



AMERICAN
CONSTITUTION
SOCIETY FOR
LAW AND POLICY

Choice at the End of Life: Lessons from Oregon

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June 2008

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I. Introduction

Just over a decade ago, the U.S. Supreme Court decided two cases challenging state statutes that banned a practice then widely referred to as physician-assisted suicide, *Washington v. Glucksberg*¹ and *Vacco v. Quill*.² While the Court rejected the constitutional challenges to these laws, it concluded its decision in *Glucksberg* with these words: “Throughout the Nation, Americans are engaged in an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society.”³ The Court thus effectively invited the states to experiment in this area.

So far, only one state – Oregon – has chosen to do so. Oregon’s Death with Dignity Act (Dignity Act),⁴ which became fully effective in 1998, legalizes assistance in dying for terminally ill patients. The Oregon law empowers terminally ill, mentally competent adult Oregonians to control the timing and manner of their deaths, subject to careful procedures. It recognizes that a fraction of dying patients confront a dying process so prolonged and marked by such extreme suffering and deterioration that, even with excellent pain and symptom management, they determine that hastening impending death is the least bad alternative. The data assembled since passage of this law show that it has harmed no one and has benefited both the relatively few patients *in extremis* who make use of it and a great many more who draw comfort from knowing this option is available.

In the past decade, other states have grappled with the issue as well, and it may be put to the voters in one state this year. An initiative to pass a measure virtually identical to Oregon’s Dignity Act has been introduced in Washington State, and if sufficient signatures are gathered, it will appear on the ballot there this November.

It is therefore especially timely now to assess the lessons offered by Oregon’s experience. As this paper will show, the evidence provides a sound basis on which to conclude that citizens and lawmakers in other states should consider following Oregon’s lead and offering the same compassionate option that Oregon offers to terminally ill, competent patients who wish to end their suffering.

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¹521 U.S. 702 (1997).

²521 U.S. 793 (1997).

³*Glucksberg*, 521 U.S. at 735.

⁴OR. REV. STAT. §§ 127.800-995 (2005).

II. A Preliminary Note On Terminology

An important evolution has occurred in the terminology used to discuss the choice of a terminally ill patient to self-administer medications to bring about a peaceful death. At the time of the *Glucksberg* and *Quill* litigation, the term “physician-assisted suicide” was commonly used. It is increasingly recognized, however, that it is inaccurate to consider this choice to be “suicide.” Oregon’s Dignity Act provides that such actions “shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law.”⁵ The Oregon Department of Human Services, which reports on the implementation of the Dignity Act, likewise rejects referring to this practice as “assisted suicide” or “physician assisted suicide.”⁶

From a mental health perspective, there is a stark difference between “suicide” and the choice of a dying patient to hasten impending death in a peaceful and dignified manner. The American Psychological Association has recognized 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.”⁷ Many medical experts,⁸ public health experts,⁹ and legal experts¹⁰ also have come to recognize that the term “suicide” or “assisted suicide” is inappropriate. Thus, the term “assisted suicide” has been replaced (except by those who oppose the practice altogether and seek to malign it) by more accurate and value-neutral terms such as “aid in dying” or “physician-assisted dying.” This paper uses those terms.

⁵*Id.* § 127.880.

⁶*E.g.*, Kevin B. O’Reilly, *Oregon Nixes Use of Term “Physician-Assisted Suicide*, AM. MED. NEWS, Nov. 6, 2006, available at <http://www.ama-assn.org/amednews/2006/11/06/prsc1106.htm> (“Oregon’s Dept. of Human Services announced . . . that it no longer would use the term ‘physician-assisted suicide’ to describe terminally ill patients who ask doctors to help them die.”); Policy Statement, Am. Pub. Health Ass’n, Supporting Appropriate Language Used to Discuss End of Life Choices: Policy No. LB-06-02 (Nov. 8, 2006), available at http://www.compassionandchoices.org/pdfs/APHA_Policy.pdf (urging “that accurate, value-neutral terms such as ‘aid in dying’ or ‘patient directed dying’ be used to describe this choice”).

Rhea K. Farberman, Am. Psychological Ass’n, *Terminal Illness and Hastened Death Requests: The Important Role of the Mental Health Professional*, 28 PROF. PSYCHOL.: RES. & PRAC. 544, 544 (1997), quoted in Brief of Amicus Curiae Coalition of Mental Health Professionals in Support of Respondents at 17, *Gonzales v. Oregon*, 546 U.S. 243 (2006) (No. 04-623); see also David M. Smith & David Pollack, *A Psychiatric Defense of Aid in Dying*, 34 COMMUNITY MENTAL HEALTH J. 547 (1998).

⁸See, e.g., Position Statement, Am. Med. Women’s Ass’n, Aid in Dying (Sept. 9, 2007), <http://www.amwadc.org> (follow “Advocacy” hyperlink; then follow “Position Statements” hyperlink); see also Position Statement, Am. Acad. of Hospice & Palliative Med., Physician-Assisted Death (Feb. 14, 2007), available at <http://www.aahpm.org/positions/suicide.html> (rejecting the term physician-assisted suicide as “emotionally charged” and inaccurate); CHARLES F. MCKHANN, A TIME TO DIE: THE PLACE FOR PHYSICIAN ASSISTANCE (1999); Joseph B. Straton, *Physician Assistance with Dying: Reframing the Debate; Restricting Access*, 15 TEMP. POL. & CIV. RTS. L. REV. 475, 475 (2006) (arguing that “the process of permitting people to actively end their lives before their disease ends their lives” ought to be referred to as “physician assistance with dying,” instead of “physician-assisted suicide.”).

⁹Policy Statement, Am. Pub. Health Ass’n, Supporting Appropriate Language Used to Discuss End of Life Choices: Policy NO. LB-06-02 (Nov. 8, 2006), available at http://www.compassionandchoices.org/pdfs/APHA_Policy.pdf (urging “that accurate, value-neutral terms such as ‘aid in dying’ or ‘patient directed dying’ be used to describe this choice”).

¹⁰*E.g.*, James E. Dallner & D. Scott Manning, *Death with Dignity in Montana*, 65 MONT. L. REV. 309, 314-15 (2004).

