Physician-Assisted Suicide (Aid in Dying)
&
Palliative Sedation
in the United States

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Overview: Here, we examine two important ethical issues. The first is physician-assisted suicide, which is now called *aid in dying* or *physician-assisted dying*. As of this writing, this practice is legal only in Oregon,[1] Washington,[2] Montana,[3] Vermont,[4] and New Mexico.[5] The second is palliative sedation, which is legal in each of the United States.

For most people, the public face of the aid-in-dying debates has been Jack Kevorkian. The late Michigan physician, who is still portrayed in the media as *Dr. Death*, claimed to have helped more than 100 people end their lives through "physician-assisted suicide." But Jack Kevorkian, MD, was convicted of the second-degree murder of one of his patients.[6] Although Dr. Kevorkian raised Americans' awareness of the aid-in-dying debate, it was not, perhaps, in the way that its supporters had hoped.

But the optics of the aid-in-dying movement changed—dramatically—when, on November 1, 2014, Brittany Maynard ended her life under Oregon's Death with Dignity Act. Brittany Maynard, who had an incurable malignant glioblastoma, was only 29.[7]

Arthur L. Caplan, Ph.D., of New York University's Division of Medical ethics, wrote: "Brittany Maynard ... [is] ... young, vivacious, attractive, a newlywed, has a dog, and is a very different kind of person from the average middle-aged or older person who has to confront issues about terminal illness ... " She therefore " ... changes the optics of the debate."[8]

More about Brittany Maynard's influence on the aid-in-dying debate will appear in *Some final thoughts,* which concludes this chapter. But now the authors present the laws that govern hastening death in terminally ill Americans.

Introduction: Other than in Oregon, Washington, Montana, Vermont, and New Mexico, American law has condemned having physicians hasten their terminally ill patients' death.[9] Yet for centuries, physicians have discreetly done just that; and despite widespread opposition, Americans have tacitly approved.[10] By 1996, popular support for the practice reached 75%, in 2013 popular support dropped a bit to 70%;[11] but in 2014 popular support rebounded to 74%.[12]

Many find the term *physician-assisted suicide* to be inaccurate and inappropriate. They have, therefore, adopted the value-neutral, less emotionally-charged, and more accurate terms *Aid in Dying* or *Physician-Assisted Dying*.[13] Where appropriate in historical context, the term *aid in dying* will appear in this chapter.

In November 2014, legal scholar David Orentlicher MD, JD, wrote: "As state governments respond to the needs of their aging populations, an issue of particular concern is health care at the end of life. With the many advances in public health and medical treatment—as well as in education, wealth, and other socioeconomic metrics—Americans are living much longer lives. But many Americans also face prolonged illness at the end of life that can result in great suffering. Often the suffering can be relieved with good palliative care, but for some Americans continued life becomes intolerable."[14]

Basic Definitions: Suicide is the act of taking one's own life.[15] Assisted suicide is the act of providing medical means or knowledge that allows others to take their lives.[16] In assisting suicide, a facilitator, usually a physician, provides drugs that can end life and instruction in their use. The patient then administers the lethal dose.

Euthanasia is the act of causing death, most often for reasons of mercy, in one suffering from an incurable, usually painful condition.[17] In active euthanasia, a facilitator, usually a physician, provides drugs that can end life and then administers the lethal dose. In contrast, passive euthanasia is the act of allowing a terminally ill person to die by withholding or withdrawing life-sustaining medical treatment. The patient dies, therefore, from the consequences of the underlying illness.[18]

Palliative sedation allows physicians to relieve extreme pain, agitation, delirium, or breathing difficulty by sedating dying patients into unconsciousness. Sedated into coma, the patient often dies within days.[19]

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

Basic Legal Precepts: Federalism defines the division of power between states and the federal government; and the laws of hastening death in America invoke its precepts.[20] Medical practice has long been regulated by the individual states; and federal law will preempt state law only where federal and state law conflict.[21] Before making policies that may affect the states, the federal government must first inform the states. Then, analyzing potential conflicts "with the greatest caution," federal law must defer to state law.[22]

Citizens derive their rights from constitutions, statutes, and the common law. A constitution defines a government's fundamental laws, character, and sovereign power. It guarantees individual civil rights and civil liberties.[23] The United States and each state have a separate constitution and a court that acts as its final arbiter. In the federal system, that court is the United States Supreme Court.

Statutes are laws passed by legislators.[24] In republican democracies, citizens elect state and federal legislators, respectively, in state legislatures and in Congress. Those legislators then enact statutes that govern their constituents' conduct.

Common law is the body of law derived from judicial decisions, and American common law devolves from the English law that appears in commentaries dating to the thirteenth century.[25] A respected commentator has described common law as "the power of judges to create new law under the guise of interpreting it."[26]

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

The Laws That Govern Hastening Death in America:

Suicide: Under medieval English law, suicide was considered a felony.[27] Thus under the common law, early Colonial American courts punished suicide with forfeiture of the decedent's estate.[28] But later Colonial American courts and legislatures, discerning the injustice in punishing a decedent's family for the decedent's wrongdoing, viewed suicide as a grave public wrong, and not a crime.[29] Currently, no state views suicide or attempted suicide as a crime. But assisting suicide is another matter.

Assisted Suicide: Under the common law and statutes respectively, Colonial American courts and legislatures forbade assisting suicide. Neither the patient's consent, nor extremity of suffering, nor the imminence of death from illness, injury, nor condemnation by a jury provided a defense against criminal charges.[30]

Currently, 34 states and the District of Columbia view assisting suicide as a crime. Conflicting legal doctrine, however, leaves uncertain whether North Carolina, Ohio, Utah, Virginia, and Wyoming view assisting suicide as a crime.

As already noted, only Oregon, Washington, Montana, Vermont, and New Mexico allow assisted suicide (aid in dying)—but only by a physician under expressly prescribed, closely monitored circumstances.[31]

Active Euthanasia: Euthanasia involves inducing a gentle and easy death.[32] But no matter how well-intentioned, active euthanasia remains the intentional taking of another human's life. In each of the 50 United States and the District of Columbia, therefore, active euthanasia is punishable as murder or as manslaughter.

Thus in 1999, a jury convicted Jack Kevorkian, MD, of second-degree murder. He was sentenced to spend ten-to-twenty-five years in prison because, unlike his conduct in his other cases, Dr. Kevorkian, and not the patient, administered the lethal drug.[33]

Refusing Medical Treatment and Passive Euthanasia: The law distinguishes refusing medical treatment from suicide.[34] The common-law right to preserve one's bodily integrity permits competent adults, defined as those with decision-making capability, to refuse any medical treatment.[35]

Before 1976, the relatively few treatment-refusal cases that courts decided involved treatment that the patient's religious beliefs forbade, such as blood-transfusion. But with the advent of respirators and artificial nutrition, courtroom battles forced Americans to confront the legitimacy of their right-to-die.

The seminal case, *In re Quinlan,* was the first state-court decision to allow physicians to withdraw a respirator from a patient who was in a persistent vegetative state.[36] Since *Quinlan*, courts have invariably held that no distinction exists between withholding or withdrawing life-sustaining medical treatment.[37] Those who facilitate passive euthanasia by withholding or withdrawing life-sustaining treatment under relevant state law therefore risk *no* criminal liability.

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

Palliative Sedation and the Double-Effect Doctrine: Formerly called terminal sedation, palliative sedation allows physicians to relieve extreme pain, agitation, delirium, or breathing difficulty by sedating dying patients into unconsciousness. Sedated into coma, the patient often dies within only a few days.[38]

Allowing an action that causes serious harm (such as death) as a side effect of promoting some good invokes the ancient doctrine of double effect.[39] Attributed to Thomas Aquinas, the double-effect doctrine states that one may *not* deliberately cause harm in order to promote some good. But one *may* promote some good even if serious harm comes from a foreseeable side-effect.[40] Physicians thus prescribe controlled substances to relieve pain, agitation, delirium, or breathing difficulty in the terminally-ill, even if doing so foreseeably hastens the patient's death.

