

THE OREGON DEATH WITH Dignity ACT

FOUR CHALLENGES THAT ENSURED THE LAW'S SUCCESS



Eli Stutsman

By Eli Stutsman

Just over twenty years ago, on November 8, 1994, Oregon became the first state to decriminalize “physician assisted suicide.” On that day, by a margin of 51 to 49 percent, voters passed the Oregon Death with Dignity Act, a ballot initiative now codified at ORS 127.800 to 127.897.

The Death with Dignity Act permits state licensed, Drug Enforcement Administration (DEA) registered physicians and pharmacies, to prescribe and dispense Schedule II and lower controlled substances to competent, terminally ill, adult patients seeking to hasten an impending death in narrowly defined circumstances. *See, e.g.*, ORS 127.815 (responsibilities of the attending physician).

I was a lead author of the Oregon Death With Dignity Act. I was also the

lead political and legal strategist during the 1994 campaign to pass the law, and again during the 1997 campaign to prevent its legislatively inspired repeal. I also represented the law’s chief petitioners during the first round of federal court litigation (1995-1997), and a physician and a pharmacist during the second round of federal court litigation (2002-2006).

Key to understanding the lens through which I view end of life issues is knowing that I have two physicians in my family (both now deceased) and, as a new lawyer, I worked for a firm defending physicians. This exposure has provided me with valuable perspective, particularly with respect to the all important medical standard of care. More important, however, was the time I spent as an undergraduate student in religious studies, an experience that informs my thinking on ethical issues as much or more than does being a lawyer.

And key to understanding the Oregon Death with Dignity Act is knowing that the law has never been as controversial, as many may have first assumed.

Four days before its passage, 20 years ago, Pulitzer Prize winning columnist Ellen Goodman quoted me as saying, “We haven’t tried to change the way people die or the way people ask for help. We have attempted to bring something out of the dark and into the light and at the same time provide safeguards.” Ellen

Goodman, “Gentle Into the Night,” *The Baltimore Sun*, November 4, 1994. My point then was that dying patients were already hastening their deaths by accumulating and ingesting prescription drugs, occasionally with assistance from their physicians, and we had codified that covert practice into a ballot initiative. We had also proposed a medical standard of care, along with sensible public policy limits, that we termed “safeguards.”

Although I did not view the narrowly written Oregon Death with Dignity Act as controversial, controversy was plentiful in the early 1990s. The so-called “right to die” movement was riding a fresh wave of support. By 1990, Dr. Jack Kevorkian was already notoriously famous when Janet Adkins left her comfortable southwest Portland home and traveled to Michigan to hasten her death in Dr. Kevorkian’s Volkswagen bus. The next year, 1991, Derek Humphry, a prominent advocate working and living in the Eugene area, published his book, “Final Exit,” a how-to manual for those seeking to hasten death. It went straight to the top of *The New York Times* best-seller list. That same year, Washington voters defeated Initiative 119, a citizens’ initiative that would have permitted euthanasia and lethal injection. The following year, 1992, California voters defeated Proposition 162, another similar proposal that would have permitted

See Death With Dignity p 40

euthanasia and lethal injection.

It was in this politically charged climate that the Oregon Death with Dignity Act was drafted by a small group in 1993. One of our goals was to remove the controversy. We sought to keep Dr. Kevorkian's conduct illegal, while rendering Derek Humphry's book unnecessary, at least in Oregon. We very briefly debated, but unanimously rejected, the concepts of euthanasia and lethal injection. These concepts were central to the recently defeated ballot initiatives in Washington and California and they were very important to the political advocates at the time, but they were also concepts borrowed from other countries. What I discovered through my direct observations during the 1991 and 1992 campaigns in Washington and California, and what we all learned from our work in Oregon leading up to 1993, is this: Political advocates aside, no patient

or family member was asking for help along the lines of euthanasia or lethal injection. Patients and their families, instead, wanted access to oral medications that they could later ingest, with the guidance and support of their physicians. They not only wanted it, they were getting it, sometimes with the help of their physicians. Once we understood and accepted this fact, we were able to draft the Oregon Death with Dignity Act, a public policy breakthrough. This is the point I was stressing to Ellen Goodman (quoted above) four days before that fateful election 20 years ago. We had codified an existing covert practice and added a medical standard of care with clear boundaries.