III. The Constitutional Landscape

A. *Glucksberg* and *Quill*: The Court's Invitation to Action

Glucksberg and *Quill* were federal constitutional challenges to the state laws in Washington and New York, respectively, that prohibited physician-assisted death. Patients and physicians argued that prohibiting doctors from providing medications to competent dying patients to enable them to hasten death were unconstitutional under the liberty and equality guarantees of the Fourteenth Amendment of the U.S. Constitution. Two federal courts of appeals, including the Ninth Circuit sitting en banc, agreed.¹¹ The Supreme Court reversed, holding that there is no general right to physician-assisted suicide under either the substantive due process or the equal protection guarantee of the Fourteenth Amendment.

The opinions in these cases, while disappointing to advocates of aid in dying, nonetheless left the door open to future legislative reform – in fact, they seemed to invite it. The opinion of the Court in *Glucksberg* did so in the passage quoted at the beginning of this paper, noting that the Court's ruling would allow the debate to continue, and 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,”¹² and that “the legislative process is to be preferred.”¹³ 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”¹⁴

B. An Unexpected Outcome: Support for Aggressive Pain Management

The practice of sedating patients with intractable pain into unconsciousness and withholding food and water until death inevitably ensues is known as terminal or palliative sedation. It was endorsed as an acceptable option by the American Medical Association and other amici in the *Glucksberg* and *Quill* cases.¹⁵ Some argued, in fact, that the existence of this option made physician-assisted dying unnecessary.

In the Supreme Court's decisions, several members of the Court spoke favorably of the availability of this option. In a concurring opinion joined by Justice Breyer, Justice O'Connor stated that “a patient who is suffering from a terminal illness and who is experiencing great pain has no legal barriers to obtaining medication, from qualified physicians, to alleviate that suffering, even to the point of causing unconsciousness and hastening death.”¹⁶ She further

¹¹See *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 (2d Cir. 1996), *rev'd*, 521 U.S. 793.

¹²*Glucksberg*, 521 U.S. at 789 (Souter, J., concurring).

¹³*Id.* at 788.

¹⁴*Id.* at 737 (O'Connor, J., concurring) (second and third omissions in original) (citation and internal quotation marks omitted).

¹⁵See, e.g., Brief of the American Medical Ass'n et al. in Support of Petitioners at 6, *Vacco v. Quill*, 521 U.S. 793 (1997) (No. 95-1858), 1996 WL 656281.

¹⁶*Glucksberg*, 521 U.S. at 736-37 (O'Connor, J., concurring).

wrote, “There is no dispute that dying patients . . . can obtain palliative care, even when doing so would hasten their deaths.”¹⁷ Several commentators have concluded from these statements that some members of the Court went so far as to recognize a constitutional right to adequate pain medication, including the practice of terminal or palliative sedation.¹⁸

In the years since the Court’s decisions, palliative sedation has become steadily incorporated in end-of-life care, and authoritative literature in medical journals detailing the practice is burgeoning.¹⁹ This is a positive development. It does not mean, however, as some argue,²⁰ that a right to aid in dying is simply not needed. While palliative sedation may be an acceptable option for some, others abhor an induced coma and lingering demise while family members stand vigil for the week or ten days it takes for dehydration and starvation to bring about death.²¹ Aid in dying is an important option for those suffering intolerably who do not want to submit to palliative sedation.

IV. The Oregon Experience: Has the Laboratory Served Its Function?

A. Challenges to the Death With Dignity Act

Oregon’s Dignity Act was enacted in 1994 through the initiative process but its implementation was obstructed for several years by a lawsuit asserting that the law denied the terminally ill equal protection of the laws. The Ninth Circuit dismissed that case on the ground that the plaintiffs lacked standing.²² Opponents also made an effort to force a repeal through another ballot initiative in 1997. That effort failed when sixty percent of Oregon voters rejected the repeal.²³

¹⁷*Id.* at 737–38; *see also id.* at 791 (Breyer, J., concurring) (“[The challenged statutes] do not prohibit doctors from providing patients with drugs sufficient to control pain despite the risk that those drugs themselves will kill.”). Justice Ginsburg supported O’Connor’s opinion without joining it. *Id.* at 789. Justice Stevens’s statement that “there are situations in which an interest in hastening death . . . is entitled to constitutional protection” seems to contemplate aggressive treatment for pain. *Id.* at 741–42 (Stevens, J., concurring). And Justice Souter indicated “lesser concern” about the difficulty of assessing a patient’s wishes “in cases involving limitations on life incidental to pain medication.” *Id.* at 784 n.16 (Souter, J., concurring).

¹⁸*E.g.*, Robert A. Burt, *The Supreme Court Speaks: Not Assisted Suicide but a Constitutional Right to Palliative Care*, 337 NEW ENG. J. MED. 1234 (1997); David Orentlicher, *The Supreme Court and Terminal Sedation: Rejecting Assisted Suicide, Embracing Euthanasia*, 24 HASTINGS CONST. L.Q. 947, 951–54 (1997); *see also* Rob McStay, *Terminal Sedation: Palliative Care for Intractable Pain, Post Glucksberg and Quill*, 29 AM. J.L. & MED. 45, 52–53 (2003).

¹⁹*E.g.*, Nat’l Ethics Comm., Veterans Health Admin., *The Ethics of Palliative Sedation as a Therapy of Last Resort*, 23 AM. J. HOSPICE & PALLIATIVE MED. 483, 484 (2007) (“There is broad professional agreement that palliative sedation is a clinically and ethically appropriate response when patients who are near death suffer severe, unremitting symptoms.”); Zev D. Schuman et al., *Implementing Institutional Change: An Institutional Case Study of Palliative Sedation*, 8 J. PALLIATIVE MED. 666 app. at 672 (2005) (“In the United States, there is legal and professional support for palliative sedation. The United States Supreme Court (in *Vacco v. Quill* . . .) recognized the right of patients to receive palliative sedation if that is what is required to relieve their suffering at the end of life.”) (citation omitted); *see also* Bernard Lo & Gordon Rubinfeld, *Palliative Sedation in Dying Patients*, 294 JAMA 1810 (2005).

