
Empowering Patients at the End of Life

Law, Advocacy, Policy

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Imagine you have a cancerous tumor growing in your neck that continues to grow even after surgery, radiation, and chemotherapy, and is spreading cancer throughout your body.

Imagine that the surgery required removal of most of your tongue, so that you can barely swallow or speak, cannot eat, and are often choking on secretions.

Imagine that you had to have a tube surgically implanted into your stomach to provide nutrition and hydration.

Imagine that the tumor has eaten through the flesh of your neck and there is a seeping, open wound, with foul-smelling emissions.

Imagine that this tumor causes severe pain, in addition to all the other symptoms, and that you must choose between taking enough medicine to control the pain and accepting the loss of alertness that accompanies such sedation, or remaining in pain but with your alertness intact.

Imagine that you have been told that the location of the tumor makes it highly likely that as it grows it will breach the large artery in your neck and you will bleed to death. Imagine that your life, until now, has been one in which you enjoyed a good deal of control and autonomy.

If you were in this situation, would you know what options were available to you?

Options for the Seriously Ill

In every state, patients who are seriously ill or dying are entitled to aggressive pain management. Guidelines for treatment of pain associated with terminal

illness have proliferated.¹ Medical organizations establishing standards or guidelines for pain treatment include the World Health Organization, the American Pain Society, the American Medical Association, the Agency for Health Care Policy and Research, the Federation of State Medical Boards, and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).² These guidelines all indicate the importance of pain management as an element of medical treatment. For instance, the *Model Guidelines for the Use of Controlled Substances for the Treatment of Pain* state that the “principles of quality medical practice dictate that . . . people . . . have access to appropriate and effective pain relief. . . . The Board encourages physicians to view effective pain management as a part of quality medical practice for all patients with pain, acute or chronic, and it is especially important for patients who experience pain as a result of terminal illness.”

If a clinician fails to provide adequate pain management, a patient or the patient’s survivors can file a complaint with the state’s medical board or bring a lawsuit for monetary damages.³ A number of such complaints and cases have been brought in recent years, bringing much needed attention to this problem. Some patients will find that taking enough pain medication to obtain relief requires that they surrender more consciousness than they are willing to, and will opt to be in pain rather than insensate. Other patients will welcome the relief of pain, despite the surrender of consciousness. The choice should be left to the patient, not made for the patient by the health-care provider.

If pain cannot be brought under control with conventional pain management, an aggressive therapy known as palliative sedation, also referred to as terminal or total sedation, is an option. This involves a physician inducing unconsciousness via intravenously administered medication and withholding artificial nutrition and hydration until death ensues days or weeks later. The patient is kept unconscious the entire time and is unaware of pain or other distressing symptoms.⁴ The choice for palliative sedation has been recognized in law by the U.S. Supreme Court and in U.S. medical practice and offers an option some patients consider acceptable.⁵ For others it might seem barbaric to linger in this way.

Sometimes a medical care provider has personal, moral, or religious beliefs that impede his or her willingness to provide the care a patient chooses. For example, a significant number of physicians are opposed to palliative sedation for personal reasons and do not tell patients about or offer

this option.⁶ It is interesting to note that a survey of physicians showed that almost 100 percent would choose this if they were dying of Chronic Obstructive Pulmonary Disease (COPD), yet only 1 percent tell their patients about it.⁷

These conflicts are increasingly common because of the consolidation of health-care facilities involving the merger of Catholic and secular facilities.⁸ Catholic health-care facilities are subject to the Ethical and Religious Directives for Catholic Health Care Services (the ERDs), promulgated by the National Conference of Catholic Bishops in 1995, and revised in 2009 (4th edition). A number of these directives may undermine a patient's ability to control end-of-life care, including:

24. . . . a Catholic health care institution will make available to patients information about their rights to make an advance directive. The institution, however, *will not honor an advance directive that is contrary to Catholic teaching.*
28. . . . The free and informed health care decision of the person or the person's surrogate is to be followed *so long as it does not contradict Catholic principles.*
55. [Dying patients] should also be offered the appropriate medical information that would make it possible to address *the morally legitimate choices* available to them.
58. There should be a *presumption in favor of providing nutrition and hydration to all patients*, including patients who require medically assisted nutrition and hydration, as long as this is of sufficient benefit to outweigh the burdens involved to the patient.
59. The free and informed judgment made by a competent adult patient concerning the use of withdrawal of life-sustaining procedures should always be respected and normally complied with, *unless it is contrary to Catholic moral teaching.*
61. . . . Since a person has the right to prepare for his or her death while fully conscious, he or she should not be deprived of consciousness without a compelling reason. . . . *Patients experiencing suffering that cannot be alleviated should be helped to appreciate the Christian understanding of redemptive suffering.* [Emphasis added.]⁹