In moral philosophy, in medical ethics, and in law, the double-effect doctrine has long been controversial.[41] But the American Medical Association [AMA] has incorporated it into its Code of Ethics.[42] Thus the Attorney General, Congress, and the Supreme Court have proclaimed the double-effect doctrine legitimate practice.[43] As a result, the double-effect doctrine has become the bedrock on which hospices, and now hospitals, manage severe pain in the terminally ill.[44]

But in purporting to be a reasonable option in caring for the terminally ill, the double-effect doctrine invites scrutiny. Under the double-effect doctrine, the morality or legality of physicians' conduct turns on intent. Did the physician intend to hasten death? Or did the physician intend only to relieve pain, agitation, delirium, or breathing difficulty—with death foreseeably following?[45] Deciding intent mires physicians in ethical and legal quandaries.

From an idealized ethical perspective, intent is clear and distinct. But in real end-of-life situations, physician intent is complex, ambiguous, and contradictory.[46] In treating the terminally ill, physicians rarely act with only one intent. Instead, they act with several intents—that may include a real possibility of hastening their patients' death.[47] Where physicians may incur civil, criminal, or administrative penalties based on their intent, their ethical and legal quandaries turn on just who may rightfully determine that intent.

Under basic jurisprudence, intent may be inferred from conduct. But under the double-effect doctrine, what physicians *say* becomes more important than what they *do*.

To avoid civil, criminal, or administrative penalties for their prescribing practices, physicians must never admit to honoring a patient's or a family's request for a patient's death. Instead, physicians must assert that they have prescribed only to relieve pain and suffering. And that perpetuates their ethical and legal quandaries, because of who may rightfully determine physicians' intent when they prescribe.

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

The double-effect doctrine creates other ethical and legal quandaries; and it may do nothing more than rationalize euthanasia. David Orentlicher, MD, JD, observes that the double-effect doctrine has blurred the distinction between withdrawing treatment and euthanasia.[48] Dr. Orentlicher, who served as general counsel to the AMA and chaired its Council on Ethical and Judicial Affairs, wrote: "... [palliative] sedation is essentially a form of euthanasia."[49] And in " ... relying on ... [palliative] sedation," writes Dr. Orentlicher, " ... the [Supreme Court] Justices rejected assisted suicide only by embracing euthanasia.[50]

Regulating Medical Practice in the Context of End-of-life Care: At first, end-of-life decisions involved only patients and their physicians. And *Quinlan* held that in end-of-life decisions, patient judgments must prevail over physician judgments.[51] Since 1976, when *Quinlan* was decided, courts and legislatures have struggled to fix medical management's legal boundaries in the context of end-of-life care.

In *Cruzan v. Department of Health,* in 1990, the Supreme Court made its first foray into end-of-life issues.[52] The Court held that should a competent adult become incompetent, states can require clear and convincing evidence of that patient's wishes before allowing the family to discontinue life support.[53] The Supreme Court thus recognized that regulating medical practice in the context of end-of-life care is a right reserved by the states.

Seven years later, in 1997, the Supreme Court reaffirmed that regulating medical practice in the context of end-of-life care is a right reserved by the states. And it did so by reversing decisions in which two federal appeals courts held that state bans on "physician-assisted suicide" violate the federal constitution.[54] Reversing the appeals courts in *Vacco v. Quill* and in *Washington v. Glucksberg*, the Supreme Court held that New York's and Washington's bans on "physician-assisted suicide" do *not* violate the federal constitution.[55]

In *Quill* and in *Glucksberg* respectively, the Supreme Court held that the neither the Equal Protection Clause nor the Due Process Clause confer a constitutional right to assisted suicide.[56] But these decisions do not prevent state legislatures from conferring such a right.[57] To the contrary, the Court encouraged continued debate over the "morality, legality, and practicality of physician-assisted suicide" by the states.[58] With the Supreme Court's urging states to protect "terminally ill, mentally competent individuals who would seek to end their suffering," Oregon's legislature did just that.[59]

Oregon's Death with Dignity Act: When its voters approved the Death with Dignity Act in 1994, Oregon became the first—and only—state to make physician aid in dying legal.[60]

(The full text of Oregon's Death with Dignity Act appears as Appendix A)

But responding to a lawsuit, a federal district court quickly prevented Oregon from implementing the Act.[61] The injunction continued for three years, until a federal appeals court vacated it.[62] On November 4, 1997, voters in Oregon rejected a legislative proposal to repeal the Act. By a 60-40% margin, those voters ensured that obtaining a physician's aid in hastening the death of terminally-ill Oregonians would remain legal.[63]

The terminally ill have incurable, irreversible disease that is expected to cause death within six months.[64] Under the Death with Dignity Act, competent, terminally-ill Oregonians may make a written request for self-administered medication to end their lives in a "humane and dignified manner."[65] The patient must sign and date the request, which two unrelated, disinterested individuals must witness. A physician must inform the patient of the alternatives to hastening death, and two physicians must confirm the patient's medical diagnosis and mental competence to make health-related decisions.[66] Physicians who are unwilling to participate have no duty to do so; and physicians and pharmacists who participate in the Act risk no civil, criminal, or professional-disciplinary actions.[67] Outside the Act, aiding suicide is second-degree manslaughter.[68] Health care providers must file reports with Oregon's Department of Human Services documenting their actions taken under the Act.[69] Because barbiturates have been the drugs-of-choice in effecting physician aid in dying, Oregon's Death with Dignity Act incorporates the federally-enacted Controlled Substances Act.

The Controlled Substances Act: In 1970, Congress enacted the Controlled Substances Act.[70] Enacted to deal with drug abuse in the United States, the Act ensures that legally available drugs remain legally distributed and legally used.[71] Physicians who violate the Act risk losing their prescribing privileges and they risk incurring severe criminal penalties.[72]

A 1971 regulation adopted under the Attorney General's limited power to implement the Act states that controlled substances must be prescribed for "a legitimate medical purpose."[73] But nothing in the Controlled Substances Act or its implementing regulations defines "a legitimate medical purpose."[74]

A 1984 amendment to the Act targeted physicians who divert legitimate prescription drugs to illegitimate uses.[75] The 1984 amendment thus empowers the Attorney General to deny registration under the Act for conduct "inconsistent with the public interest."[76] To determine the public interest, the Attorney General must consider compliance with state law and "threats to public health."[77] But nothing in the Controlled Substances Act or its implementing regulations defines conduct "inconsistent with the public interest" or "threats to public health."[78]

The Act empowers the Attorney General to place drugs on, or to remove drugs from, any of the Act's five schedules.[79] But first, the Secretary of Health and Human Services must provide a "scientific and medical" evaluation and advice that the Attorney General must accept and follow.[80]

In enacting the Controlled Substances Act, Congress did not intend to regulate physicians as the states do.[81] Nor did Congress intend to regulate medical practices allowed by state law that are unrelated to drug abuse or trafficking.[82] In determining accepted medical practice, the Attorney General can make no credible claim to any medical expertise.[83]

But some government officials who oppose Oregon's Death with Dignity Act have tried to subvert it by amending or interpreting the Controlled Substances Act.

