

**A CALL TO LEGALIZE PHYSICIAN ASSISTANCE IN
DYING FOR THE TERMINALLY ILL: LESSONS FROM
THE OREGON EXPERIENCE**

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A CALL TO LEGALIZE PHYSICIAN ASSISTANCE IN DYING FOR THE TERMINALLY ILL: LESSONS FROM THE OREGON EXPERIENCE

Almost everyone has some familiarity with the debates over the last couple of decades about whether we should legalize assistance in dying, in particular, whether we should allow physicians to prescribe medications for terminally ill patients, which these patients can then use to end their lives. Currently, Oregon has a statute (the Oregon Death with Dignity Act, or ODWDA; see Appendix for the full text) that authorizes physician assistance in dying, but attempts in other states to enact similar legislation have failed, although usually by narrow margins. Advocates on both sides of this issue continue to be active, and the debate over this important issue shows no signs of fading away.

Using basic norms that nearly everyone accepts (what is sometimes referred to as “common morality”), this paper maintains that physician assistance in dying is morally permissible in certain situations. Specifically, as argued below, it is permissible when a competent, terminally ill patient makes an informed and voluntary request for such assistance, after consultation with a physician and after considering other options.

Establishing that an action is morally permissible also provides a good reason for concluding that it should be legal as well. But it does not provide a conclusive reason. We sometimes prohibit actions even when we recognize that in certain circumstances they may be morally acceptable because we are concerned about the consequences that would follow from removing legal prohibitions. For example, in most cases there is no morally significant difference between a person who is twenty years old drinking alcohol and a person who is twenty-one performing the same action. Nonetheless, most of us believe there should be some minimum age established for consumption of alcoholic beverages

because of the harmful consequences that would result from eliminating age-based restrictions.

One of the principal arguments against legalizing assistance in dying is that legalization will have too many harmful consequences. Opponents of legalization contend the practice will be impossible to regulate effectively. Persons who really want to live will be put to death. Moreover, some maintain that the quality of health care of dying patients will decline, as there will be an incentive to push them into “choosing” death.

One benefit of Oregon’s decade-long experience under the ODWDA is that it has provided us with data to help determine whether these fears are justified. They are not. Indeed, there is substantial empirical evidence that legalization of assistance in dying pursuant to a statute similar to Oregon’s law poses no significant threat of undesirable consequences. In fact, the evidence from Oregon’s experience in the past decade should dispel many of the misconceptions about legal assistance in dying, such as the belief that following legalization many persons will be pressured into requesting assistance in dying, that the “vulnerable” (usually defined as women, racial minorities, the poor, and the disabled) will be especially susceptible to pressure, and that the quality of health care, especially palliative care (that is, care that seeks to relieve pain and suffering), will decrease, because the emphasis will be on “killing” patients rather than easing their suffering. The record in Oregon establishes there has been no documented case of any person being forced to request assistance, the overwhelming majority of those requesting assistance are white, well-educated and financially secure, their gender reflects that of the general population, and the quality of palliative care has actually improved in Oregon since adoption of the ODWDA. Accordingly, provided physicians and their patients

comply with certain regulatory safeguards, concern about harmful consequences does not justify maintaining a ban on assistance in dying for the terminally ill.

However, opposition to legalizing assistance in dying is not just based on unfounded fears of harmful consequences. Opposition is also based on the view that assistance in dying violates the principle that we must always respect the sanctity of life, and the law must never permit conduct that is so seriously immoral. Because the sanctity-of-life principle is often advanced in the context of a religious argument, and religious arguments are not susceptible to resolution in democratic debate, some may question whether opposition to legalizing assistance in dying can ever be overcome. But scholarly defenders of the sanctity-of-life principle characterize this principle as based on secular considerations. They recognize that to be taken seriously in a public policy debate, one cannot simply claim that “my religion says this is wrong.” In the last section of this paper, we will examine the secular foundations for the sanctity-of-life argument and consider whether it provides a sound reason for opposing legalization of assistance in dying.