However, as recognized by the U.S. Supreme Court in *Cruzan v. Mo. Dept. of Health*, 497 U.S. 261 (1990), patients in every state have the right to direct

the withdrawal of life-sustaining interventions, including a feeding tube supplying artificial nutrition and hydration. Those caring for patients who choose to refuse, or direct the withdrawal of, such treatment should provide supportive comfort care in the days or weeks that follow until death ensues. Hopefully, such patients have been informed about and enrolled in hospice care, which is available for patients with life expectancy of six months or less.¹⁰ Hospice providers are specially trained in caring for terminally ill patients and are expert in providing pain and symptom management.¹¹ A patient's right to choose this course is well recognized in both law and medicine. Even if a patient is not dependent upon a feeding tube and has the ability to consume food and fluid by mouth, the option to voluntarily stop eating and drinking is available.¹²

A number of federal and state court cases address the right to choose to forgo, or direct the withdrawal of, feeding tubes or other life-prolonging types of care, and thereby bring about death. The courts considering such cases have based their decisions on principles of autonomy, privacy and liberty.¹³ Medical practice also supports a patient's decision to choose this course. For some this will be satisfactory. For others, the slow, inexorable deterioration to death may seem barbaric.

Confronted by certain suffering and death in the near future due to cancer, you might determine that the cumulative burden is intolerable. You might want a prescription for medication which you could consume to bring about a peaceful death—at home, in bed, surrounded by loved ones. This option is not affirmatively made legal in any state other than Oregon.¹⁴ If you want such a prescription and live outside Oregon, you may or may not find a physician willing to provide one, as discussed below.

An Additional End-of-Life Option

If you live in Oregon and are diagnosed with a terminal illness, with a prognosis of less than six months to live, and are mentally competent, you could ask your physician for a prescription for medication which can be self-administered to bring about a peaceful death. This is legal in Oregon under the Death with Dignity Act (Dignity Act) and has been since 1994. Oregon's law has survived a series of attacks brought by opponents in court, by federal legislators, and by the former United States attorney general.¹⁵ All such attacks have failed and the law remains intact.

Under the Dignity Act, you would need to follow a strict set of procedures to establish that you are eligible to obtain the medications. A physician must determine that you have less than six months' life expectancy; you must make multiple requests, waiting at least fifteen days between the first and last request; you must establish that you are capable to make medical decisions for yourself; and you must be informed of palliative-care options such as hospice, if you are not already receiving such services.¹⁶ If all of these procedures are followed, and you are deemed eligible by the physician to obtain the life-ending medication, an Oregon physician can provide a prescription for such medication.

The terminology used to refer to a physician's prescribing medications that can be self-administered to bring about a peaceful death has evolved. In the past, the term *physician-assisted suicide* was used. Yet, the Dignity Act explicitly states: "Actions taken in accordance with Oregon Revised Statutes (ORS) 127.800 to 127.897 shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law (emphasis added). When this was pointed out to the Oregon Department of Human Services (DHS), which reports on the Dignity Act, an official there acknowledged "[it] probably has not been correct for us to be using this language all along."¹⁷ Accordingly, the DHS has since rejected the term "assisted suicide" in describing deaths under the Dignity Act.

Health policy organizations such as the American Public Health Association (APHA) have also addressed the terminology issue, recognizing the importance of using accurate language to describe care options and rejecting use of the term *suicide* or *assisted suicide* when discussing the choice of a mentally competent, terminally ill patient to seek medications that he or she could consume to bring about a peaceful and dignified death.¹⁸

Mental health professionals readily appreciate that "suicide" and the choice of a dying patient to hasten impending death in a peaceful and dignified manner are starkly different from a mental health perspective. Profound psychological differences distinguish suicide from deaths under the Dignity Act. As one psychiatrist recently summarized the differences:

The term "assisted suicide" is inaccurate and misleading with respect to the DIGNITY ACT. These patients and the typical suicide are opposites:

- The suicidal patient has no terminal illness but wants to die; the DWD patient has a terminal illness and wants to live.