Aid in Dying's Opponents:

Congressional Conservatives and the Drug Enforcement Administration: Only a day after voters approved Oregon's Death with Dignity Act—for the second time—Congressional conservatives induced the Drug Enforcement Administration [DEA] to act against Oregon's law. With neither Justice Department nor Congressional approval, the DEA proclaimed that physicians who prescribe controlled substances to assist suicide could find their prescribing privileges subject to revocation.[84] Fear of DEA reprisals—even under the duly enacted Death with Dignity Act—led Oregon's physicians to refuse to prescribe for aid in dying. But in 1998, after a seven-month long, thorough investigation by the Justice Department, then-Attorney General Janet Reno rejected the DEA's position.[85] She ruled that in enacting the Controlled Substances Act, Congress intended to block drug trafficking but *not* physician aid in dying.[86] She upheld that the "morality, legality, and practicality" of "physician-assisted suicide" was to be resolved in state legislatures.[87] She ruled that "adverse action against a physician who has assisted in a suicide in full compliance with the Oregon Act would *not* be authorized by the Controlled Substances Act."[88]

Only hours after receiving Ms. Reno's ruling, conservatives in both Houses of Congress sprung into action to amend the Controlled Substances Act. Under two separate proposals, an amended Controlled Substances Act proclaimed that prescribing controlled substances to relieve pain—even if death follows—would be legitimate medical practice.[89] But prescribing controlled substances to assist suicide would *not* be legitimate medical practice. So physicians' controlled-substances registration would be subject to revocation.[90] And physicians would now risk criminal prosecution and a 20-year mandatory prison term.[91] Even complying with the Death with Dignity Act's every provision would not furnish a defense.[92] Ostensibly aimed at pain relief and not the Death with Dignity Act, either proposed federal statute would, if enacted into law, effectively annul it.[93]

Attempts to amend the Controlled Substances Act, first under the Lethal Drug Abuse Prevention Act and later under the Pain Relief Promotion Act, stalled indefinitely in the Senate. Yet the Pain Relief Promotion Act passed in the House of Representatives by a 271-156 majority.[94] Many ascribe that to the position opposing physician-assisted suicide (aid in dying) championed by the AMA.

The American Medical Association: The AMA Code of Ethics condemns assisting suicide for being "fundamentally incompatible with the physician's role as healer."[95] Under the AMA Code of Ethics, even physicians who comply with every provision of Oregon's Death with Dignity Act behave unethically.

But the AMA does not acknowledge that substantial numbers of American physicians support physician aid in dying.[96] Two-thirds of American physicians do not even belong to the AMA.[97] And the AMA's Council on Ethical and Judicial Affairs, an appointed body that authors its Code of Ethics, routinely issues ethical guidelines *without* polling physicians.[98] Still, Congress and the Supreme Court accord AMA positions pivotal deference.[99]

The AMA supports "providing effective palliative treatment even though it may foreseeably hasten death."[100] The AMA therefore praised the Pain Relief Promotion Act for "reducing physicians' exposure to criminal investigation and prosecution for legitimate medical practices."[101] But the AMA's reasoning, on which Congress relied in debating the Pain Relief Promotion Act, and on which the Supreme Court relied in deciding *Quill* and *Glucksberg*, raises constitutional concerns.[102]

The Pain Relief Promotion Act would impose a national solution on issues that historically have been handled by the states. DEA agents would intrude into the physician-patient relationship.[103] When physicians prescribe controlled substances, DEA agents would interpret physicians' intent.[104] In settings where even physicians disagree, DEA agents—not physicians—would determine appropriate prescribing practices.[105] Finally, the Attorney General would act as though Oregon's Death with Dignity Act, a duly enacted state law, does not exist.[106] Still this has not lessened the AMA's resolve.[107]

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

The United States Department of Justice: Undaunted by their failing to thwart physician aid in dying in Oregon, its opponents tried a new tactic. That tactice would avoid the open, thorough legislative debate required by Congress. Seeking refuge with then-Attorney General John Ashcroft, they tried to "get through the administrative door that which they could not get through the congressional door."[108] They found Mr. Ashcroft ready to reverse the Justice Department's earlier interpretation of the Controlled Substances Act with an administrative directive that attempted to rewrite federal law.

John Ashcroft's closed-door process took only a few months.[109] He acted without public hearings or debate, without warning to the medical community, and without the data or input from Oregon that he had earlier agreed to consider.[110]

In what has become known as the "Ashcroft Directive," the then-Attorney General, who can make no credible claim to medical expertise, defined "legitimate medical purpose." Under the Ashcroft Directive issued on November 6, 2001, using controlled substances to aggressively manage pain is a "legitimate medical purpose." But under the Ashcroft Directive, using controlled substances to assist suicide is "inconsistent with the public interest" and is *not* a "legitimate medical purpose."[111] Under the Ashcroft Directive, even when done under Oregon law, prescribing, dispensing, or administering controlled substances to assist suicide violates the Controlled Substances Act.[112]

Under the Ashcroft Directive, the records required by Oregon's Death with Dignity Act would self-incriminate physicians who obey that Act.[113] Under the Ashcroft Directive, physicians who assist suicide, even under Oregon law, risk investigation, prosecution, and punishment. Under the Ashcroft Directive, those physicians risk having their prescribing privileges suspended or revoked—and 20 years in prison.

The Ashcroft Directive, which disclaimed Janet Reno's 1998 ruling that reached the opposite conclusion, effectively annulled the Death with Dignity Act and Oregon's then four-year experience in applying it.[114]

The Ashcroft Directive's unwarranted intrusion into Oregon's sovereign interests caused physicians, terminally-ill patients, and Oregon's Government to sue to prevent giving the Ashcroft Directive any legal effect.[115]

The Ashcroft Directive in federal district court: In his April 17, 2002, decision, the Honorable Robert E. Jones restrained the Ashcroft Directive permanently.[116]

Judge Jones first noted: "Many of our citizens, including the highest respected leaders of this country, oppose assisted suicide." But, he warned, while "opposition to assisted suicide may be fully justified ... [that] ... does not permit a federal statute to be manipulated from its true meaning to satisfy even a worthy goal."[117]

Judge Jones wrote: "The determination of what constitutes a legitimate medical practice or purpose traditionally has been left to the individual states. State statutes, state medical boards, and state regulations control the practice of medicine."[118] Thus " ... the Ashcroft Directive is not entitled to deference under any standard and is invalid."[119]

Judge Jones admonished: "To allow an attorney general—an appointed executive whose tenure depends entirely on whatever administration occupies the White House—to determine the legitimacy of a particular medical practice without a specific congressional grant of such authority would be unprecedented and extraordinary."[120]

Five months later, on September 23, 2002, Mr. Ashcroft appealed his defeat in the federal district court to the Ninth Circuit Court of Appeals.

The Ashcroft Directive in the Ninth Circuit Court of Appeals: A three-judge panel from the Ninth Circuit Court of Appeals took almost two years to affirm the district court. In a two-to-one vote, the Court of Appeals declared the Ashcroft Doctrine invalid.[121]

On May 26, 2004, a year after oral arguments, Judge Richard C. Tallman, writing for the majority, held: "The attorney general's unilateral attempt to regulate general medical practices historically entrusted to state lawmakers interferes with the democratic debate about physician-assisted suicide and far exceeds the scope of his authority under federal law."[122]

Judge Tallman wrote: "We express no opinion on whether the practice is inconsistent with the public interest or constitutes illegitimate medical care." "This case is simply about who gets to decide."[123] And under " ... our concept of federalism, which requires that state lawmakers, not the federal government, are the primary regulators of professional medical conduct," the *states* do.[124]

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

The Ashcroft Directive in the United State Supreme Court: On November 9, 2004, the day on which Americans learned that John Ashcroft had resigned as Attorney General, he asked the U.S. Supreme Court to review the Ninth Circuit's decision. Three months later, on February 22, 2005, the Court agreed. Thus on October 5, 2005, the Court heard oral arguments under the case's new name, *Gonzalez v. Oregon*. And on January 17, 2006, the Court dealt the Ashcroft Doctrine its final rebuke.[125]

In a 6-3 ruling that was notably focused and technical, the Court based its decision on administrative law to uphold the earlier decisions of the federal district and appellate courts. The Court did not address whether there is a constitutional right to die, nor did it find Congress powerless to override state laws that allow physicians to help patients hasten death. Writing for the majority, Justice Anthony Kennedy held only that the Controlled Substances Act " ... does not authorize the Attorney General to bar dispensing controlled substances for assisted suicide in the face of a state medical regime permitting such conduct."[126]

Justice Kennedy found that Mr. Ashcroft acted " ... without consulting Oregon or apparently anyone outside his department."[127] He also found that: "The authority claimed by the attorney general is both beyond his expertise and incongruous with the statutory purposes and design."[128]

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

Other states that allow aid in dying: In 2008, eleven years after Oregonians ensured that obtaining a physician's aid in hastening death of the terminally ill would remain legal, Washington passed The Washington Death with Dignity Act.