²⁰For an example of such an argument, see Susan M. Wolf, *Pragmatism in the Face of Death: The Role of Facts in the Assisted Suicide Debate*, 82 MINN. L. REV. 1063, 1100 (1998).

²¹*See* Kathryn L. Tucker, *The Chicken and the Egg: The Pursuit of Choice for a Human[e] Hastened-Death as a Catalyst for Improved End-of-Life Care; Improved End-of-Life Care as a Precondition for Legalization of Assisted Dying*, 60 N.Y.U. ANN. SURV. AM. L. 355, 356 (2004).

²²*Lee v. Oregon*, 891 F. Supp. 1429 (D. Or. 1995), *vacated*, 107 F.3d 1382 (9th Cir. 1997).

²³David J. Garrow, *The Oregon Trail*, N.Y. TIMES, Nov. 6, 1997, at A31; Kim Murphy, *Voters in Oregon Soundly Endorse Assisted Suicide*, L.A. TIMES, Nov. 5, 1997, at A1.

Although the law finally went fully into effect in 1998, opponents continued their efforts to thwart it. The next strategy was to seek relief from the federal government, urging the Drug Enforcement Administration (DEA) to take action against Oregon physicians acting in compliance with the law on the basis that such activity violated the federal Controlled Substances Act (CSA). The DEA initially opined that its agents could revoke the registrations of physicians who assisted in hastening deaths under the Dignity Act. However, U.S. Attorney General Janet Reno overruled this position, concluding that the CSA did not reach such conduct.²⁴ Reno stated that “[t]here is no evidence that Congress, in the CSA, intended to displace the states as the primary regulators of the medical profession, or to override a state’s determination as to what constitutes legitimate medical practice in the absence of a federal law prohibiting that practice.”²⁵

Opponents then sought, in two successive sessions of Congress, to expand the scope of the CSA to reach the Dignity Act.²⁶ Both efforts failed in the face of strong opposition from the medical community, founded on the concern that the proposed measures would exacerbate physicians’ fears regarding the use of controlled substances in pain management.²⁷

A change in federal administration and philosophy led to a change in legal interpretation. The Bush Administration’s first Attorney General, John Ashcroft, issued a directive in November 2001 (the “Ashcroft Directive”),²⁸ advising that the Department of Justice had concluded that prescribing controlled substances under the Dignity Act violated the CSA. The directive stated that “assisting suicide is not a ‘legitimate medical purpose’ within the meaning of” the regulations governing implementation of the CSA and that therefore “prescribing, dispensing, or administering federally controlled substances to assist suicide violates the [CSA].”²⁹ In particular, “[s]uch conduct by a physician registered to dispense controlled substances may ‘render his registration . . . inconsistent with the public interest’ and therefore subject to possible suspension or revocation under [the CSA].”³⁰

The Ashcroft Directive was challenged in federal court by the state of Oregon, an Oregon physician, and a group of terminally ill Oregonians, who asserted that it violated the CSA, the Administrative Procedure Act, and the U.S. Constitution. The district court reached only the question of whether the directive was within the scope of the CSA. The court concluded that it exceeded the authority granted under the CSA, and a permanent injunction was entered:

²⁴Statement of Attorney General Reno on Oregon’s Death with Dignity Act, 98 Op. Att’y Gen. 259 (1998) (“The Department has conducted a thorough and careful review of the issue We have concluded 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 CSA.”).

²⁵*Id.*

²⁶Pain Relief Promotion Act of 1999, H.R. 2260, 106th Cong. (1999); Lethal Drug Abuse Prevention Act of 1998, H.R. 4006, 105th Cong. (1998).

²⁷See Marcia Angell, Editorial, *Caring for the Dying Congressional Mischief*, 341 NEW ENG. J. MED. 1923, 1923 (1999) (“If the bill becomes law, it will almost certainly discourage doctors from prescribing or administering adequate doses of drugs to relieve the symptoms of dying patients.”); David Orentlicher & Arthur Caplan, *The Pain Relief Promotion Act of 1999: A Serious Threat to Palliative Care*, 283 JAMA 255, 255 (2000) (“[P]rogress in [the area of improved pain care] may be dealt a severe setback should Congress decide to enact the [PRPA] of 1999 [T]he most likely effect of PRPA would be to discourage physicians nationwide from adequately treating the suffering of their dying patients.”).

²⁸Dispensing of Controlled Substances to Commit Suicide, Att’y Gen. Order No. 2534-2001, 66 Fed. Reg. 56,607 (Nov. 9, 2001).

²⁹*Id.* at 56,608.

³⁰*Id.* (omission in original) (citation omitted).

The determination of what constitutes a legitimate medical practice or purpose traditionally has been left to the individual states. . . . The CSA was never intended, and the USDOJ and DEA were never authorized, to establish a national medical practice or act as a national medical board. 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.³¹

The Ninth Circuit affirmed the lower court’s rejection of this back-door attack on the Dignity Act through the Controlled Substances Act.³² And in January 2006, the U.S. Supreme Court affirmed, leaving Oregon’s landmark law intact.

B. Implementation of the Act

The Oregon Death with Dignity Act has now been in force for 10 years, and experience under the law demonstrates that a carefully crafted aid in dying law can work well.

The Dignity Act establishes tightly controlled procedures under which competent, terminally ill adults who are under the care of an attending physician may obtain a prescription for medication to allow them to control the time, place, and manner of their own impending death.³³ The attending physician must, among other things, determine that the patient is mentally competent and an Oregon resident, and confirm the patient’s diagnosis and prognosis.³⁴ To qualify as “terminally ill,” a person must have “an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.”³⁵

The attending physician also must inform persons requesting such medication of their diagnosis and prognosis, the risks and probable results of taking the medication, and alternatives to taking their own lives, including, but not limited to, hospice care and pain relief.³⁶ A consulting physician must confirm the attending physician’s medical opinion.³⁷

Once a request from a qualifying patient has been properly documented and witnessed, and all waiting periods have expired,³⁸ the attending physician may prescribe, but not administer, medication to enable the patient to end his or her life in a humane and dignified manner. The Dignity Act protects physicians and pharmacists who act in compliance with its comprehensive

³¹Oregon v. Ashcroft, 192 F. Supp. 2d 1077, 1092 (D. Or. 2002), *aff’d*, 368 F.3d 1118 (9th Cir. 2004), *aff’d sub nom.*, Gonzalez v. Oregon, 546 U.S. 243 (2006).