- Typical suicides bring shock and tragedy to families and friends; DWD deaths are peaceful and supported by loved ones.
- Typical suicides are secretive and often impulsive and violent. Death in DWD is planned; it changes only timing in a minor way, but adds control in a major and socially approved way.
- Suicide is an expression of despair and futility; DWD is a form of affirmation and empowerment.¹⁹

The American Psychological Association points out: "It is important to remember that the reasoning on which a terminally ill person (whose judgments are not impaired by mental disorders) bases a decision to end his or her life is fundamentally different from the reasoning a clinically depressed person uses to justify suicide."²⁰ Medical organizations and legal experts also recognize that the terms *suicide* and *assisted suicide* are inappropriate when discussing the choice of a mentally competent, terminally ill patient to seek medications that he or she could consume to bring about a peaceful and dignified death.²¹

Over the decade that aid in dying has been legal in Oregon, roughly thirty terminally ill patients a year have gone through the process, obtained and taken the medication, and died peacefully. Those present at these deaths report that the patient was enormously relieved to be able to make this choice. On a date chosen by the patient, loved ones may gather around for a final good-bye. The patient consumes the medication, soon becomes drowsy, falls deeply asleep, and after a short period of time ceases to breathe.²² The long road from diagnosis to curative treatment to palliative care to death has ended on terms acceptable to this patient. More patients obtain the medication than go on to use it; some fraction each year get the medication, put it in the medicine cabinet, feel comforted to know it is there, and never take it.²³

Oregon collects a great deal of demographic data about the patients who choose to use the Dignity Act. The data show that most patients choosing to obtain life-ending medications have cancer.²⁴ The next most common condition is ALS (Lou Gehrig's disease). Patients using the law are insured, well educated, and receive comprehensive pain and symptom management, typically through hospice services.²⁵ The data show that the concerns that opponents voiced before the law was passed have not materialized. Opponents had argued that such a law would be forced on the uninsured,

the poor, minorities, or disabled persons. The evidence is that this has not happened.²⁶

A number of unexpected developments were observed in Oregon after the Dignity Act took effect: Referral of patients to hospice care and physician enrollment in continuing education courses on how to treat pain and symptoms associated with terminal illness increased dramatically.²⁷ Oregon now has the highest hospice enrollment rate in the nation. It is likely that physicians want to ensure that no patient makes use of the Dignity Act due to inadequate pain and symptom management, and this galvanized both the increase in hospice referrals and physician efforts to learn more about treating pain and symptoms.

If You Do Not Live in Oregon

What if you do not happen to live in Oregon, yet still want to obtain medication that you could take to bring about a peaceful death? In this case you would have to resort to the underground.

It is well known that terminally ill patients across the nation ask their physicians, and most often their cancer doctors, for aid in dying.²⁸ Many physicians agree to help.²⁹ In this situation there are no safeguards or procedures to follow, as there are in Oregon. In a murky legal environment, many physicians decline to assist, even if they would do so if the practice were legal.

Researchers have found that outside of Oregon, complications are more likely due to covert, unsanctioned, and unregulated practice.³⁰ For example, there is greater chance of an extended time until death after consuming lethal medications if the practice is unregulated or unsanctioned.³¹ In addition, the stress and anxiety for the patient and family is much higher when no physician can legally be involved to counsel the patient and family and provide a prescription.³²

When patients do not feel able to discuss the desire for aid in dying with their physicians, or cannot find a physician willing to provide it, the patients may seek assistance in hastening death from a family member or loved one. Unfortunately, these incidents often involve a violent means to death, such as gunshot. Cases of this nature appear with some frequency in the newspapers. For example, in March of 2005, headlines in Connecticut newspapers detailed the death of John Welles, who was dying of prostate cancer and

asked his friend Huntington Williams to clean and hand him his gun so he could self-inflict a fatal gunshot wound.³³ Deaths like these are not peaceful or dignified. The situation for a patient seeking aid in dying outside of Oregon is reminiscent of the situation faced by women seeking to terminate unwanted pregnancies when abortion was not legal.

Some patients in this situation have sought relief in court. In the mid-1990s, groups of terminally ill patients and physicians who treated such patients brought lawsuits in the states of New York and Washington, arguing that the patient had the right to choose aid in dying under the guarantees of liberty and privacy of the U.S. Constitution. I represented these patients and physicians in these lawsuits.