Incorporating the same safeguards and procedures as Oregon's Death with Dignity Act, Washington's Act passed on November 4, 2008. It went into effect on March 5, 2009, making Washington's Death with Dignity Act a reality.[129]

(The full text of Washington's Death with Dignity Act can be accessed by inserting the following link into any web browser: http://www.wsha.org/files/i1000%20text.pdf)

Soon afterwards, citing concerns for privacy and dignity, a Montana State court followed suit. Declaring that the state legislature had not moved fast enough to recognize aid-in-dying rights, Judge Dorothy McCarter decided that she was obligated to decide for it: "Montana constitutional rights of individual privacy and human dignity, taken together, encompass the right of a competent terminally (ill) patient to die with dignity." By an only 4-3 margin on December 31, 2009, Montana's Supreme Court affirmed.[130]

(The decision can be accessed by inserting the following link into any web browser: http://nightingalealliance.org/pdf/Baxter_v_Montana.pdf)

Four years later, Vermont's General Assembly passed The Patient Choice and Control at End of Life Act (Act 39), which was signed into law on May 20, 2013.[131] Act 39 "provides Vermont residents with terminal disease the option to be prescribed a dose of medication to hasten the end of their life. This option requires the participation of a Vermont physician." "For the next three years, physicians and patients must adhere to a process laid out by the Act. In 2016, that process sunsets but the law continues to provide immunity for patients and physicians who wish to take steps under the Act. No patient, physician, or pharmacist may be required to participate in activities under Act 39. Every step must be voluntary."[132]

(Act 39 can be accessed by inserting the following link into any web browser: http://www.leg.state.vt.us/docs/2014/Acts/ACT039.pdf)

Then, in January 2014, a New Mexico District Court held that the substantive due process clause of the New Mexico State Constitution grants terminally ill, mentally competent patients a fundamental right to aid in dying.[133]

"This Court cannot envision a right more fundamental, more private or more integral to the liberty, safety and happiness of a New Mexican than the right of a competent, terminally ill patient to choose aid in dying. If decisions made in the shadow of one's imminent death regarding how they and their loved ones will face that death are not fundamental and at the core of these constitutional guarantees, [then] what decisions are?" wrote Judge Nan G. Nash. She continued: "… The Court therefore declares that the liberty, safety and happiness interest of a competent, terminally ill patient to choose aid in dying is a fundamental right under our New Mexico Constitution."[134]

Noting that the ruling protects physicians from prosecution only in Bernalillo County, New Mexico, the advocacy group Compassion & Choices has stated that: "If affirmed, the ruling will impact the entire state."[135]

Compassion & Choices, therefore, describes this ruling as a "landmark decision" that " ... May Set Precedent for Challenging 'Assisted Suicide' Laws in Other States."[136]

Appearing to agree with Compassion & Choices, Gary King, New Mexico's Attorney General has appealed the ruling, arguing that it fails to set a statewide precedent on the issue. But Mr. King and his conservatives allies are, in fact, attempting to overturn it.[137]

(The decision can be accessed by inserting the following link into any web browser: http://www.patientsrightscouncil.org/site/wp-content/uploads/2014/01/Morris_v_NM_Decision_01_13_14.pdf)

Other states that could allow aid in dying: While many bills are drafted in state legislatures every year, opposition lobbying and financial contributions by conservative and religious groups cause most of them to fail. But advocacy groups view these bills as testament to growing support of the Death with Dignity movement, the public's will, and the strength of the Oregon, Washington, and Vermont legislation.[138]

In Pennsylvania for example, Senate Bill 1032, The Death with Dignity Act, introduced in June 2013 to the Judiciary committee, can be considered through 2014.[139]

In New Jersey, the State Assembly passed Assembly Bill 2270, its own version of Death with Dignity on November 13, 2014.[140] A companion bill, Senate Bill 382 awaits attention in the state Senate.[141] But Governor Chris Christie has threatened to veto it.[142]

Oregon's Death with Dignity Act in action: Because it has been in effect since 1997, we have 16 years to analyze how Oregon's Death with Dignity Act really works. As required, experience with the Death with Dignity Act has been documented and evaluated in detail.[143]

Year 16 - 2013 of Oregon's Death with Dignity Act was released on January 28, 2014. It provides statistics over the 16 years during which aid in dying has been legal in Oregon.[144]

Patients who chose to hasten death under the Act were educated, overwhelmingly white, and motivated by issues relating to quality-of-life.[145] Indeed, 26.5% had some college education, 45.6% had a baccalaureate or higher degree, and 97.3% were white.[146]

Most (78.9%) suffered from end-stage or incurable cancers and dreaded the inexorable loss of their autonomy (91.4%), their ability to participate in activities that make life enjoyable (88.9%); their loss of dignity (80.9%); and their loss of body functions (50.3%).

Almost all (98.3%) had medical insurance.[147] Fears that the Act would be disproportionately forced on, patients who were poor, uneducated, uninsured, or afraid of the financial consequences of their illness have proven unfounded.[148]

The number of prescriptions that physicians wrote for controlled substances in lethal doses and the number of Oregonians who died using those prescriptions appear here:[149]

Oregon Death with Dignity Act; Year Sixteen		
year	lethal ℞	patients died
1998	24	16
1999	33	27
2000	39	27
2001	44	21
2002	58	38
2003	68	42
2004	60	37
2005	65	38
2006	65	46
2007	85	49
2008	88	60
2009	95	59
2010	97	65
2011	114	71
2012	116	85
2013	122	71
totals	1173	752

Throughout those 16 years, the most frequently reported concerns have remained remarkably consistent. Those most frequently reported were: loss of autonomy (91.4%); lessened ability to participate in activities that make life enjoyable (88.9%); loss of dignity (80.9%); loss of control over bodily functions (50.3%); and burden on family, friends, and care givers (40.0%). And the median age has remained remarkably consistent at 71.[150]

The overwhelming number of Oregonians who chose to hasten their death under the Act did *not* cite uncontrollable pain or financial implications of treatment as a major factor.[151]

Finally, the Act has reduced the underground practice of physician-assisted dying that was widespread in Oregon—and remains underground throughout the rest of the nation.[152]

Some final thoughts: More than two centuries ago, Sir William Blackstone observed that "Law is the embodiment of the moral sentiment of the people."[153] The laws that govern aid in dying blend ethics, philosophy, and morality with medicine and the law. They touch our most fundamental beliefs about life, death, illness, religion, autonomy, and dignity. People of good conscience, therefore, can disagree about aid in dying's and palliative sedation's morality and wisdom.[154]

The legal issues that surround aid in dying affect the balance of power between the state and federal governments in the realm of medical practice. Many believe that the Attorney General should interpret the Controlled Substances Act in a way that effectively subverts the Death With Dignity Act. But many believe that doing so subverts federalism's basic precepts, the Supreme Court's guidance, and sovereign state interests.[155]

In 2013, Vermont became the first state to legalize aid in dying through legislation. Oregon and Washington had done so by referendum, and in Montana and New Mexico it was effectively done through court decisions.