This paper is organized as follows: First, there will be a brief discussion of terminology. Next, the paper will provide an argument in favor of legalization, which will show both that physician assistance in dying for the terminally ill is morally permissible and that a lawful, open practice is more likely to benefit terminally ill patients than continuing a ban on such assistance. The paper will then consider the argument that legalization will produce too many harmful consequences, in particular, that the law will be abused and patients will be pressured into dying. Finally, we will examine the argument against legalization based on the sanctity of life. We will show that this

argument cannot be used as a basis for opposing assistance in dying, at least not without enmeshing the proponent of the sanctity of life in unacceptable inconsistencies. One cannot oppose assistance in dying on the basis of the sanctity of life without also opposing the refusal of life-saving treatment by competent patients.

Terminology

Before proceeding to this paper's argument, a word about terminology. This paper uses the phrase "assistance in dying" rather than "assisted suicide." Use of this phrase does not stem from any squeamishness about suicide or a desire to gain a polemical advantage through use of euphemisms. Instead, this terminology reflects both a desire for accuracy and an invitation to opponents of assistance in dying (or if they prefer, assisted suicide) to discuss the real issues, instead of offering arguments that score empty victories through redefinitions.

For example, Neil Gorsuch (recently appointed to the federal appellate judiciary by President Bush) has authored a book against legalizing assistance in dying. Although the book does contain some arguments that merit consideration, Gorsuch's principal argument can be summarized as follows: 1) Intentional killing of another human is always wrong; 2) Assisted suicide involves the intentional killing of another human; 3) What takes place in Oregon under the ODWDA is assisted suicide because the doctor intends to kill the patient; Therefore, the ODWDA should be repealed and no state should permit assistance in dying (2006, pp. 157–66).

This argument has at least two questionable premises, namely the first and the third. This paper will deal with the first at length below, but the third simply ignores the

reality of what takes place under the ODWDA. Under the ODWDA, not only must the patient be terminally ill before requesting a prescription for a lethal dose of medication from his physician, but the patient maintains control of the process throughout and decides when, *if at all*, he will ingest the medication. Fully one-third of the patients who seek a prescription under the ODWDA *never* take the drug; others ingest the drug months after it is prescribed. To claim, in the face of these facts that the prescribing physician always intentionally kills the patient distorts the reality of the practice in Oregon. What the physician intends to do is to ease the patient's suffering and anxiety by providing the patient with some measure of control over the timing of his death. Accordingly, use of the term "assisted suicide" can be misleading to describe the practice in Oregon.

Enough of preliminaries. Let us turn now to consider the reasons why assistance in dying is both morally permissible and provides an important benefit to some patients.

The Importance of Assistance in Dying for the Terminally Ill

As indicated, this paper will provide an argument in favor of legalizing physician assistance in dying that is based, in part, on "common morality." By "common morality" this paper means those moral norms that virtually everyone accepts. Our moral disagreements tend to hide the fact that there is substantial agreement in our culture about core moral norms. It could not be otherwise if in fact we are to live together successfully. In our day-to-day dealings with each other, we accept certain behaviors as given. We assume most people will not steal from us, will not maim us, will not break their promises to us, will not kill us, etc. Society would collapse if we could not rely on others

to conduct themselves appropriately *most* of the time. And almost all of us are in agreement about what is appropriate conduct on most occasions.

This paper maintains that specialized study in ethics is not required to understand the argument for physician assistance in dying. To the contrary, physician assistance in dying can be morally justified by reflecting upon some commonly accepted moral norms, in conjunction with some commonly accepted factual beliefs. Consideration of these norms and facts will show that we have an obligation to respect a person's decision regarding matters that are important for that person, provided the decision does not place others at undue risk. We will then contend that deciding whether to continue living is an important choice and laws prohibiting assistance in dying interfere with that choice.

To begin, we can presumably agree that people have an interest in making decisions for themselves. We can call this the interest in "self-determination" or the interest in "autonomy."

Second, self-determination appears to be both valued and valuable. In other words, most people prefer to make their own decisions, especially on important issues, so that their lives reflect their beliefs, values, and objectives. For example, at least in current culture, no one wants to be forced to marry someone else. As a society, we also regard self-determination as objectively valuable. We want persons to have the ability to give direction to, and find fulfillment in, their own lives. We believe that liberty and the pursuit of happiness are to be treasured and protected. Many of our laws and policies encourage individuals to take responsibility for their own lives. To cite just one example from a relevant health care context, the federal Patient Self-Determination Act

encourages individuals to specify the care they want in end-of-life situations by completing advance directives.

