, <http://www.brainstormnw.com>.

¹⁴⁶ *Ibid.*

¹⁴⁷ *Ibid.*

¹⁴⁸ David Reinhard, “The pills don’t kill: The case, first of two parts,” *Portland Oregonian*, March 23, 2000 and David Reinhard, “The pills don’t kill: The cover-up, second of two parts,” March 26, 2000.

¹⁴⁹ *Ibid.*

The Matheny death and the case described by Cynthia Barrett may be the only times that complications have arisen in conjunction with the Oregon assisted suicide law. Or they may be just the tip of the iceberg.

Dr. Sherwin Nuland of Yale University School of Medicine, who favors physician-assisted suicide, has questioned the absence of complications in the official Oregon reports. He noted that, in the Netherlands where there have been years to learn ways to overcome complications, Dutch reports show significant problems, yet Oregon's reports portray the practice as problem-free. He wrote, "The Dutch findings seem more credible."¹⁵⁰

Disturbing New Findings

One of the more significant findings in the third report deals with patients' reasons for choosing induced death. As in the previous two reports, fears about losing autonomy, the ability to participate in enjoyable activities, and control over bodily functions topped the list of reasons. However, for the first time, a clear majority (63 percent) of those whose deaths occurred in 2000 said they feared becoming burdens on their families, friends and caregivers, compared to twenty-six percent in the previous year.¹⁵¹

Most revealing is the fact that only five patients (19 percent) in 2000 were referred for psychological evaluation.¹⁵² But even then, the evaluations may have been slipshod and impersonal as the case of Joan Lucas indicates.

One of the assisted suicide deaths tallied in the third annual Oregon report was that of 65-year-old Joan Lucas who had ALS. Lucas had tried to overdose on sleeping pills in January 2000, but the suicide attempt failed.

After several doctors refused to assist her death, Lucas' son called CID and finally found a willing doctor. The doctor requested that Lucas get a psychological evaluation because, he said, "I wanted to cover my ass."¹⁵³

A cooperative psychologist was located, but, because Lucas was not able to travel to his office, he didn't see her in person. Instead, he sent her the Minnesota Multiphasic Personality Inventory test to take. Lucas children took turns reading the "hundreds" of questions to her and writing the answers.

Based on those responses, the psychologist determined that any depression Lucas experienced was related to her illness and was a completely normal response. Therefore, she was eligible for assisted suicide.

Although Lucas' death was in the tally, none of the details surrounding her prior suicide attempt or her "psychological evaluation" were included in the third year report.

¹⁵⁰ Sherwin Nuland, "Physician-Assisted Suicide and Euthanasia in Practice, *New England Journal of Medicine* 342(8) (February 24, 2000): 583–584.

¹⁵¹ *Supra* note 129, Table 3.

¹⁵² *Ibid.*

¹⁵³ Bill Kettler, "Stricken by ALS, Joan Lucas decides to die—then acts," *Medford (Oregon) Mail Tribune*, June 25, 2000.

Clearly, the picture of the Oregon experience differs greatly from the calm portrait painted by those who would make it a model for medical practice throughout the country.

Conclusion

The debate over assisted suicide will continue to be waged at the ballot box, in legislatures, in courts of law and in the court of public opinion. Its importance merits not only meticulous examination, but also the commitment and dedication of those who seek to protect individuals, families and society.

Like moving one part of a Rubik's Cube, removing current protections against assisted suicide would cause problems that could be difficult, if not impossible, to remedy.