Aid-in-dying issues especially concern citizens of Oregon, Washington, Montana, Vermont, and New Mexico who face critical end-of-life decisions—and health care's lawful role in those decisions.[156] In medical and medical-ethics communities the limits of legitimate medical practice and of physicians' conduct still cause deep disagreements.[157]

For physicians, patients, religious groups, ethicists, philosophers, and legislators, whether the terminally ill should be allowed to hasten their deaths still ignites controversy.

Three days after Brittany Maynard died under Oregon's Death with Dignity Act, Monsignor Ignacio Carrasco de Paula, president of the Vatican's Pontifical Academy for Life, described her assisted suicide act as "an absurdity" and "reprehensible."[158]

Saying that he judged the act rather than the individuals who did them, Msg. Carrasco de Paula, the Vatican's top bioethics official, condemned her actions loudly and publically. And for doing that, he earned immediate loud, public rebukes.

One came from Rev. Dr. Ignacio Castuera, a United Methodist Pastor who serves as a board member of Compassion & Choices. He replied that Maynard was not Catholic and that it would be wrong to impose a set of religious beliefs on people who do not share them. "People of faith are free to follow their own beliefs and consciences. But it is wrong to use the police power of government to impose a set of religious beliefs on people who do not share them. It is not the American way."[159]

Brittany's mother, Debbie Ziegler, defended her daughter's decision. In a letter released by Compassion and Choices, she wrote that: "My twenty-nine-year-old daughter's choice to die gently rather than suffer physical and mental degradation and intense pain does not deserve to be labeled as reprehensible by strangers a continent away who do not know her or the particulars of her situation."[160] (Her letter appears, in full, in endnote 161.)[161]

Brittany herself wrote: "Who has the right to tell me that I don't deserve this choice? That I deserve to suffer for weeks or months in tremendous amounts of physical and emotional pain? Why should anyone have the right to make that choice for me?"[162]

Social media, with its associated technology, has profoundly influenced events domestically and throughout the world.[163] It has influenced elections in Egypt, the Iranian Revolution, the Arab Spring, and in the United States, the 2008 presidential elections, the shooting in Ferguson, Missouri, and LGBT rights.[164]

Brittany Maynard publicized that she and her husband had moved to Portland, Oregon, from Northern California so she could use Oregon's law to end her life on her own terms. In doing that, she grabbed social media's spotlight.[165]

After Brittany Maynard died, social media has been abuzz with comments about the Vatican's condemning her death. Citing Thomas Paine, supporters wrote about the separation of church and state. "Of all the tyrannies that affect mankind, tyranny in religion is the worst; every other species of tyranny is limited to the world we live in; but this attempts to stride beyond the grave, and seeks to pursue us into eternity."[166]

Arthur L. Caplan, Ph.D., of New York University's Division of Medical ethics, wrote: "Now we have a young woman getting people in her generation interested in the issue."[167] "Critics are worried about her partly because she's speaking to that new audience, and they know that the younger generation of America has shifted attitudes about gay marriage and the use of marijuana, and maybe they are going to have that same impact in pushing physician-assisted suicide forward."[168]

It's too soon to know the effect of Brittany Maynard's heartrending story. Vital and feisty to the end, her obituary appears in Appendix B. Supporters are optimistic that the young teacher's ordeal may be enough to tip the balance their way. And opponents are equally optimistic that her ordeal will spur opposition to new aid-in-dying laws.

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

Appendix A

(Author's note: The full text of Oregon's Death with Dignity Act can also be accessed by inserting the following link into any web browser: http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/statute.pdf)

The Oregon Death with Dignity Act [169]

Oregon Revised Statutes

(General Provisions)

(Section 1)

Note: The division headings, subdivision headings and leadlines for 127.800 to 127.890, 127.895 and 127.897 were enacted as part of Ballot Measure 16 (1994) and were not provided by Legislative Counsel.

127.800 s.1.01. Definitions.

The following words and phrases, whenever used in ORS 127.800 to 127.897, have the following meanings:

(1) "Adult" means an individual who is 18 years of age or older.

(2) "Attending physician" means the physician who has primary responsibility for the care of the patient and treatment of the patient's terminal disease.

(3) "Capable" means that in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, psychiatrist or psychologist, a patient has the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available.

(4) "Consulting physician" means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's disease.

(5) "Counseling" means one or more consultations as necessary between a state licensed psychiatrist or psychologist and a patient for the purpose of determining that the patient is capable and not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.

(6) "Health care provider" means a person licensed, certified or otherwise authorized or permitted by the law of this state to administer health care or dispense medication in the ordinary course of business or practice of a profession, and includes a health care facility.

(7) "Informed decision" means a decision by a qualified patient, to request and obtain a prescription to end his or her life in a humane and dignified manner, that is based on an appreciation of the relevant facts and after being fully informed by the attending physician of:

(a) His or her medical diagnosis;

(b) His or her prognosis;

(c) The potential risks associated with taking the medication to be prescribed;

(d) The probable result of taking the medication to be prescribed; and

(e) The feasible alternatives, including, but not limited to, comfort care, hospice care and pain control.

(8) "Medically confirmed" means the medical opinion of the attending physician has been confirmed by a consulting physician who has examined the patient and the patient's relevant medical records.

(9) "Patient" means a person who is under the care of a physician.

(10) "Physician" means a doctor of medicine or osteopathy licensed to practice medicine by the Board of Medical Examiners for the State of Oregon.

(11) "Qualified patient" means a capable adult who is a resident of Oregon and has satisfied the requirements of ORS 127.800 to 127.897 in order to obtain a prescription for medication to end his or her life in a humane and dignified manner.

(12) "Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months. [1995 c.3 s.1.01; 1999 c.423 s.1]

(Written Request for Medication to End One's Life in a Humane and Dignified Manner)

(Section 2)

127.805 s.2.01. Who may initiate a written request for medication.

(1) An adult who is capable, is a resident of Oregon, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner in accordance with ORS 127.800 to 127.897.

(2) No person shall qualify under the provisions of ORS 127.800 to 127.897 solely because of age or disability. [1995 c.3 s.2.01; 1999 c.423 s.2]

127.810 s.2.02. Form of the written request.

(1) A valid request for medication under ORS 127.800 to 127.897 shall be in substantially the form described in ORS 127.897, signed and dated by the patient and witnessed by at least two individuals who, in the presence of the patient, attest that to the best of their knowledge and belief the patient is capable, acting voluntarily, and is not being coerced to sign the request.

(2) One of the witnesses shall be a person who is not:

(a) A relative of the patient by blood, marriage or adoption;

(b) A person who at the time the request is signed would be entitled to any portion of the estate of the qualified patient upon death under any will or by operation of law; or

(c) An owner, operator or employee of a health care facility where the qualified patient is receiving medical treatment or is a resident.

(3) The patient's attending physician at the time the request is signed shall not be a witness.

(4) If the patient is a patient in a long term care facility at the time the written request is made, one of the witnesses shall be an individual designated by the facility and having the qualifications specified by the Oregon Health Authority by rule. [1995 c.3 s.2.02]

(Safeguards)

(Section 3)

127.815 s.3.01.Attending physician responsibilities.