³²Ashcroft, 368 F.3d 1118, *aff’d sub nom.* Gonzalez, 546 U.S. 243.

³³See OR. REV. STAT. § 127.805 (2005).

³⁴*Id.* § 127.815.

³⁵*Id.* § 127.800(12).

³⁶*Id.* § 127.800(7).

³⁷*Id.* §§ 127.800(4), .800(8), .820.

³⁸*Id.* §§ 127.840-850. The Dignity Act requires a fifteen day waiting period between the patient’s initial oral request and the writing of the prescription, and a forty-eight hour waiting period between the patient’s written request and the writing of the prescription. *Id.* § 127.850.

procedures from civil or criminal sanctions, and any professional disciplinary actions based on that conduct.³⁹

The Dignity Act requires healthcare providers to file reports with the state documenting their actions,⁴⁰ which means that there is extensive documentation of Oregon's experience. To date, the Oregon Public Health Division and Department of Human Services have issued nine annual reports that present and evaluate the state's experience with the Dignity Act.⁴¹ Related reports and articles also have been published in leading medical journals.⁴² These reports constitute the only source of reliable data regarding actual experience with legal, regulated physician-assisted dying in America.

C. Findings: The Laboratory Has Served Its Function

Oregon's annual reports demonstrate that the use of physician-assisted dying has been limited. During the first nine years in which physician-assisted dying was a legal option, only 292 Oregonians chose it.⁴³ And although there has been a gradual increase in the rate of those opting for physician-assisted dying, the overall rate remains low: the 38 terminally ill adults who chose this option in 2005 represented only 12 deaths for every 10,000 Oregonians who died that year.⁴⁴ A 2000 survey of Oregon physicians found that they granted 1 in 6 requests for aid in dying, and that only 1 in 10 requests resulted in hastened death.⁴⁵ Roughly one-third of those patients who complete the process of seeking medications under the Dignity Act do not go on to consume the medications. These individuals derive comfort from having the option to control the time of death yet ultimately die of their disease without exercising that control.⁴⁶

The evidence also shows that vulnerable populations have not been placed at risk. At the time *Glucksberg* was litigated, opponents asserted that recognition of a right to aid in dying

³⁹*Id.* § 127.885(1)-(2).

⁴⁰*Id.* § 127.865.

⁴¹OR. PUB. HEALTH DIV., OR. DEP'T OF HUMAN SERVS., DEATH WITH DIGNITY ACT ANNUAL REPORTS, <http://oregon.gov/dhs/ph/pas/ar-index.shtml> (last visited Jan. 19, 2008) [hereinafter ANNUAL REPORTS].

⁴²*E.g.*, Andrew I. Batavia, *So Far So Good: Observations on the First Year of Oregon's Death With Dignity Act*, 6 PSYCHOL. PUB. POL'Y & L. 291 (2000); Margaret P. Battin et al., *Legal Physician-Assisted Dying in Oregon and the Netherlands: Evidence Concerning the Impact on Patients in "Vulnerable" Groups*, 33 J. MED. ETHICS 591 (2007); Arthur E. Chin et al., *Legalized Physician-Assisted Suicide in Oregon — The First Year's Experience*, 340 NEW ENG. J. MED. 577 (1999); David Orentlicher, *The Implementation of Oregon's Death With Dignity Act: Reassuring, But More Data Are Needed*, 6 PSYCHOL. PUB. POL'Y & L. 489 (2000) (stating that implementation of Oregon law has so far been limited to terminally ill patients with a clear, persistent, and voluntary request for hastened death); Amy D. Sullivan et al., *Legalized Physician-Assisted Suicide in Oregon — The Second Year*, 342 NEW ENG. J. MED. 598 (2000); *see also* Straton, *supra* note 8; Timothy E. Quill & Christine K. Cassel, *Professional Organizations' Position Statements on Physician-Assisted Suicide: A Case for Studied Neutrality*, 138 ANNALS INTERNAL MED. 208 (2003).

⁴³OR. PUB. HEALTH DIV., OR. DEP'T OF HUM. SERVS., DEATH WITH DIGNITY ANNUAL REPORTS: YEAR 9 – 2006 SUMMARY (2007), <http://oregon.gov/dhs/ph/pas/docs/year9.pdf> [hereinafter NINTH ANNUAL REPORT]. Some commentators have observed that legal medical interventions that will bring about death, such as removal of feeding tubes, are reluctantly taken, and have reasoned from this that if aid in dying were legal it would also be rare. *See* David Orentlicher & Christopher M. Callahan, *Feeding Tubes, Slippery Slopes, and Physician-Assisted Suicide*, 25 J. LEGAL MED. 389 (2004). The Oregon data supports this contention.

⁴⁴OFFICE OF DISEASE PREVENTION & EPIDEMIOLOGY, OR. DEP'T OF HUMAN SERVS., EIGHTH ANNUAL REPORT ON OREGON'S DEATH WITH DIGNITY ACT 4-5 (2006), available at <http://oregon.gov/dhs/ph/pas/docs/year8.pdf> [hereinafter EIGHTH ANNUAL REPORT].

⁴⁵Linda Ganzini et al., *Physicians' Experiences with the Oregon Death with Dignity Act*, 342 NEW ENG. J. MED. 557, 557 (2000) (finding that the availability of palliative care led some, but not all, patients to change their mind about hastened death).