First steps down a long path

Although voters passed the Death with Dignity Act in November 1994, a significant accomplishment in itself, our work was only beginning. There would be a succession of legal and political chal-

lenges initiated by our opponents that would all fail but help ensure our eventual success. First, before Oregon's new law could take effect, it was enjoined from operation by a federal district court, *Lee v. State*, 869 F. Supp. 1491 (D. Or. 1994). The law would not go into effect for another three years, until a reversal was obtained from the Ninth Circuit Court of Appeals. *Lee v. State of Oregon*, 107 F.3d 1382 (9th Cir. 1997). What has never been acknowledged is that the district court's injunction helped us. But for that injunction, the Oregon Death with Dignity Act would have taken effect 30 days after its passage. Or. Const. Art. IV § 4(d). Few, however, and certainly not the institutional stakeholders necessary to the law's eventual success, were ready so soon after the 1994 election to implement such a major policy reform. With the benefit of hindsight, the federal court injunction intended to forever prevent the law, instead preserved it for successful implementation three years later, in the fall of 1997.

Second, because our eventual success on appeal seemed highly likely in 1997, opponents had been lobbying the Oregon Legislature to repeal the new law. A direct legislative repeal was not possible, because Governor John Kitzhaber, M.D., said he would veto a repeal. Instead, the legislators referred a repeal measure, Ballot Measure 51, to the voters. Thus, in 1997, to preserve the Death with Dignity Act, we were now required to win both our appeal and a second statewide election. We won both. The Ninth Circuit Court of Appeals reversed the lower court and vacated its judgment, *Lee v. State of Oregon*, *supra*, 107 F.3d 1382, and, in October of 1997, the United States Supreme Court denied the government's petition for certiorari. *Lee v. Harclerod*, 522 U.S. 927, 118 S. Ct. 328, 139 L. Ed. 2d 254 (1997). The law was in effect. Soon thereafter, on November 4, 1997, Oregon voters defeated Measure 51 by a margin of 60 to 40 percent. The repeal effort had backfired.

MEDICAL VOCATIONAL PLANNING

LEGAL NURSE CONSULTANT

CERTIFIED REHAB COUNSELOR

CERTIFIED LIFE CARE PLANNER

ADDITIONAL SERVICES INCLUDE

- ◆ Medical / Legal Comprehensive Chart Review
- ◆ Expert Testimony
- ◆ Medical Research
- ◆ Locate Medical Experts
- ◆ Vocational Evaluation
- ◆ Loss of Earning Capacity
- ◆ Life Care Plans



Michele Nielsen

RN, MA, CCM, CRC, COHN-S, CPDM, CLCP

19363 Willamette Drive, #134

West Linn, OR 97068

Office—503-650-9327

Fax—503-655-6986

Cell—503-888-6358

Email—michele@medvocplan.com

www.medvocplan.com

Before the second election, opponents often criticized the narrow passage of the Death with Dignity Act in 1994 as evincing too little support for too controversial a subject, but the 1997 repeal effort changed all that. It produced a clear voter mandate — 60 percent of voters defeated the repeal of the Oregon Death with Dignity Act. Voter support had never been higher. Popular support was higher still. The second statewide election, like the district court's injunction, ensured the eventual success of Oregon's new law. The political controversy in Oregon had been settled, and, with the benefit of three more years of public discussion while the Death with Dignity Act was under injunction, all involved were not only better prepared, but much more willing to implement Oregon's new law.

Having won two statewide ballots (1994 and 1997) and the first round federal court litigation spanning 1995-1997, the Oregon Death with Dignity Act was for finally free of legal or political challenge. It was only the quiet before the storm, however. The third significant challenge was about to unfold in Congress, where members concerned about Oregon's new law, including then-Senator John Ashcroft, sent a letter in 1997 to the Director of the DEA, contending that the use of controlled substances to hasten a terminally ill patient's death was not a legitimate medical practice and therefore violated the Controlled Substances Act (CSA). That letter further invited the DEA to prosecute Oregon physicians and pharmacists who aided patients under Oregon's novel law. Although the director of the DEA, Thomas Constantine, responded favorably, Attorney General Janet Reno concluded that the DEA could not prosecute Oregon practitioners who acted in accordance with Oregon law, because the CSA did not authorize the DEA to "displace the states as the primary regulators of the medical profession, or to override a state's determination as to what constitutes le-

gitimate medical practice."¹ Soon thereafter, legislation was introduced in Congress to grant to the DEA the explicit authority that Reno found lacking. The Lethal Drug Abuse Prevention Act was introduced in 1998, followed by the Pain Relief Promotion Act in 1999. Ei-



ther Act would have enabled prosecutions of practitioners acting under Oregon's new law, but neither passed. The Death with Dignity Act survived yet another challenge, this time from Congress.