(1) The attending physician shall:

(a) Make the initial determination of whether a patient has a terminal disease, is capable, and has made the request voluntarily;

(b) Request that the patient demonstrate Oregon residency pursuant to ORS 127.860;

(c) To ensure that the patient is making an informed decision, inform the patient of:

(A) His or her medical diagnosis;

(B) His or her prognosis;

(C) The potential risks associated with taking the medication to be prescribed;

(D) The probable result of taking the medication to be prescribed; and

(E) The feasible alternatives, including, but not limited to, comfort care, hospice care and pain control;

(d) Refer the patient to a consulting physician for medical confirmation of the diagnosis, and for a determination that the patient is capable and acting voluntarily;

(e) Refer the patient for counseling if appropriate pursuant to ORS 127.825;

(f) Recommend that the patient notify next of kin;

(g) Counsel the patient about the importance of having another person present when the patient takes the medication prescribed pursuant to ORS 127.800 to 127.897 and of not taking the medication in a public place;

(h) Inform the patient that he or she has an opportunity to rescind the request at any time and in any manner, and offer the patient an opportunity to rescind at the end of the 15 day waiting period pursuant to ORS 127.840;

(i) Verify, immediately prior to writing the prescription for medication under ORS 127.800 to 127.897, that the patient is making an informed decision;

(j) Fulfill the medical record documentation requirements of ORS 127.855;

(k) Ensure that all appropriate steps are carried out in accordance with ORS 127.800 to 127.897 prior to writing a prescription for medication to enable a qualified patient to end his or her life in a humane and dignified manner; and

(L)(A) Dispense medications directly, including ancillary medications intended to facilitate the desired effect to minimize the patient's discomfort, provided the attending physician is registered as a dispensing physician with the Board of Medical Examiners, has a current Drug Enforcement Administration certificate and complies with any applicable administrative rule; or

(B) With the patient's written consent:

(i) Contact a pharmacist and inform the pharmacist of the prescription; and

(ii) Deliver the written prescription personally or by mail to the pharmacist, who will dispense the medications to either the patient, the attending physician or an expressly identified agent of the patient.

(2) Notwithstanding any other provision of law, the attending physician may sign the patient's death certificate. [1995 c.3 s.3.01; 1999 c.423 s.3]

127.820 s.3.02. Consulting physician confirmation.

Before a patient is qualified under ORS 127.800 to 127.897, a consulting physician shall examine the patient and his or her relevant medical records and confirm, in writing, the attending physician's diagnosis that the patient is suffering from a terminal disease, and verify that the patient is capable, is acting voluntarily and has made an informed decision. [1995 c.3 s.3.02]

127.825 s.3.03. Counseling referral.

If in the opinion of the attending physician or the consulting physician a patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment, either physician shall refer the patient for counseling. No medication to end a patient's life in a humane and dignified manner shall be prescribed until the person performing the counseling determines that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment. [1995 c.3 s.3.03; 1999 c.423 s.4]

127.830 s.3.04. Informed decision.

No person shall receive a prescription for medication to end his or her life in a humane and dignified manner unless he or she has made an informed decision as defined in ORS 127.800 (7). Immediately prior to writing a prescription for medication under ORS 127.800 to 127.897, the attending physician shall verify that the patient is making an informed decision. [1995 c.3 s.3.04]

127.835 s.3.05. Family notification.

The attending physician shall recommend that the patient notify the next of kin of his or her request for medication pursuant to ORS 127.800 to 127.897. A patient who declines or is unable to notify next of kin shall not have his or her request denied for that reason. [1995 c.3 s.3.05; 1999 c.423 s.6]

127.840 s.3.06. Written and oral requests.

In order to receive a prescription for medication to end his or her life in a humane and dignified manner, a qualified patient shall have made an oral request and a written request, and reiterate the oral request to his or her attending physician no less than fifteen (15) days after making the initial oral request. At the time the qualified patient makes his or her second oral request, the attending physician shall offer the patient an opportunity to rescind the request. [1995 c.3 s.3.06]

127.845 s.3.07. Right to rescind request.

A patient may rescind his or her request at any time and in any manner without regard to his or her mental state. No prescription for medication under ORS 127.800 to 127.897 may be written without the attending physician offering the qualified patient an opportunity to rescind the request. [1995 c.3 s.3.07]

127.850 s.3.08. Waiting periods.

No less than fifteen (15) days shall elapse between the patient's initial oral request and the writing of a prescription under ORS 127.800 to 127.897. No less than 48 hours shall elapse between the patient's written request and the writing of a prescription under ORS 127.800 to 127.897. [1995 c.3 s.3.08]

127.855 s.3.09. Medical record documentation requirements.

The following shall be documented or filed in the patient's medical record:

(1) All oral requests by a patient for medication to end his or her life in a humane and dignified manner;

(2) All written requests by a patient for medication to end his or her life in a humane and dignified manner;

(3) The attending physician's diagnosis and prognosis, determination that the patient is capable, acting voluntarily and has made an informed decision;

(4) The consulting physician's diagnosis and prognosis, and verification that the patient is capable, acting voluntarily and has made an informed decision;

(5) A report of the outcome and determinations made during counseling, if performed;

(6) The attending physician's offer to the patient to rescind his or her request at the time of the patient's second oral request pursuant to ORS 127.840; and

(7) A note by the attending physician indicating that all requirements under ORS 127.800 to 127.897 have been met and indicating the steps taken to carry out the request, including a notation of the medication prescribed. [1995 c.3 s.3.09]

127.860 s.3.10. Residency requirement.

Only requests made by Oregon residents under ORS 127.800 to 127.897 shall be granted. Factors demonstrating Oregon residency include but are not limited to:

(1) Possession of an Oregon driver license;

(2) Registration to vote in Oregon;

(3) Evidence that the person owns or leases property in Oregon; or

(4) Filing of an Oregon tax return for the most recent tax year. [1995 c.3 s.3.10; 1999 c.423 s.8]

127.865 s.3.11. Reporting requirements.

(1)(a) The Health Services shall annually review a sample of records maintained pursuant to ORS 127.800 to 127.897.

(b) The division shall require any health care provider upon dispensing medication pursuant to ORS 127.800 to 127.897 to file a copy of the dispensing record with the division.

(2) The Health Services shall make rules to facilitate the collection of information regarding compliance with ORS 127.800 to 127.897. Except as otherwise required by law, the information collected shall not be a public record and may not be made available for inspection by the public.

(3) The division shall generate and make available to the public an annual statistical report of information collected under subsection (2) of this section. [1995 c.3 s.3.11; 1999 c.423 s.9]

127.870 s.3.12. Effect on construction of wills, contracts and statutes.

(1) No provision in a contract, will or other agreement, whether written or oral, to the extent the provision would affect whether a person may make or rescind a request for medication to end his or her life in a humane and dignified manner, shall be valid.

(2) No obligation owing under any currently existing contract shall be conditioned or affected by the making or rescinding of a request, by a person, for medication to end his or her life in a humane and dignified manner. [1995 c.3 s.3.12]

127.875 s.3.13. Insurance or annuity policies.

The sale, procurement, or issuance of any life, health, or accident insurance or annuity policy or the rate charged for any policy shall not be conditioned upon or affected by the making or rescinding of a request, by a person, for medication to end his or her life in a humane and dignified manner. Neither shall a qualified patient's act of ingesting medication to end his or her life in a humane and dignified manner have an effect upon a life, health, or accident insurance or annuity policy. [1995 c.3 s.3.13]

127.880 s.3.14. Construction of Act.

Nothing in ORS 127.800 to 127.897 shall be construed to authorize a physician or any other person to end a patient's life by lethal injection, mercy killing or active euthanasia. Actions taken in accordance with ORS 127.800 to 127.897 shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law. [1995 c.3 s.3.14]

(Immunities and Liabilities)

(Section 4)

127.885 s.4.01. Immunities; basis for prohibiting health care provider from participation; notification; permissible sanctions.

Except as provided in ORS 127.890:

(1) No person shall be subject to civil or criminal liability or professional disciplinary action for participating in good faith compliance with ORS 127.800 to 127.897. This includes being present when a qualified patient takes the prescribed medication to end his or her life in a humane and dignified manner.

(2) No professional organization or association, or health care provider, may subject a person to censure, discipline, suspension, loss of license, loss of privileges, loss of membership or

other penalty for participating or refusing to participate in good faith compliance with ORS 127.800 to 127.897.

(3) No request by a patient for or provision by an attending physician of medication in good faith compliance with the provisions of ORS 127.800 to 127.897 shall constitute neglect for any purpose of law or provide the sole basis for the appointment of a guardian or conservator.