⁴⁶*See* ANNUAL REPORTS, *supra* note 41; NINTH ANNUAL REPORT, *supra* note 43 (showing number of prescription recipients each year compared to number of deaths from use of prescriptions).

would jeopardize vulnerable populations and potentially subject them to abuse. Some expressed concerns about disproportionate use of this option by the elderly, women, the uninsured, people with low educational status, the poor, and others. A vocal segment of the community of persons with physical disabilities also argued as *amici curiae* against empowering terminally ill patients with the right to choose aid in dying, expressing a fear that persons with disabilities would be considered marginal and expendable and come under pressure to end their lives prematurely.⁴⁷

Researchers who have examined the experience in Oregon have concluded that there is no evidence to suggest that these concerns were well founded.⁴⁸ The data demonstrates that the option of physician-assisted dying has not been forced upon those who are poor, uneducated, uninsured or otherwise disadvantaged.⁴⁹ For example, the eighth annual report found that a higher level of education is strongly associated with the use of physician-assisted dying; those with a baccalaureate degree or higher were 7.9 times more likely than those without a high school diploma to choose physician-assisted dying.⁵⁰ The report found that 100% of patients opting for physician-assisted dying under the Dignity Act had either private health insurance, Medicare, or Medicaid, and 92% were enrolled in hospice care.⁵¹ In one report that looked at the effects on vulnerable populations in Oregon, the researchers concluded, “We found no evidence to justify the grave and important concern often expressed about the potential for abuse – namely, the fear that legalized physician-assisted dying will target the vulnerable or pose the greatest risk to people in vulnerable groups.”⁵²

Outside observers, after carefully studying implementation of the Oregon law, also have concluded that it poses no risk to patients. For example, a report prepared for the Vermont legislature, after a thorough review of the Oregon experience, concluded that “it is quiet [sic] apparent from credible sources in and out of Oregon that the Death with Dignity Act has not had an adverse impact on end-of-life care and in all probability has enhanced the other options.”⁵³ Leading scholars have come to conclusions such as this: “I worried about people being pressured to do this But this data confirms . . . that the policy in Oregon is working. There is no evidence of abuse or coercion, or misuse of the policy.”⁵⁴

⁴⁷Brief for Not Dead Yet et al. as Amici Curiae in Support of Defendants-Appellants, *Glucksberg v. WA*, 521 U.S. 702 (1997), 1996 WL 707992.

⁴⁸For a recent comprehensive overview of the Oregon experience, urging that medical associations adopt a position of neutrality on assisted dying laws, see Quill & Cassel, *supra* note 42. See also Linda Ganzini et al., *Oregon Physicians’ Attitudes About and Experiences With End-of-Life Care Since Passage of the Oregon Death with Dignity Act*, 285 JAMA 2363 (2001); Melinda A. Lee & Susan W. Tolle, *Oregon’s Assisted Suicide Vote: The Silver Lining*, 124 ANNALS INTERNAL MED. 267 (1996); Straton, *supra* note 8.

⁴⁹*E.g.*, CTR. FOR DISEASE PREVENTION & EPIDEMIOLOGY, OR. HEALTH DIV., DEP’T OF HUMAN RES., OREGON’S DEATH WITH DIGNITY ACT: THE FIRST YEAR’S EXPERIENCE 7 (1999), available at <http://oregon.gov/dhs/ph/pas/docs/year1.pdf> (“Patients who chose physician-assisted suicide were not disproportionately poor (as measured by Medicaid status), less educated, lacking in insurance coverage, or lacking in access to hospice care.”); see also Battin et al., *supra* note 42; Kant Patel, *Euthanasia and Physician-Assisted Suicide Policy in the Netherlands and Oregon: A Comparative Analysis*, 19 J. HEALTH & SOC. POL’Y 37 (2004) (finding no empirical evidence of slippery slope in Oregon, but more potential for a slide in the Netherlands).

⁵⁰EIGHTH ANNUAL REPORT, *supra* note 44, at 12.

⁵¹*Id.* at 23.

⁵²Battin, *supra* note 42 at 597.

⁵³VT. LEGISLATIVE COUNCIL, OREGON’S DEATH WITH DIGNITY LAW AND EUTHANASIA IN THE NETHERLANDS: FACTUAL DISPUTES § 3E (2004), available at http://www.leg.state.vt.us/reports/05Death/Death_With_Dignity_Report.htm.

⁵⁴William McCall, *Assisted-Suicide Cases Down in ’04*, COLUMBIAN (Vancouver, Wash.), Mar. 11, 2005, at C2 (quoting Arthur Caplan, director of the Center for Bioethics at the University of Pennsylvania School of Medicine); see also Straton, *supra* note 8, at 480-82.

Some disability rights advocates continue to express concerns about the potential impact of aid in dying on persons with disabilities. Researchers who have examined the Oregon data, however, have reported that there is “no evidence of heightened risk” for people with non-terminal physical disabilities.⁵⁵ They found that “no one received physician-assistance in dying who was not determined by two physicians to be terminally ill – that is, no one received such assistance for disability alone.”⁵⁶ Moreover, the Executive Director of the Oregon Advocacy Center (OAC), which provides legal advocacy for individuals with mental and physical disabilities throughout Oregon and is mandated by law to investigate complaints of abuse or neglect of individuals with disabilities, including inappropriate actions taken to hasten the death of such an individual, has stated under oath that OAC “has never received a complaint that a person with disabilities was coerced to make use of the Dignity Act.”⁵⁷ The only complaints OAC had received, he said, were a few expressing concern that some persons who wish to make use of the Act might be prevented by their physical disabilities from self-administering medication as permitted under the Act. He went on to say, “I am not aware of any data that suggest that Oregonians with disabilities that are not related to a terminal illness have made use of the Dignity Act.”⁵⁸ If disability advocates nonetheless remain concerned about whether enough data is being collected, advocates of aid in dying would fully support the collection of additional data on the impact of the law on the disabled.

Not only have the harms some feared failed to materialize, but the Dignity Act has produced distinct benefits. First, the Dignity Act has galvanized significant improvements in the care of the dying in Oregon. Oregon doctors report that since the passage of the Dignity Act, steps have been taken to improve their ability to provide adequate end-of-life care. These efforts include improving their knowledge of the use of pain medications for the terminally ill, improving their ability to recognize depression and other psychiatric disorders, and more frequently referring their patients to hospice programs.⁵⁹ One survey of Oregon physicians on their efforts to improve end-of-life care since 1994 found that 30% of respondents increased their number of referrals to hospice care and 76% made efforts to increase their knowledge of pain medication.⁶⁰ A survey of hospice nurses and social workers in Oregon revealed that between 1998 and 2003 they observed an increase in physicians’ knowledge of palliative care, as well as an increase in physicians’ willingness to refer patients to hospice and to care for hospice patients.⁶¹

⁵⁵Battin et al., *supra* note 42, at 594.