These patients were dying of cancer, AIDS, and heart failure. They had all sought curative therapy, but all had come to the point where a cure was not an option and they faced certain death due to their illness. These patients valued their autonomy and felt strongly that the decision to control their final days was deeply personal and involved their most deeply held values and beliefs. In these cases, state laws criminalizing “assisted suicide” were challenged, to the extent that they prohibited doctors from providing medications to competent dying patients that the patients could use to hasten death if they so chose.³⁴ Liberty and equality guaranteed by the Fourteenth Amendment of the U.S. Constitution formed the basis of the claims.³⁵ Two federal courts of appeal, including the Ninth Circuit sitting en banc, agreed that statutes preventing patients from exercising this option were unconstitutional.³⁶ The Supreme Court reversed these decisions, but left the door open to both future legislative reform and a future successful constitutional claim (*Glucksberg* case).³⁷

The opinions, both majority and concurring, invited legislative reform. The majority opinion stated: “Throughout the Nation, Americans are engaged in an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide [sic]. Our holding permits this debate to continue, as it should in a democratic society.”³⁸

Justice Souter’s concurring opinion stated an explicit preference for legislative action in this area. He wrote that “[t]he Court . . . should stay its hand to allow reasonable legislative consideration,” and that “the legislative process is to be preferred.”³⁹ Similarly, Justice O’Connor’s concurrence demonstrated her concern that state legislatures be given the first opportunity to address the issue: “States are presently undertaking extensive and

serious evaluation of physician-assisted suicide and other related issues. In such circumstances, the . . . challenging task of crafting appropriate procedures for safeguarding . . . liberty interests is entrusted to the ‘laboratory’ of the States. . . .”⁴⁰

In support of the patients and physicians in these cases, many citizens of Washington and New York shared their stories in a brief filed with the Supreme Court, detailing the suffering of loved ones who did not have access to medications that they could self-administer to hasten death when their dying process became intolerable.⁴¹ Countless citizens began the discussion about aid in dying in the wake of the publication of these stories.

Dozens of briefs were filed on both sides by those interested in the outcome. Groups supporting the patients included the American Civil Liberties Union, Americans United for Separation of Church and State, the Older Women’s League, and the American College of Legal Medicine. Groups opposing the patients included the Catholic Church, many so-called right-to-life groups, some disability groups, and the American Medical Association.

When the cases were presented to the U.S. Supreme Court, there was no data to inform the question of whether a legal practice of aid in dying would pose a risk to patients or populations deemed vulnerable. Many of the opponents claimed that such a risk would arise. The Court was influenced by this lack of data and, while acknowledging the possibility that it would find such a right in the future, it urged the states to grapple with the issue first.⁴²

In the course of these cases’ movement through the courts, a tremendous amount of public education and debate was stimulated on both improving the end-of-life care and a dying patient’s right to choose to hasten impending death by self-administering medications prescribed by a physician for this purpose.⁴³ This discussion took place in newspapers and in academic conferences and publications. Medical, nursing, bioethics, health policy, and hospice programs all brought new attention and resources to this issue. Programs to improve end-of-life care proliferated throughout the country. A tremendous amount of funding was funneled through these programs, and no doubt the awareness levels of the importance of good end-of-life care increased among health-care professionals and the public.

At the time the cases were considered by the Supreme Court, the arguments made by those opposed to aid in dying were focused primarily on the contention that if aid in dying were legal, patients would be put at risk. Arguments were advanced that the uninsured, the poor, the disabled, or

minorities, all deemed to be vulnerable populations, would be disproportionately encouraged to make this choice. As discussed above, ten years' experience in Oregon shows no evidence of this. Now, with the Oregon experience providing data on how aid in dying actually works, observers are concluding that laws like Oregon's Dignity Act can safely be supported and ought to be passed elsewhere. For example, the American Medical Women's Association and the American Public Health Association have adopted policy supporting passage of Oregon-type aid-in-dying laws.⁴⁴

Public support for aid in dying is strong. Polls routinely show 70 percent of American citizens favor passage of laws similar to Oregon's. A poll released by the Pew Research Center in January 2006 found that 60 percent of Americans "believe a person has a moral right to end their life if they are suffering great pain and have no hope of improvement," an increase of nearly 20 percentage points since 1975, and 53 percent "believe a person has a moral right to end their life if suffering from an incurable disease."⁴⁵ A Harris poll published in January 2002 found that 65 percent of respondents support legalization of the right to aid in dying and 41 percent favored implementation of a version of the Dignity Act in their own states.⁴⁶ Another group of studies found that between 63 percent and 90 percent of people with a terminal illness support a right to physician aid in dying and would like to have the option available to them.⁴⁷ In California, surveys in February 2005 and February 2006 found that 70 percent of California residents support the idea that "incurably ill patients have the right to ask for and get life-ending medication."⁴⁸ Organizations advocating for civil liberties, seniors, and patients actively support passage of such laws. Certain religious groups, most notably the Catholic Church, and some disability groups continue to zealously oppose passage of such laws. The vocal, well-funded opposition from aid-in-dying opponents has succeeded, until recently, in limiting the legal practice to the State of Oregon.