Third, everyone in a community has to accept some limitations on their actions when their actions affect others adversely, including when their actions affect the autonomy of others. You may like to listen to country music at 2:00 AM, but I do not want to listen to your music at that hour, maybe because I need to go to work in a few hours or maybe because I simply do not care to have your musical tastes imposed on me. Accordingly, you have an obligation to turn down your music or wear earphones.

Fourth, some decisions are more important than others because of the centrality of these decisions to a person's life. Despite the amount of attention this issue attracts in popular culture, deciding between boxers and briefs is a fairly trivial choice; deciding whether to have a child is not. Although there may be no clear line between critical life choices and other choices, it seems plausible to maintain that choosing a spouse, deciding whether to have a child, and deciding what career to pursue are all appropriately characterized as critical life choices. All these choices help define the identity of a person and will have tremendously significant consequences for the shape and direction of a person's life. If I am prevented from marrying the person of my choice, I have been deprived of a whole range of possibilities and I am compelled to relinquish one of the central projects of my life.

Fifth, all other things being equal, the more important a choice is for someone, the stronger the justification needed for prohibiting that person from making that choice.

Note: prohibition of a critical life choice does not mean ascertaining whether someone is competent to make a judgment or providing that person with relevant information that we

may suspect he has overlooked. Prohibition of a critical life choice means prohibiting that person from making the choice even when we are assured he is competent to make a decision of that nature.

We can conclude from this series of premises that preventing someone from making a critical life choice results in a severe infringement of that person's autonomy and requires a compelling justification. It is not impossible to justify denying someone the right to have a child, but it would require something akin to a grave and imminent danger of serious harm to others.

These observations and judgments should be fairly noncontroversial. Most individuals in the United States, indeed, most individuals in Western democracies would agree with these observations and judgments. There are certain liberties so fundamental that they can be denied only under extraordinary circumstances. As the Supreme Court observed in *Planned Parenthood v. Casey*, 505 U.S. 833, 851 (1992), fundamental liberty interests are those matters involving "the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy." Among such choices are decisions about bearing or begetting a child and about the choice of a spouse.

Fine, you may say, but what does this have to do with assistance in dying?

The answer is this: *There can be no more intimate, self-defining decision for a person than the decision whether to continue living.* If the degree to which someone's autonomy is violated is a function of the extent to which a person is forced to reorder her life, to redefine herself, then it is no exaggeration to state that a person forced to remain alive against her will has been totally deprived of her autonomy. When a person who is

competent to make decisions for herself has reached the conclusion that her life is, on balance, too painful, too degrading, too restricted to be worth living, then *for her* there are no activities worth pursuing given the conditions in which she finds herself. To force her to continue living is to condemn her to an existence that has lost any value. If a person in such circumstances longs to die, but is prevented from doing so, she can no longer make any autonomous choice because her entire existence is compelled. As the legal philosopher Joseph Raz has observed, a “person whose every decision is extracted from him by coercion is not an autonomous person” (1986, p. 373).

But is a person who has been denied *assistance* in dying truly compelled to live? Cannot a person who is truly miserable put an end to his misery without any assistance?

In his classic, 1958 article against the legalization of assisted dying, legal scholar Yale Kamisar argued, among other points, that the extent which laws against assisted dying infringe on liberty and autonomy interests had been overstated. Prohibitions on assisted suicide, after all, are directed against the person providing assistance, not the person who received the assistance. There are no longer any criminal penalties for suicide or attempted suicide, so, superficially, any person’s interest in escaping a life he finds unacceptable could be accommodated by a simple policy of non-interference in suicides. As Kamisar put it:

Finally, taking those who may have such a desire [to die], again I must register a strong note of skepticism that many cannot do the job themselves . . . [A] laissez-faire approach in such matter [may be preferable to] an approach aided and sanctioned by the state (1958, p. 1011).