⁵⁶*Id.*

⁵⁷Affidavit of Robert Joondeph, October 18, 2007 (on file with author).

⁵⁸*Id.*

⁵⁹See Ganzini et al., *supra* note 48; see also Lee & Tolle, *supra* note 48, at 268-69; Lawrence J. Schneiderman, *Physician-Assisted Dying* 293 JAMA 501, 501 (2005); Quill & Cassel, *supra* note 42, at 209. Schneiderman notes that

one of the unexpected yet undeniable consequences of Oregon’s Death with Dignity Act permitting physician aid-in-dying is that “many important and measurable improvements in end-of-life care” occurred following the Act’s implementation. Rather than becoming the brutal abattoir for hapless patients that some critics predicted, the state is a leader in providing excellent and compassionate palliative care.

Schneiderman, *supra*, at 501 (reviewing and quoting PHYSICIAN-ASSISTED DYING: THE CASE FOR PALLIATIVE CARE AND PATIENT CHOICE (Timothy E. Quill & Margaret P. Battin eds., 2004)).

⁶⁰Ganzini et al., *supra* note 48, at 2363.

⁶¹Elizabeth R. Goy et al., *Oregon Hospice Nurses and Social Workers’ Assessment of Physician Progress in Palliative Care Over the Past 5 Years*, 1 PALLIATIVE & SUPPORTIVE CARE 215 (2004).

Moreover, in addition to the improvement of end-of-life care, the legal option of physician-assisted death has psychological benefits for both the terminally ill and the healthy. The availability of the option of aid in dying gives the terminally ill autonomy, control and choice, which physicians in Oregon have identified as the overwhelming motivational factor behind the decision to request assistance in dying.⁶² Healthy Oregonians know that if they ever face a terminal illness, they will have control and choice over their manner of death.⁶³

In short, the data demonstrate that, far from posing any hazard to patients or the practice of medicine, making the option of assisted dying available has brought about improvements in end-of-life care and widespread benefits for terminally ill, and other, Oregonians.

V. Beyond Oregon: Are Other States Ready to Make Aid in Dying Legal?

A. What Currently Happens Outside of Oregon

Physicians throughout the country report that they regularly receive requests for assistance in dying. A significant percentage of primary care physicians and an even larger percentage of oncologists in the United States report having been asked for their assistance in a patient's hastened death.⁶⁴ Because Oregon is the only jurisdiction in the United States where aid in dying is legal, however, when it occurs outside of Oregon, it occurs in covert, underground practice, where complications are more likely to occur – much like the era when women could not legally choose to terminate an unwanted pregnancy and had to resort to dangerous, “back alley” abortions.⁶⁵ For example, there is a much higher chance of an extended time until death after consuming lethal medications under covert practice.⁶⁶ Moreover, the stress and anxiety for

⁶²Kathy L. Cerminara & Alina Perez, *Therapeutic Death: A Look at Oregon's Law*, 6 PSYCHOL. PUB. POL'Y & L. 503, 512-13 (2000) (acknowledging possible negative effects of legalized aid in dying, but concluding that the data from Oregon in one year justifies an optimistic view); see also Linda Ganzini et al., *Experiences of Oregon Nurses and Social Workers with Hospice Patients who Requested Assistance with Suicide*, 347 NEW ENG. J. MED. 582 (2002) (reporting that nurses and social workers rated desire to control circumstances of death as the most important reason for requesting aid in dying); Linda Ganzini et al., *Oregon Physicians' Perceptions of Patients Who Request Assisted Suicide and Their Families*, 6 J. PALLIATIVE MED. 381 (2003) (finding physicians receiving requests for lethal medication perceive patients as wanting to control their deaths).

⁶³See Tucker, *supra* note 21. Other reasons that put to rest the fear that passage of aid-in-dying laws will put patients at risk have been offered. For example, one commentator studied the reluctance of patients and providers to withdraw feeding tubes, an option legal in every state. See Orentlicher & Callahan, *supra* note 43, at 390. He concluded that the data show that feeding tubes are overutilized and argues that this demonstrates reluctance to take steps that will precipitate death and that such reluctance will apply in the context of aid in dying. *Id.*

⁶⁴See EJ Emanuel, *Euthanasia and physician-assisted suicide, A review of the empirical data from the United States*, ARCHIVES OF INTERNAL MEDICINE 2002;162:142-152(the prevalence of requests for aid in dying between 1991 and 2000 ranged widely, from 5% to 56% of surveyed physicians. This variability was attributed in part to different methods used, year of the survey, geographic region, and surveyor-specific characteristics, as well as the medical specialty of those being surveyed. Overall, Emanuel concluded that less than 20% of nononcologists had received requests for assistance dying, while up to half of oncologists had received such a request. These data also indicate that the percentage of surveyed physicians who had performed aid in death or voluntary active euthanasia ranged from 2.5% to 53%, with the highest prevalence reported among oncologists and Human Immunodeficiency Virus (HIV) specialists.). Monica Davey, *Kevorkian Freed After Years in Prison for Aiding Suicide*, N.Y. TIMES, June 2, 2007, at A8.

⁶⁵When 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. See Monica Davey, *Kevorkian Freed After Years in Prison for Aiding Suicide*, N.Y. TIMES, June 2, 2007, at A8.

the patient and family is much higher when no physician can legally be involved to counsel the patient and family and provide the prescription for medications.⁶⁷

Thus, the question is not whether assisted dying will occur, but whether it will occur in a regulated and controlled fashion with safeguards and scrutiny — or covertly, in a random, dangerous, and unregulated manner.