Citizens in Washington invoked the initiative process in 2008, as was used in Oregon, to pass an aid-in-dying law. In the initiative process a measure is placed on the ballot and voted upon directly by citizens, does not need legislator support, and is not subject to the legislative process. The measure was approved in the November 2008 election, making Washington the second state in which aid in dying is a legal option. Another way aid in dying could become legal in a state would be if a case like *Glucksberg* were brought to a state high court, asserting that a state

constitution provides greater protection than does the federal. Florida and Alaska state courts have decided cases of this sort, both declining to find state constitutional protection extended to this choice. Another such case was filed in the State of Montana in 2007, brought by two terminally ill individuals, four Montana physicians, and the group Compassion and Choices, claiming that the Montana Constitution's guarantees of privacy, liberty, and dignity protect the choice of aid in dying (*Baxter v. Montana*).⁴⁹

The case filed in Montana has at least two significant advantages over the previously brought state cases. First, Montana's state constitution is broader and more protective of individual choice and includes a unique explicit protection of individual dignity. Second, the Montana court will consider the issue with the benefit of a decade of experience in Oregon, which shows there is no harm to patients, physicians, or society when this choice is available. The Oregon experience undermines the argument about risk that the state is likely to advance.⁵⁰ A Montana Supreme Court opinion recognizing a state constitutional right in this arena would have persuasive influence in other courts considering the issue in the future.

On December 5, 2008, District Court Judge Dorothy McCarter issued summary judgment to plaintiffs, holding that the state constitution's individual dignity clause and the constitution's "stringent" right of privacy are "intertwined insofar as they apply to plaintiffs' assertion that competent terminal patients have the constitutional right to determine the timing of their death and to obtain physician assistance in doing so." The court said that "the decision as to whether to continue life for a few additional months when death is imminent certainly is one of personal autonomy and privacy." The right of personal autonomy encompassed in the right to privacy and the right to dignity "mandate" that a mentally competent, terminally ill patient has the right to decide to end his or her life, and to obtain lethal drugs prescribed by a physician, according to the court. The "fundamental" right to die with dignity is constitutionally protected in Montana and "necessarily incorporates the assistance" of a doctor, the court said. The court concluded that the state can address its interests in preventing potential abuses while allowing patients to choose to die with dignity by adopting safeguards.

The state has appealed. The state sought a stay of the lower court ruling, pending review by the Supreme Court; this request was denied. Plaintiffs

have reason to be optimistic that the lower court will be affirmed. In *Baxter*, plaintiffs acknowledged that the state could act to protect legitimate state interests with narrowly tailored regulation. The district court agreed that the state could do this.

At this time it does not appear that any legislation governing aid in dying will be passed in the 2009 legislative session. It is important to keep in mind that while the provisions of Oregon's law might offer ideas on possible regulation, any such regulation would need to meet constitutional scrutiny. Neither Oregon nor Washington courts have considered the question of whether their constitutions protect a citizen's right to choose aid in dying. The situation in Montana is quite different; the question for any measure regulating aid in dying in Montana is whether the measure would impose an undue burden on the exercise of a right recognized as protected by Montana's constitution. If so, the measure ought not be enacted, or if enacted it would be vulnerable to challenge.

It is likely that through one of these avenues other states will soon legalize the choice of aid in dying. A fraction of dying patients, even with excellent pain and symptom management, confront a dying process so prolonged and marked by such extreme suffering and deterioration that they determine that hastening impending death is the least bad alternative. Passage of aid-in-dying laws harms no one and benefits both the relatively few patients in extremis who make use of the option and a great many more who would draw comfort from knowing it is available, should their dying process become intolerable to them. The question, finally, is simply this: is a state sufficiently compassionate to allow the choice of aid in dying to terminally ill, competent patients who are receiving sufficient end-of-life care but are still suffering?