Kamisar's contention has some merit if one focuses only on the physically robust. Indeed, offering assistance to those truly capable of doing "the job themselves" may improperly circumvent an important psychological barrier to hasty, ill-considered suicides—leaving aside any moral problems that may be raised by the offer of such assistance. Generally speaking, if a healthy, able-bodied person is too ambivalent to kill himself without assistance, suicide is for him, almost surely the wrong decision. There is no need to debate here whether an act of suicide by a physically healthy individual is ever rationally defensible and morally justifiable. There probably are such circumstances. For example, consider a captured spy who might under torture reveal secrets that would endanger national security. But everyone recognizes that most suicides by physically healthy individuals are the result of either temporary or permanent emotional or mental instability. Such suicides are almost always tragedies that should be avoided, if at all possible. For healthy individuals contemplating suicide, no offer of assistance is needed or morally appropriate.

However, it is important to bear in mind that the topic of our discussion is *physician* assistance in dying for the *terminally ill*. Let us first consider the importance of terminal illness. Ending one's life without assistance is an option only for those with access to the proper means and the physical strength to use them. One crucial fact seldom acknowledged by the opponents of assistance in dying is that the State and its licensed agents control access to medications that are efficient in bringing about a peaceful death. You cannot obtain a barbiturate on your own. You need to have a physician prescribe it and a pharmacist dispense it. Because the State maintains control of the dispensation of lethal medications, a person must have access to firearms, knives, ropes or other means of

death *and* possess the ability to use these means effectively if he is to kill himself without assistance. In the last stages of a terminal illness “the patient is likely to lack the capacity to commit suicide on his own” (Posner 1995, p. 238). Many of the terminally ill are physically frail and confined to a bed or wheelchair. For someone in such a situation, being denied assistance effectively results in that person being kept alive against his will. One reason why the terminally ill have such a strong liberty interest in assistance in dying is because they need assistance to hasten their deaths, should they choose to do so. In contrast, the overwhelming majority of those who are not terminally ill require no assistance to end their lives.

Of course, not only does the fact that someone is terminally ill distinguish his situation from the healthy suicide in terms of their respective access to the means of bringing about death, but a person’s terminal illness also provides us some assurance that his request for assistance in dying is not the product of some hasty, irrational decision. Unlike the typical healthy suicide who is overreacting to some temporary setback—perhaps more imagined than real—a person who is dying is confronted with an objectively verifiable condition which will bring about his death in a relatively short time. (Under Medicare regulations and the ODWDA, a terminally ill person is someone who is expected to die within six months.) The statistics collected in Oregon confirm that all those who have sought assistance have been in the terminal stages of cancer, amyotrophic lateral sclerosis, AIDS or some other terminal, distressing condition. These are not volatile individuals reacting to serious but passing problems, such as dismissal from a job, rejection by a lover, or taunting from schoolmates. They do not seek the means to cut short a potentially long and rewarding life, but rather the means of hastening an

inevitable death if and when their condition becomes truly unbearable. Simply put, their choice is between dying peacefully now or dying after pointless suffering within a few more weeks.

Perhaps not unexpectedly, some of those who oppose assistance in dying have tried to use the short period of time the terminally ill have left as a basis for dismissing the importance of assistance in dying. Essentially, the argument is, “What’s the big deal? They’ll be dead soon anyway.” This attitude has been exhibited from Yale Kamisar’s article decades ago to Gorsuch’s recent brief against assistance in dying. Kamisar asked “why is allowing some cancer victim to suffer a little longer too great a price to pay for the ‘sanctity of life’” (1958, p. 977) and Gorsuch has suggested that requesting assistance in dying is “more of a lifestyle choice” (2006, p. 222). A “lifestyle choice”? Like taking up golf?

This condescending dismissal of the plight of the terminally ill is insensitive, to say the least. But the callousness of some opponents is not the issue. The relevant point is that even though the suffering endured by the terminally ill may not last years, it is avoidable suffering nonetheless—and it can be quite severe. For some of the terminally ill, the last few weeks is a period that will be devoid of even the simplest pleasures, with a loss of functional capacity, possibly unremitting pain, and long hours of the consciousness of the hopelessness of their condition. Unless we permit the terminally ill the option of hastening their deaths, we are imprisoning them in a condition many of us would find intolerable. The option of requesting assistance in dying is a critically important option, and it should not be denied absent a compelling justification.