B. Support for Aid in Dying Laws

In support of the patients and physicians in *Glucksberg* and *Quill*, many citizens of Washington and New York shared their stories in an *amicus* brief to the Supreme Court, detailing the suffering of loved ones who were not allowed to self-administer medications to hasten death when their dying process became intolerable.⁶⁸ Countless citizens have joined the discussion since then.⁶⁹

According to a number of polls, support for aid in dying is widespread nationwide. A 2006 poll found that 60% 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% “believe a person has a moral right to end their life if suffering from an incurable disease.”⁷⁰ A poll published in January 2002 found that 65% of respondents support legalization of the right to physician-assisted dying and 61% favored implementation of a version of the Dignity Act in their own states.⁷¹ Another group of studies found that between 63% and 90% of people with a terminal illness support a right to physician-assisted dying and would like to have the option available to them.⁷² In California, surveys in February 2006 and February 2005 found that 70% of California residents support the idea that “incurably ill patients have the right to ask for and get life-ending medication.”⁷³

Support is also strong among physicians. A national survey conducted in February 2005 found that 57% of the 1088 physicians polled believe it is ethical for a physician to assist a competent, dying patient to hasten death.⁷⁴ A 2001 survey published by the *Journal of the American Medical Association* found that 51% of responding

⁶⁶See Helene Starks et al., *Family Member Involvement in Hastened Death*, 31 DEATH STUD. 105 (2007).

⁶⁷*Id.* at 112–17.

⁶⁸Brief Amicus Curiae Of Surviving Family Members In Support Of Physician-Assisted Dying, *Glucksberg*, 521 U.S. 702 (NO. 96-110), 1996 WL 722032.

⁶⁹DVD: Ethics in America II: Three Farewells: Medicine & the End of Life (Fred Friendly Seminars 2007), available at <http://www.learner.org/resources/series207.html>; see also *Frontline: Living Old* (PBS television broadcast Nov. 21, 2006), available at <http://www.pbs.org/wgbh/pages/frontline/livingold> (depicting stories of elderly patients and their families struggling to maintain dignity as they face age and disease).

⁷⁰Pew Research Ctr. For The People & The Press, *More Americans Discussing — and Planning — End-of-Life Treatment: Strong Public Support for Right to Die*, at 8 (Jan. 5, 2006), <http://people-press.org/reports/pdf/266.pdf>.

⁷¹Humphrey Taylor, Harris Interactive, *2-to-1 Majorities Continue to Support Rights to Both Euthanasia and Doctor-Assisted Suicide* (Jan. 9, 2002), http://www.harrisinteractive.com/harris_poll/index.asp?PID=278 (last visited Oct 19, 2007).

⁷²Andrew I. Batavia, *The Relevance of Data on Physicians and Disability on the Right to Assisted Suicide: Can Empirical Studies Resolve the Issue?*, 6 PSYCHOL. PUB. POL’Y & L. 546, 553 (2000) (citing William Breitbart et al., *Interest in Physician-Assisted Suicide Among Ambulatory HIV-Infected Patients*, 153 AM. J. PSYCHIATRY, 238, 240 (1996), 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*, 6 J. ACQUIRED IMMUNE DEFICIENCY SYNDROME 1069, 1069 (1993)).

⁷³Mark DiCamillo & Mervin Field, Field Research Corp., *Release #2188: Continued Support for Doctor-Assisted Suicide*, at 2 (Mar. 15, 2006), <http://www.field.com/fieldpollonline/subscribers/RLS2188.pdf>.

⁷⁴Louis Finkelstein Inst. for Religious & Soc. Studies, Jewish Theological Seminary, PHYSICIAN-ASSISTED SUICIDE SURVEY (Feb. 2005), <http://www.jtsa.edu/x5533.xml> (last visited Oct. 6, 2007).

physicians in Oregon supported the Dignity Act and legalization of physician-assisted dying.⁷⁵ A nationwide survey published in 2001 in the *Journal of General Internal Medicine* found that 45% of responding physicians believed that physician-assisted death should be legal, whereas only 34% expressed views to the contrary.⁷⁶

At the same time, however, certain groups remain staunchly opposed. These include the “right to life” lobby⁷⁷ and the Catholic Church. A segment of the disability community remains opposed as well, despite the lack of evidence from Oregon indicating that disabled persons are put at risk by the availability of aid in dying. In addition, some major medical groups remain opposed, most notably the American Medical Association. The opposition of the AMA is difficult to understand, given that a majority of physicians support the option of aid in dying. In addition, other medical organizations have softened their stance on the issue; for example, the American Academy of Hospice and Palliative Medicine transitioned from opposition to a neutral position, noting that its membership was divided.⁷⁸ Other medical associations, including the American Medical Women’s Association and the American Medical Students Association, have adopted policies strongly supporting the practice.⁷⁹

C. Aid in Dying Measures in Other States

Efforts to pass laws similar to Oregon’s Dignity Act have been launched in other states, including Hawaii, Maine, Michigan, Vermont, Connecticut, Wisconsin, Arizona, and California. The California Compassionate Choices Act (CCCA), introduced in 2007, would allow a mentally competent, terminally ill patient with a prognosis of three months or less to obtain a prescription to bring about hastened death.⁸⁰ The CCCA, while modeled on the Oregon law, is more restrictive in certain respects, as a result of amendments offered and accommodations made in the legislative process. For example, the CCCA would permit use of the law only when a patient has up to three months life expectancy⁸¹ rather than six months as permitted in Oregon.⁸² In

⁷⁵Ganzini et al., *supra* note 48, at 2365.

⁷⁶Simon N. Whitney et al., *Views of United States Physicians and Members of the American Medical Association House of Delegates on Physician-Assisted Suicide*, 16 J. GEN. INTERNAL MED. 290, 292–93 (2001). An additional nationwide survey, published in the *New England Journal of Medicine* in 1998, focused on doctors who practiced in one of the ten medical specialties identified as likely to encounter dying patients (e.g., cardiology, geriatrics, neurology). Of the responding physicians, 36% said that, if it were legal to do so, they would be willing to hasten death by medication, and 24% stated that they would be willing to do so by injection. Diane E. Meier et al., *A National Survey of Physician-Assisted Suicide and Euthanasia in the United States*, 338 NEW ENG. J. MED. 1193, 1199 (1998).

⁷⁷That this advocacy community has turned its attention to end-of-life issues was made abundantly clear in the sensationalized case involving Terri Schiavo, where so-called right to life groups sought to prevent the patient’s wishes from being implemented and to force continued tube feeding on a woman who had permanently lost all cognitive function and was in a permanent vegetative state. For extended discussion of who these groups were and how they are funded, see JON B. EISENBERG, USING TERRI: THE RELIGIOUS RIGHT’S CONSPIRACY TO TAKE AWAY OUR RIGHTS (2005), and RELIGIOUS COAL. FOR REPROD. CHOICE, THE MEDICAL RIGHT (2007) (examining the concerted effort of the religious right to intrude religious values in to the practice of medicine) *available at* <http://www.rcrc.org>. The National Right to Life Committee filed an amicus brief opposing aid in dying in *Glucksberg*, 1996 U.S. S. Ct. Briefs LEXIS 731.