NOTES

1. See, e.g., A. Jacox, D. Carr, and R. Payne, "New Clinical Practice Guidelines for the Management of Pain in Patients with Cancer," *New England Journal of Medicine* 330 (1994): 651; David Joranson, "State Medical Board Guidelines for Treatment of Intractable Pain," *American Pain Society Bulletin* 5, no. 3 (May/June 1995).
2. World Health Organization, *Cancer Pain Relief* (1986). American Pain Society, "Quality Improvement Guidelines for the Treatment of Acute Pain and Cancer Pain," *Journal of the American Medical Association* 274 (1995): 1874. W. T. McGivney et al.,

- “The Care of Patients with Severe Chronic Pain in Terminal Illness,” *Journal of the American Medical Association* 251 (1984): 1182. Agency for Health Care Policy and Research (AHCPR), “Acute Pain Management: Operative or Medical Procedures and Trauma Clinical Practice Guideline” <http://www.ahrq.gov/clinic/medtep.acute.htm> (accessed February 18, 2000) and *Clinical Practice Guideline No. 9: Management of Cancer Pain*, Publication 94–0592(1994). “Model Guidelines for the Use of Controlled Substances for the Treatment of Pain,” *Federation of State Medical Boards* (2004); Federation Bulletin: *Journal of Medical Licensure and Discipline* 85 (1998): 84. JCAHO, *Comprehensive Accreditation Manual for Hospitals: The Official Handbook (CAMH)* http://www.jcaho.org/standard/pm_ac.html (accessed May 31, 2000).
3. For an example of one such case, see Tanya Albert, “Doctor Guilty of Elder Abuse for Under-treating Pain,” *American Medical News*, July 23, 2001.
 4. Z. Schuman et al., “Implementing Institutional Change: An Institutional Case Study of Palliative Sedation,” *Journal of Palliative Medicine* 8, no. 3, 166 (2005); B. Lo, “Palliative Sedation in Dying Patients,” *Journal of the American Medical Association* 294 (2005): 1810–1816.
 5. *Washington v. Glucksberg*, 521 U.S. 702 (1997); Schuman et al., “Implementing Institutional Change: An Institutional Case Study of Palliative Sedation.”
 6. Farr A. Curlin et al., “Religion, Conscience, and Controversial Clinical Practices,” *New England Journal of Medicine* 356 (2007): 508.
 7. J. Lynn and N. Goldstein, “Advance Care Planning for Fatal Chronic Illness: Avoiding Commonplace Errors and Unwarranted Suffering,” *Annals of Internal Medicine* 138 (May 20, 2003): 812–18.
 8. See http://www.mergerwatch.org/hospital_mergers.html; see also, Religious Coalition for Reproductive Choice, *Report on the Medical Right* (2007).
 9. See generally, Robert McClory, “A Question of Last Rights: What If a Catholic Hospital Doesn’t Respect Your Wishes?” *Chicago Tribune*, October 21, 2007.
 10. Medicare provides a hospice benefit, designed to provide comfort care, pain relief, and emotional and spiritual support to individuals with a terminal illness, generally in a home setting. United States Government Accounting Office, “End-of-Life Care: Key Components Provided by Programs in Four States,” GAO-08-66 (December 14, 2007), <http://www.gao.gov/new.items/do866.pdf?source=ra> (accessed January 15, 2008).
 11. Information about hospice is available on the Web site of the National Hospice and Palliative Care Organization, www.nhpco.org; see generally, G. Gazelle, “Understanding Hospice—An Underutilized Option for Life’s Final Chapter,” *New England Journal of Medicine* 357 (2007): 321–4.
 12. See, e.g., J. Schwartz, “Exploring the Option of Voluntarily Stopping Eating and Drinking within the Context of a Suffering Patient’s Request for a Hastened Death,” *Journal of Palliative Medicine* 10 no. 6 (2007): 1288–1297.
 13. See, e.g., *Cruzan v. Mo. Dept. of Health*, 497 U.S. 261 (1990); *Bouvia v. Superior Court*, 225 Cal Rptr. 297 (1986).
 14. Or. Rev. Stat. §§ 127.800–.995 (2005). Washington passed a similar measure in the November 2008 election, see *infra*.