Some may question my claim that the terminally ill cannot “do the job themselves,” provided they act quickly. Granted, not everyone who has just been diagnosed with a terminal illness will lack the vigor necessary to end his life through violent means. But presumably we want the terminally ill both to live as long as possible *and* to consult with their physicians before reaching a decision about whether to hasten their death. These last two points are critical and are often overlooked in the debate over assistance in dying.

A ban on assistance in dying pushes the terminally ill to end their lives while they are still able, without discussing their plans with anyone, resulting in many precipitous or unnecessary suicides (as well as botched attempts, which simply lead to more suffering). Not only might some bring about their deaths while they have months left to live, but also others may kill themselves who, had they been able to wait to determine whether they wanted assistance in dying, would not have found their lives unbearable. In other words, assuming we desire a regulatory scheme that encourages persons to live as long as they find their lives worthwhile, a policy of permitting physician assistance in dying for the terminally ill is much more likely to accomplish this objective than banning assistance in dying. As Judge Richard Posner has perceptively stated:

If the only choice is suicide now and suffering later, individuals will frequently choose suicide now. If the choice is suicide now or suicide at no greater cost later, they will choose suicide later because there is always a chance that they are mistaken in believing that continued life will impose unbearable suffering or incapacity on them. . . . The possibility of physician-assisted suicide enables them to wait until they have more information before deciding whether to live or die (1995, pp. 247–28).

Let us now consider the significance of the physician's role, and why it is important not just to allow assistance in dying, but to authorize *physician* assistance in dying. The role of a treating physician is crucial in the context of end-of-life care. Legalizing physician assistance in dying allows the terminally ill to consult openly and candidly with their doctors, discussing all aspects of their condition and treatment with a knowledgeable and—one would hope—caring expert. By encouraging a frank exploration of options, a patient will be able to make an informed decision and may be persuaded to hold on longer, secure in the knowledge that he can obtain assistance when needed. Sensitive physicians will use the full extent of their training and experience in assessing the patient's condition and the prospects for effective palliative care. In consultation with the patient, they can evaluate what alternatives might be feasible and acceptable. And, of course, the physician's expertise is important for determining whether the patient is competent to make a decision concerning the course of treatment.

All these considerations suggest that physician-provided assistance in dying increases the likelihood that patients' decisions will be informed and deliberate as opposed to uninformed and hasty. Moreover, the availability of such assistance will prompt many to live longer than they would have otherwise.

The claim that legal physician assistance in dying will encourage many to live longer, and some to forego hastening their death altogether, is not mere speculation. Oregon's experience confirms this. Although about 15 in 100 dying Oregonians seriously consider hastening their deaths, and although many of these discuss this option with their physicians, only about 1 in 100 decide to request assistance, only about 1 in 600 actually receive a prescription from their physician, and only about 1 in 800 use the

prescribed medication to hasten their deaths (Oregon Department of Human Services 2006, pp. 4–5; Tolle et al. 2004, pp. 111–18; Ganzini et al. 2000, pp. 557–63).

Knowledge that escape is always available diminishes the felt need to end one’s life and frank consultation with physicians can allow for a thorough consideration of other options, including alternative symptom management and hospice care.

Legalizing physician assistance in dying for the terminally ill shows both compassion and respect for their desire to make critical decisions about their own lives, whereas denying them the possibility of this assistance compels them to live in suffering. Moreover, lawful physician assistance in dying brings added benefits, including reducing the number of premature suicides. Therefore, we can conclude—at least tentatively—that physician assistance in dying is both morally permissible and that a complete legal ban on such assistance is unjustified. We should allow the terminally ill to have some measure of control over the timing of their deaths, absent weighty, countervailing considerations.