(4) No health care provider shall be under any duty, whether by contract, by statute or by any other legal requirement to participate in the provision to a qualified patient of medication to end his or her life in a humane and dignified manner. If a health care provider is unable or unwilling to carry out a patient's request under ORS 127.800 to 127.897, and the patient transfers his or her care to a new health care provider, the prior health care provider shall transfer, upon request, a copy of the patient's relevant medical records to the new health care provider.

(5)(a) Notwithstanding any other provision of law, a health care provider may prohibit another health care provider from participating in ORS 127.800 to 127.897 on the premises of the prohibiting provider if the prohibiting provider has notified the health care provider of the prohibiting provider's policy regarding participating in ORS 127.800 to 127.897. Nothing in this paragraph prevents a health care provider from providing health care services to a patient that do not constitute participation in ORS 127.800 to 127.897.

(b) Notwithstanding the provisions of subsections (1) to (4) of this section, a health care provider may subject another health care provider to the sanctions stated in this paragraph if the sanctioning health care provider has notified the sanctioned provider prior to participation in ORS 127.800 to 127.897 that it prohibits participation in ORS 127.800 to 127.897:

(A) Loss of privileges, loss of membership or other sanction provided pursuant to the medical staff bylaws, policies and procedures of the sanctioning health care provider if the sanctioned provider is a member of the sanctioning provider's medical staff and participates in ORS 127.800 to 127.897 while on the health care facility premises, as defined in ORS 442.015, of the sanctioning health care provider, but not including the private medical office of a physician or other provider;

(B) Termination of lease or other property contract or other nonmonetary remedies provided by lease contract, not including loss or restriction of medical staff privileges or exclusion from a provider panel, if the sanctioned provider participates in ORS 127.800 to 127.897 while on the premises of the sanctioning health care provider or on property that is owned by or under the direct control of the sanctioning health care provider; or

(C) Termination of contract or other nonmonetary remedies provided by contract if the sanctioned provider participates in ORS 127.800 to 127.897 while acting in the course and scope of the sanctioned provider's capacity as an employee or independent contractor of the sanctioning health care provider. Nothing in this subparagraph shall be construed to prevent:

(i) A health care provider from participating in ORS 127.800 to 127.897 while acting outside the course and scope of the provider's capacity as an employee or independent contractor; or

(ii) A patient from contracting with his or her attending physician and consulting physician to act outside the course and scope of the provider's capacity as an employee or independent contractor of the sanctioning health care provider.

(c) A health care provider that imposes sanctions pursuant to paragraph (b) of this subsection must follow all due process and other procedures the sanctioning health care provider may have that are related to the imposition of sanctions on another health care provider.

(d) For purposes of this subsection:

(A) "Notify" means a separate statement in writing to the health care provider specifically informing the health care provider prior to the provider's participation in ORS 127.800 to 127.897 of the sanctioning health care provider's policy about participation in activities covered by ORS 127.800 to 127.897.

(B) "Participate in ORS 127.800 to 127.897" means to perform the duties of an attending physician pursuant to ORS 127.815, the consulting physician function pursuant to ORS 127.820 or the counseling function pursuant to ORS 127.825. "Participate in ORS 127.800 to 127.897" does not include:

(i) Making an initial determination that a patient has a terminal disease and informing the patient of the medical prognosis;

(ii) Providing information about the Oregon Death with Dignity Act to a patient upon the request of the patient;

(iii) Providing a patient, upon the request of the patient, with a referral to another physician; or

(iv) A patient contracting with his or her attending physician and consulting physician to act outside of the course and scope of the provider's capacity as an employee or independent contractor of the sanctioning health care provider.

(6) Suspension or termination of staff membership or privileges under subsection (5) of this section is not reportable under ORS 441.820. Action taken pursuant to ORS 127.810, 127.815, 127.820 or 127.825 shall not be the sole basis for a report of unprofessional or dishonorable conduct under ORS 677.415 (2) or (3).

(7) No provision of ORS 127.800 to 127.897 shall be construed to allow a lower standard of care for patients in the community where the patient is treated or a similar community. [1995 c.3 s.4.01; 1999 c.423 s.10]

Note: As originally enacted by the people, the leadline to section 4.01 read "Immunities." The remainder of the leadline was added by editorial action.

127.890 s.4.02. Liabilities.

(1) A person who without authorization of the patient willfully alters or forges a request for medication or conceals or destroys a rescission of that request with the intent or effect of causing the patient's death shall be guilty of a Class A felony.

(2) A person who coerces or exerts undue influence on a patient to request medication for the purpose of ending the patient's life, or to destroy a rescission of such a request, shall be guilty of a Class A felony.

(3) Nothing in ORS 127.800 to 127.897 limits further liability for civil damages resulting from other negligent conduct or intentional misconduct by any person.

(4) The penalties in ORS 127.800 to 127.897 do not preclude criminal penalties applicable under other law for conduct which is inconsistent with the provisions of ORS 127.800 to 127.897. [1995 c.3 s.4.02]

127.892 Claims by governmental entity for costs incurred.

Any governmental entity that incurs costs resulting from a person terminating his or her life pursuant to the provisions of ORS 127.800 to 127.897 in a public place shall have a claim against the estate of the person to recover such costs and reasonable attorney fees related to enforcing the claim. [1999 c.423 s.5a]

(Severability)

(Section 5)

127.895 s.5.01. Severability.

Any section of ORS 127.800 to 127.897 being held invalid as to any person or circumstance shall not affect the application of any other section of ORS 127.800 to 127.897 which can be given full effect without the invalid section or application. [1995 c.3 s.5.01]

(Form of the Request)

(Section 6)

127.897 s.6.01. Form of the request.

A request for a medication as authorized by ORS 127.800 to 127.897 shall be in substantially the following form:

REQUEST FOR MEDICATION

TO END MY LIFE IN A HUMANE

AND DIGNIFIED MANNER

I, ________________, am an adult of sound mind.

I am suffering from _______, which my attending physician has determined is a terminal disease and which has been medically confirmed by a consulting physician.

I have been fully informed of my diagnosis, prognosis, the nature of medication to be prescribed and potential associated risks, the expected result, and the feasible alternatives, including comfort care, hospice care and pain control.

I request that my attending physician prescribe medication that will end my life in a humane and dignified manner.

INITIAL ONE:

_____ I have informed my family of my decision and taken their opinions into consideration.

_____ I have decided not to inform my family of my decision.

_____ I have no family to inform of my decision.

I understand that I have the right to rescind this request at any time.

I understand the full import of this request and I expect to die when I take the medication to be prescribed. I further understand that although most deaths occur within three hours, my death may take longer and my physician has counseled me about this possibility.

I make this request voluntarily and without reservation, and I accept full moral responsibility for my actions.

Signed: ___________

Dated: ___________

DECLARATION OF WITNESSES

We declare that the person signing this request:

(a) Is personally known to us or has provided proof of identity;

(b) Signed this request in our presence;

(c) Appears to be of sound mind and not under duress, fraud or undue influence;

(d) Is not a patient for whom either of us is attending physician.

__________ Witness 1/Date

__________ Witness 2/Date

NOTE: One witness shall not be a relative (by blood, marriage or adoption) of the person signing this request, shall not be entitled to any portion of the person's estate upon death and shall not own, operate or be employed at a health care facility where the person is a patient or resident. If the patient is an inpatient at a health care facility, one of the witnesses shall be an individual designated by the facility.

[1995 c.3 s.6.01; 1999 c.423 s.11]

PENALTIES

127.990

[Formerly part of 97.990; repealed by 1993 c.767 s.29]

127.995 Penalties.

(1) It shall be a Class A felony for a person without authorization of the principal to willfully alter, forge, conceal or destroy an instrument, the reinstatement or revocation of an instrument or any other evidence or document reflecting the principal's desires and interests, with the intent and effect of causing a withholding or withdrawal of life-sustaining procedures or of artificially administered nutrition and hydration which hastens the death of the principal.