15. See Kathryn Tucker, "U.S. Supreme Court Ruling Preserves Oregon's Landmark Death with Dignity Law," *NAELA Journal* 2, no. 2 (2006): 291–301.
16. Or. Rev. Stat. §§ 127.800–.995 (2005).
17. Kevin B. O'Reilly, "Oregon Nixes Use of Term 'Physician Assisted Suicide,'" *amednews.com*, November 6, 2006 (quoting Katrina Hedberg, a DHS Public Health Division medical epidemiologist). See <http://www.oregon.gov/DHS>; <http://www.ama-assn.org/amednews/2006/11/0606/prsc1106.htm>.
18. APHA policy, "Patient Self Determination at the End of Life" (adopted October 2008), <http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1372>.
19. E. J. Lieberman, Letters to the Editor, "Death with Dignity," *Psychiatric News* 41 no. 15 (August 2006): 29.
20. Brief of Amicus Curiae Coalition of Mental Health Professionals, *Wright v. Arizona*, 170 at 17, *Gonzales v. Oregon*, 126 S. Ct. 904 (2006) (No. 04–623); see also Rena K. Farberman, "Terminal Illness and Hastened Death Requests: The Important Role of the Mental Health Professional," *Professional Psychology: Research and Practice* 28 (1997): 544; Smith and Pollack, "A Psychiatric Defense of Aid in Dying," *Community Mental Health Journal* 34 (1998): 547.
21. See, e.g., American Medical Women's Association Position Statement on aid in dying; American Academy of Hospice and Palliative Medicine (AAHPM) Policy on Physician Assisted Death, adopted February 2007, available at <http://www.aahpm.org/positions/suicide.html> (rejecting the term *physician assisted suicide* as "emotionally charged" and inaccurate); James Dallner, "Death with Dignity in Montana," *Montana Law Review* 35 (2004): 309, 314–315; and, for an extended discussion of the importance of language in framing discussion in this context, Kathryn Tucker, "Patient Choices at the End of Life: Getting the Language Right," *Journal of Legal Medicine* 28 (2007): 305–325.
22. For a detailed account of one such death, See D. Colburn, "She Chose It All on the Day She Died," *Oregonian*, September 30, 2007 (profiling the death of Lovelle Svart, who was terminally ill with inoperable, metastatic lung cancer, and who chose to make use of the Dignity Act).
23. This. See also, *Death with Dignity Act Annual Reports*, Oregon Department of Human Services, <http://oregon.gov/dhs/ph/pas/ar-index.shtml>.
24. *Ibid.*
25. *Ibid.*
26. Margaret P. Battin et al., "Legal Physician-Assisted Dying in Oregon and the Netherlands: Evidence Concerning the Impact on Patients in 'Vulnerable' Groups," 33 *Journal of Medical Ethics* (2007): 591–597.
27. See, e.g., Linda Ganzini et al., "Oregon Physicians' Attitudes about and Experiences with End-of-Life Care Since Passage of the Oregon Death with Dignity Act," *Journal of the American Medical Association* 285 (2001): 2363; Melinda A. Lee and Susan W. Tolle, "Oregon's Assisted Suicide Vote: The Silver Lining," *Annals of Internal Medicine* 124 (1996): 267.
28. H. Starks et al., "Family Member Involvement in Hastened Death," *Death Studies* 31 (2007): 105–130.

29. Ibid.
30. Ibid. When patients must go underground for medical care, the risk of encountering a provider who does not practice competent, ethical medicine is greatly increased. The most well known back-alley provider for patients seeking control over their own death may be Jack Kevorkian, the Michigan pathologist who assisted patients with chronic and terminal conditions to end their lives, often in the back of an old Volkswagen van. Kevorkian was ultimately convicted of homicide in the death of Thomas Youk. After serving part of his prison sentence, Kevorkian was granted parole and released on June 1, 2007.
31. Starks et al., "Family Member Involvement."
32. Ibid. The authors of this study recommend that for patients outside of Oregon, support be sought from Compassion and Choices, a national advocacy group supporting a full range of end-of-life choices, including aid in dying. www.compassionandchoices.org.
33. Cara Rubinsky, "Connecticut Case Puts Spotlight on Assisted Suicide," Associated Press, March 5, 2005.
34. It should be noted that in these cases, it was assumed that these laws could reach the conduct of a physician prescribing medications for this purpose; this is a rather large assumption and a compelling argument could be made that such conduct is simply outside the scope of such statutes. As I have noted, there is an emerging consensus that it is inaccurate to refer to the choice of a mentally competent, terminally ill patient to seek to hasten death as "suicide"; thus it can be persuasively argued that a physician prescribing medications for such a patient does not "assist suicide."
35. These cases have been the subject of extensive commentary. A terms and connectors search conducted in December 2007 for the *Glucksberg* cite in the Westlaw Law Reviews and Journals Database yielded 1,555 cites; a similar search with the *Quill* cite yielded 456 citations.
36. See *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir. 1996) (en banc), *rev'd sub nom. Glucksberg*, 521 U.S. 702; *Quill v. Vacco*, 80 F.3d 716 (32d Cir. 1996), *rev'd*, 521 U.S. 702.
37. The fact that the door was plainly left ajar by the *Glucksberg* court decision distinguishes the *Glucksberg* ruling from *Bowers v. Hardwick*, 478 U.S. 186 (1986), and the two decisions ought not be considered of a kind. But see Brian Hawkins, "Note, The *Glucksberg* Renaissance: Substantive Due Process since *Lawrence v. Texas*," *Michigan Law Review* 105 (2006): 409, 411 (arguing *Glucksberg's* restrictive approach to due process is alive and well).
38. 521 U.S. 702, 735 (1997).
39. *Glucksberg*, 521 U.S. at 789 (Souter, J., concurring) and at 788.
40. Ibid. at 737 (O'Connor, J., concurring) (citations and internal quotation marks omitted).
41. Brief of the Surviving Family Members in Support of Physician-Assisted Dying as Amicus Curiae in Support of Respondents, *Glucksberg*, 521 U.S. 702 (No. 96-110), 1996 WL 722032.