Fight not over

As fate would have it, a fourth challenge was looming. In 2001, Senator John Ashcroft was appointed United States Attorney General. Exercising his new role presiding over the DEA, Ashcroft sought an opinion from the U.S. Department of Justice, Office of Legal Counsel, on whether a prescription issued to hasten a death under the Oregon Death with Dignity Act was a valid prescription under the CSA and its implementing regulation. On June 27, 2001, the Office of Legal Counsel issued a memorandum concluding that "assisting in suicide is not a 'legitimate medical purpose' that would justify a physician's dispensing controlled substances consistent with the CSA." On November 6, 2001, Ashcroft released an Interpretive Rule, published in the Federal Register on November 9, 2001, that adopted the analysis of that memorandum and declared that "assisting suicide is not a 'le-

gitimate medical purpose' within the meaning of 21 CFR 1306.04 (2001) and that prescribing, dispensing, or administering federally controlled substances to assist suicide violates the CSA." 66 Fed Reg 56608 (2001). The Interpretive Rule further provided that the "Attorney General's conclusion applies regardless of whether state law authorizes or permits such conduct by practitioners or others and regardless of the condition of the person whose suicide is assisted."

In response, the State of Oregon, a physician and a pharmacist (my clients), and several terminally ill patients challenged the Interpretive Rule in federal court. The U.S. District Court for the District of Oregon, Honorable Robert E. Jones presiding, issued a temporary restraining order and then a permanent injunction preventing the attorney general from enforcing his Interpretive Rule. *Oregon v. Ashcroft*, 192 F Supp 2d 1077, 1084 (D Or 2002).

On May 26, 2004, the Ninth Circuit Court of Appeals affirmed the district court's analysis and judgment. *Oregon v. Ashcroft*, 368 F3d 1118 (2004). In holding the Interpretive Rule unlawful and unenforceable, the Ninth Circuit held that it, "violates the plain language of the CSA, contravenes Congress' express legislative intent, and oversteps the bounds of the Attorney General's statutory authority." *Id.* at 1120. The Ninth Circuit concluded:

In sum, the CSA was enacted to combat drug abuse. To the extent that it authorizes the federal government to make decisions regarding the practice of medicine, those decisions are delegated to the Secretary of Health and Human Services, not to the Attorney General. The Attorney General's unilateral attempt to regulate general medical practices historically entrusted to state lawmakers interferes with the democratic debate about physician assisted suicide and far exceeds the

See Death With Dignity p 42

scope of his authority under federal law. We therefore hold that the Ashcroft Directive [i.e., the Interpretive Rule] is invalid and may not be enforced. *Id.* at 1131.

Our fight was still not over. The battle continued on to the U.S. Supreme Court where the justices affirmed the Ninth Circuit:

The Government, in the end, maintains that the prescription requirement delegates to a single executive officer the power to effect a radical shift of authority from the States to the Federal Government to define general standards of medical practice in every locality. The text and structure of the CSA show that Congress did not have this far-reaching intent to alter the federal-state balance and the congressional role in maintaining it. *Gonzales v. Oregon*, 546 US 243, 275, 126 S Ct

904, 925, 163 L Ed 2d 748 (2006) (Kennedy, J).

Twelve years after passage of the Death with Dignity Act, the second round of federal court litigation had concluded. The legal controversy was settled. The opinion of the U.S. Supreme Court in 2006 was the last word, leaving no doubt that it was the state's proper role to regulate the practice of medicine, even when that practice allows a physician to prescribe a controlled substance to hasten a terminally ill patient's death. Proponents of the Oregon Death with Dignity Act had beaten back a fourth significant challenge.

Down a road of reform

With the benefit of hindsight, the campaign to pass and protect the Oregon Death with Dignity Act was a 14-year campaign, spanning 1993 through 2006. Newly freed of the need to defend the Oregon Death with Dignity Act, proponents immediately began work with

other states to bring about similar reforms. The most notable successes include the 2008 voter-approved Washington Death with Dignity Act, codified at RCW 70.245.010-70.245.904, and the 2013 Vermont Patient Choice at the End of Life Act, codified at 18 VSA §§ 5281-5291.

That work continues.

Eli Stutsman is a private practice lawyer specializing in appeals. He was a lead author of the Oregon Death with Dignity Act and served ten years as the founding President of the Death with Dignity National Center, www.deathwithdignity.org. His office is located at 621 SW Morrison St. Ste. 1300, Portland, OR 97205. Stutsman can be reached at 503-274-4048 or elistutsman@elistutsman.com.

¹ Letter from Janet Reno to Sen. Orrin Hatch on Oregon's Death with Dignity Act (June 5, 1998), reprinted in Hearings on S. 2151 before the Senate Committee on the Judiciary, 105th Cong., 2d Sess., 56 (1999).

STRUCTURED SETTLEMENTS
PROPRIETARY ATTORNEY FEE STRUCTURES
MEDICARE SET-ASIDES
TRUSTS
LIEN RESOLUTION

MILLENNIUM

SETTLEMENT CONSULTING



Audrey Kenney

208-631-7298

akenney@msettlements.com

www.msettlements.com