(2) Except as provided in subsection (1) of this section, it shall be a Class A misdemeanor for a person without authorization of the principal to willfully alter, forge, conceal or destroy an instrument, the reinstatement or revocation of an instrument, or any other evidence or document reflecting the principal's desires and interests with the intent or effect of affecting a health care decision. [Formerly 127.585]

Appendix B

Brittany Maynard's Obituary

Brittany Lauren Maynard was born in 1984 and forged a brief but solid 29 years of generosity, compassion, education, travel, and humor. She happily met her husband Daniel Diaz in April of 2007 and they married, as best friends, 5 years later in September of 2012.

This past year, on New Year's Day, Brittany was diagnosed with brain cancer. She was given a terminal diagnosis for which there was no cure or life saving measures available. In the face of such terminal illness and pain, Brittany chose to live each day fully, traveled, and kept as physically active and busy as she possibly could.

"Do what you can, with what you have, where you are."- Theodore Roosevelt. A formula to live by, sick or well.

After being told by one doctor that "she probably didn't even have weeks to be on her feet," she was found climbing 10 mile trails along the ice fields of Alaska with her best friend in the sunshine months later. "Speak your own truth, even when your voice shakes." she would say.

Brittany graduated from UC Berkeley as an undergrad, and received a Masters in Education from UC Irvine. She believed in compassion, equity, and that people would remember most how you made them feel in life. As Faulkner said, "Never be afraid to raise your voice for honesty and truth and compassion against injustice and lying and greed. If more people all over the world would do this, the world would change."

She was an accomplished and adventuresome traveler who spent many months living solo and teaching in orphanages in Kathmandu, Nepal. That single experience forever changed her life and perspective on childhood, happiness, privilege and outcomes. She fell in love with her time in Vietnam, Cambodia, Laos, Singapore and Thailand. She spent a summer working in Costa Rica, and traveled to Tanzania, and summited Kilimanjaro with a girlfriend a month before her wedding. She took ice climbing courses on Cayambe and Cotopaxi in Ecuador and was an avid scuba diver, who relished her time in the Galapagos, Zanzibar, Caymans and pretty much any island she ever visited.

She loved her two dogs like family, a small Beagle and large Great Dane, and was always the one to take in lost dogs and find them homes. Brittany was a regular volunteer at a local animal rescue organization before her diagnosis.

Brittany chose to make a well thought out and informed choice to Die With Dignity in the face of such a terrible, painful, and incurable illness. She moved to Oregon to pass away in a little yellow house she picked out in the beautiful city of Portland. Oregon is a place that strives to protect patient rights and autonomy; she wished that her home State of California had also been able to provide terminally ill patients with the same choice.

Brittany chose to speak out and advocate for this patient right and option, which she felt is an informed choice that should be made available to all terminally ill patients across our great nation. "The freedom is in the choice," she believed. “If the option of DWD is unappealing to anyone for any reason, they can simply choose not to avail themselves of it. Those very real protections are already in place.” With great consideration, she gave personal interviews to the UK's Tonight Show prior to Death with Dignity being addressed by their Parliament, as well as participated in an American based campaign for Death With Dignity education and legislation.

She is survived by her faithful, practical, and kind husband Daniel Diaz, her loving self-less mother Deborah Ziegler and honorable step-father Gary Holmes. And by Dan's loving supportive family, parents: Carmen and Barry and brothers: David, Adrian, and Alex. All of whom she adored and loved very deeply. While she had longed for children of her own, she left this world with zero regrets on time spent, places been, or people she loved in her 29 years.

In this final message, she wanted to express a note of deep thanks to all her beautiful, smart, wonderful, supportive friends whom she “sought out like water” during her life and illness for insight, support, and the shared experience of a beautiful life.

“It is people who pause to appreciate life and give thanks who are happiest. If we change our thoughts, we change our world! Love and peace to you all.” - Brittany Maynard[170]

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2. WASH. REV. CODE § 70.245 (2014).

3. *Baxter v. Montana*, 2009 MT 449, *aff'd* DA 09-0051 (Dec 31, 2009).

4. VT. STAT. ANN. tit. 18, §§ 5281-5292 (2014).

5. *Morris v. Brandenberg*, No. D-202-CV 2012-02909 (N.M. 2d Jud. Dist. Jan. 13, 2014).

6. See page 5 of this chapter, under the heading *Active Euthanasia*, for the legal reason for Dr. Kevorkian's 1999 conviction.

7. The New York Times, Nov. 3, 2014; page B16. http://www.nytimes.com/2014/11/04/us/brittany-maynard-death-with-dignity-ally-dies-at-29.html.

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51. *Oregon v. Ashcroft*, No. 02-35587, *Brief of Amici Cruriae Margaret P. Battin, et al. in support of Plaintiffs-Appellees for Affirmance*, filed November 12, 2002 (citing *Quinlan,* 70 N.J. at 41).

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64. OR. REV. STAT. §§ 127.800-127.897 (2014)

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161. I am Brittany Maynard's mother. I am writing in response to a variety of comments made in the press and online by individuals and institutions that have tried to impose their personal belief system on what Brittany and our family feel is a human rights issue.

The imposition of "belief" on a human rights issue is wrong. To censure a personal choice as reprehensible because it does not comply with someone else's belief is immoral. My twenty-nine-year-old daughter's choice to die gently rather than suffer physical and mental degradation and intense pain does not deserve to be labelled as reprehensible by strangers a continent away who do not know her or the particulars of her situation.

Reprehensible is a harsh word. It means: "very bad; deserving very strong criticism." **Reprehensible** is a word I've used as a teacher to describe the actions of Hitler, other political tyrants and the exploitation of children by pedophiles. As Brittany Maynard's mother, I find it difficult to believe that anyone who knew her would ever select this word to describe her actions. Brittany was a giver. She was a volunteer. She was a teacher. She was an advocate. She worked at making the world a better place to live.

This word was used publicly at a time when my family was tender and freshly wounded. Grieving. Such strong public criticism from people we do not know, have never met – is more than a slap in the face. It is like kicking us as we struggle to draw a breath.

People and institutions that feel they have the right to judge Brittany's choices may wound me and cause me unspeakable pain but they do not deter me from supporting my daughter's choice. There is currently a great deal ofconfusion and arrogance standing in the way of Americans going gently into the good night. I urge Americans to think for themselves. Make your wishes clear while you are competent. Make sure that you have all the options spelled out for you if you are diagnosed with an incurable, debilitating, painful disease. Do your own research. Ask your family to research and face the harsh reality with you. Ask your doctor to be brutally honest with you. Then make your personal choice about how you will proceed. It is YOUR choice.

The "culture of cure" has led to a fairy tale belief that doctors can always fix our problems. We have lost sight of reality. All life ends. Death is not necessarily the enemy in all cases. Sometimes a gentle passing is a gift. Misguided doctors caught up in an aspirational belief that they must extend life, whatever the cost, cause individuals and families unnecessary suffering. Brittany stood up to bullies. She never thought anyone else had the right to tell her how long she should suffer. The right to die for the terminally ill is a human rights issue. Plain and simple.

(emphasis in original) Published by Compassion and Choices, Nov. 8, 2014. https://www.compassionandchoices.org/2014/11/18/brittany-maynards-mother-responds-to-vatican-other-critics-of-her-daughters-end-of-life-choice/.

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167. http://www.medscape.com/viewarticle/833603; The Washington Post, Nov. 3, 2014 http://www.washingtonpost.com/news/morning-mix/wp/2014/11/03/how-brittany-maynard-may-change-the-right-to-die-debate-after-death.

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170. http://ktla.com/2014/11/02/official-obituary-from-family-of-brittany-maynard/.