42. *Glucksberg*, 521 U.S. at 789 (Souter, J., concurring).
43. See Carol M. Ostrom, "Physician Survey: Suicide Aid Should Be Legal," *Seattle Times*, July 14, 1994; Brian Willoughby, "Suicide Debate Draws 80," *The Columbian*, August 9, 1994; "State's Medical Association Repeats Support for Reform," *The Columbian*, September 26, 1994; Carol M. Ostrom, "End-of-Life Issues Prove Perplexing—'Right to Die' Raises Legal Questions," *Seattle Times*, October 1, 1994; Carol M. Ostrom, "State ACLU Proposes Assisted-Suicide Law," *Seattle Times*, November 16, 1994; Peter M. McGough, Letter to the Editor, "Physician-Assisted Suicide—Most Patients Are Unaware of Their Treatment Options," *Seattle Times*, November 28, 1994; J. B. Deisher, Letter to the Editor, "Living and Dying—Suffering That Precedes Death Should Be the Real Enemy," *Seattle Times*, December 20, 1994; Study: Terminally Ill Fear Loss of Independence," *The Columbian*, April 11, 1996; Nancy L. Purcell, Op-Ed, "Coming to Terms with How We Treat 'The End of Life,'" *Seattle Times*, December 5, 1996; Robert A. Free et al., Op-Ed, "Compassion, Dignity In Dying—Terminal Patients Turn to Family When Living Becomes Unbearable," *Seattle Times*, January 12, 1997; Charlotte B. Hammond Sigmundish, Letter to the Editor, "Right to Die—Support for Assisted Suicide," *Seattle Times*, January 17, 1997.
44. AMWA position statement, "Aid In Dying" (adopted September 9, 2007), www.amwa-doc.org/index.cfm?objectId=242FFFE5-D567-0B25-585DC5662AB71DF9; APHA policy, "Patient Self Determination at the End of Life."
45. Pew Research Center for the People and the Press, "More Americans Discussing—and Planning—End-of-Life Treatment: Strong Public Support for Right to Die," news release, January 5, 2006, <http://people-press.org/reports/pdf/266.pdf>, at 8.
46. Humphrey Taylor, "2-to-1 Favorables Continue to Support Rights to Both Euthanasia and Doctor-Assisted Suicide," press release, Harris Interactive, January 9, 2002, http://www.harrisinteractive.com/harris_poll/index.asp?PID=278 (last visited October 19, 2007).
47. Andrew I. Batavia, "The Relevance of Data on Physicians and Disability on the Right to Assisted Suicide: Can Empirical Studies Resolve the Issue?" *Psychology, Public Policy, and Law* 7 (2000): 546, 553 (citing William Breitbart et al., "Interest in Physician-Assisted Suicide among Ambulatory HIV-Infected Patients," *American Journal of Psychiatry* 153 [1996]: 238, 240, and Brett Tindall et al., Letter to the Editor, "Attitudes to Euthanasia and Assisted Suicide in a Group of Homosexual Men with Advanced HIV Disease," *Journal of Acquired Immune Deficiency Syndrome* 6 [1993]: 1069).
48. Mark DiCamillo and Mervin Field, "Continued Support for Doctor-Assisted Suicide," press release no. 2188, Field Research Corp., March 15, 2006, <http://www.field.com/fieldpollonline/subscribers/RLS2188.pdf>, at 2.
49. *Baxter v. Montana*, No. 2007-787, Lewis and Clark County District Court.
50. For a full discussion of Montana law and how such a claim might fare, see Kathryn L. Tucker, "Privacy and Dignity at the End of Life: Protecting the Right of Montanans to Choose Aid-in-Dying," *Montana Law Review* 68 (2007): 317-333.