⁷⁸Position Statement, Am. Acad. of Hospice & Palliative Med., Physician-Assisted Death (Feb. 14, 2007), <http://www.aahpm.org/positions/suicide.html>.

⁷⁹*See, e.g.*, Position Statement, Am. Med. Women’s Ass’n, Aid in Dying (Sept. 9, 2007), <http://www.amwawdoc.org> (follow “Advocacy” hyperlink; then follow “Position Statements” hyperlink); Principles Regarding Physician-Assisted Suicide, Resolution D01, Am. Med. Student Ass’n House of Delegates (March 15, 2008) (on file with author); Jay Cohen, *CAPG Supports AB 374: The Compassionate Choices Act*, CAPG UPDATE (Cal. Ass’n of Physician Groups, L.A., Cal.), Mar. 2007, at 9, *available at* http://www.capg.org/docs/capg_update--march_2007.pdf (supporting passage of an Oregon-type aid-in-dying law in California).

⁸⁰California Compassionate Choices Act, Assemb. 374, 2007–08 Leg., Reg. Sess. (Cal. 2007).

⁸¹*Id.* § 7196(g).

addition, the CCCA explicitly requires that the patient self-administer the medications, whereas in Oregon this is implicit.⁸³ The already stringent limitations of the Oregon model were made even more stringent by California legislators seeking to devise a measure that addresses public concerns while still providing comfort and relief to dying patients who find their situation intolerable. Yet, even with a more stringent measure, and the data from Oregon demonstrating no harm to patients, the CCCA was not passed by the California legislature, due in large measure to the opposition of the Catholic Church and the California Medical Association.⁸⁴ The CMA's decision to oppose the measure was likely influenced by the continued opposition of the AMA, discussed above.

Earlier this year, an initiative to pass an aid in dying law was introduced in Washington State.⁸⁵ This measure is virtually identical to Oregon's Dignity Act, and has been endorsed by the Washington State Public Health Association.⁸⁶ If sufficient signatures are gathered, which is likely, the measure will appear on the ballot this November. Opponents formed an opposition coalition, called "The Coalition Against Assisted Suicide," and engaged the battle immediately by filing a challenge in court to the title of the measure as written by the Washington Attorney General's office and urging the inclusion of the term "assisted suicide."⁸⁷ The challenge was unsuccessful and it is quite likely that the voters of Washington will have a chance to decide this fall whether to follow in Oregon's footsteps.

State constitutional litigation may open the way for patients in other states to access aid in dying. A state version of the federal cases *Quill* and *Glucksberg* litigation is pending in Montana.⁸⁸ The plaintiffs in this case assert that mentally competent, terminally ill Montanans have a right protected under the Montana State Constitution's guarantees of privacy and dignity to choose to control their own deaths by obtaining medications from their physicians for this purpose. A number of factors suggest that protecting Montanans' choice to receive aid in dying is likely to be recognized by the Montana Supreme Court under the Montana constitution. The state constitution includes explicit guarantees of privacy and dignity,⁸⁹ provisions which have consistently been construed broadly; the Montana Supreme Court has unequivocally held that the Montana Constitution provides broader protection than the U.S. Constitution. As the court recently stated: "Montana adheres to one of the most stringent protection of its citizens' right to privacy in the country."⁹⁰ Oregon's experience under its Death with Dignity Act and the growing societal acceptance of this end of life option may also be influential.

⁸²OR. REV. STAT. §§ 127.800(12), 127.805 (2005).

⁸³California Compassionate Choices Act § 7197.7.

⁸⁴In California, Cardinal Roger Mahoney was at the forefront of opposition to AB 374, charging those who support the bill with participating in a "culture of death." See Jim Sanders, *Cardinal Scolds Núñez on Death Aid*, SACRAMENTO BEE, Apr. 3, 2007, at A1.

⁸⁵See Yes on I-1000, <http://www.yeson1000.org>, (discussing Washington Initiative Measure No. 1000) (last accessed Feb. 13, 2008).

⁸⁶Letter from Washington State Public Health Association (June 5, 2008) (on file with author).

⁸⁷Jeremy Pawloski, *End-of-life Ballot Measure Faces Fight from Coalition*, THE OLYMPIAN, Feb. 9, 2008, available at <http://www.theolympian.com/news/story/353944.html>.

⁸⁸See e.g., *Baxter v State*, No. ADV 2007-787 (1st D. Mont., filed 2007).

⁸⁹MONT. CONST. art. II, § 10 ("The right of individual privacy is essential to the well-being of a free society and shall not be infringed without the showing of a compelling state interest."). *Id.* § 4 ("The dignity of the human being is inviolable. No person shall be denied the equal protection of the laws.")

⁹⁰*State v. Burns*, 830 P.2d 1318, 1320 (Mont. 1992). See generally Kathryn L. Tucker, *Privacy and Dignity at the End of Life: Protecting the Right of Montanans to Choose Aid in Dying*, 68 MONT. L. REV. 317-333(2007); Scott A. Fisk, *The Last Best Place to Die: Physician-Assisted Suicide and Montana's Constitutional Right to Personal Autonomy Privacy*, 59 MONT. L. REV. 301 (1998).

VI. Conclusion

Ten years have passed since the U.S. Supreme Court's ruling in *Glucksberg* and Oregon's Death with Dignity Act went into effect. A wealth of information is now available about Oregon's experience with legal aid in dying, demonstrating that an aid in dying law can be enacted and implemented in a way that harms no one and that benefits both the relatively few patients *in extremis* who make use of the option and a great many more who draw comfort from knowing it is available should their dying process become intolerable to them. Citizens and lawmakers of other states across the country should heed the lessons of Oregon and show the same compassion Oregon has shown to terminally ill, competent patients who wish to end their suffering.