Of course, respect for autonomy is not a trump. Respect for self-determination always must be balanced against the harm that may result from allowing persons the freedom to choose. We all recognize that it is both legally advisable and morally permissible, if not obligatory, to restrict the actions of some individuals if these actions pose a significant threat of harm to others. On some occasions, these restrictions may even require significant infringements on personal freedom, as when we quarantine individuals who have a highly infectious, potentially fatal disease. Opponents of legalization maintain that many patients will be coerced or manipulated into requesting assistance and the quality of health care for the terminally ill will deteriorate. It is time

now to consider in more detail the experience under Oregon's statute and how that experience refutes the argument that legal assistance in dying will unduly endanger many patients. This paper will also briefly address the contention that banning assistance in dying is somehow necessary to protect patients from the consequences of mistaken diagnoses.

The Experience in Oregon: Individual Choice and Effective Prevention of Abuse

Those who oppose legal assistance in dying continually invoke Dr. Jack Kevorkian as the poster child for assistance in dying. On the very first page of Gorsuch's manifesto against assistance in dying, he refers to Kevorkian and discusses his history at some length. In a throwaway line, Gorsuch then states that "Dr. Kevorkian hardly stands alone" as a proponent of assisted suicide (2006, p.1). True, there are many other individuals, including many responsible physicians, such as Dr. Timothy Quill, and nonprofit organizations, such as Compassion and Choices, who advocate legalization of assistance in dying, which is why it is misleading for Gorsuch and other opponents to use Kevorkian as an example of how legal assistance in dying would operate. Kevorkian's methods are *not* endorsed by any noted ethicist or responsible advocate of assistance in dying. The reality is that Kevorkian's methods illustrate what happens when we maintain a legal ban on assistance in dying, not what would happen if we made physician assistance in dying lawful.

Let us discuss how Kevorkian proceeded. We will then discuss in some detail the process in Oregon, where assistance in dying is legal. Kevorkian, who by training is a pathologist, was not the treating physician for any of the patients he assisted to die. In

many cases, he hardly knew them and had little knowledge of their personal or medical history. The very first person he assisted, Janet Adkins, exemplifies some of the problems in his approach. Adkins, who had Alzheimer's disease, contacted Kevorkian by phone and then flew to Michigan to meet him. After some brief discussions with Adkins over a weekend, Kevorkian hooked Adkins up to his notorious suicide-machine-in-a-van. She pressed a button and was soon dead. Kevorkian had not bothered to take her medical history, conduct a psychiatric examination (which he would not have been qualified to conduct anyway), or contact Adkins's primary physician (Belkin 1990; see also Kevorkian 1991, pp. 221–31). He was not in a position to judge whether Adkins was even competent to make a request for assistance in dying. His “hurry-up-and-get-it-over-with” approach illustrates all that is wrong with assistance in dying—when it is done covertly and illegally.

That's just it. Kevorkian operated in an environment where assistance in dying was not legal. Kevorkian did not act ethically, but it is inappropriate to judge him too harshly. It is even more inappropriate to judge harshly those who sought his assistance. Kevorkian was the only available option for these individuals. Patients who were very concerned about the suffering and indignities they might have to endure in the future could not legally obtain assistance from their regular physicians, so they turned to Kevorkian.

Kevorkian at least was willing to provide his services openly (if not brazenly). Assistance in dying, indeed outright euthanasia, is practiced covertly everyday in the United States. Surveys indicate that numerous physicians have acceded to their patients' requests for assistance in dying (Emanuel 1996). One can only hope that they have better

knowledge of their patients' conditions and circumstances than Kevorkian had, but even a very conscientious physician is apt to act hurriedly in such a situation knowing that she can be prosecuted for assisted suicide or murder if her actions are discovered.

That is why the Oregon practice is so illuminating. It demonstrates that if assistance in dying is made legal it can be provided with the assurance that the patient is competent to request assistance and that all other available options have been thoroughly explored.

The ODWDA permits physicians to provide patients with assistance in dying only if a number of procedural requirements are satisfied (Oregon Department of Human Services 2006; see also Oregon Rev. Stat., secs. 127.800–995). (The Appendix to this paper has the complete text of the statute.) Eligibility for assistance in dying is limited to patients who have received a diagnosis from their attending physician that they have a terminal illness that will cause their death within six months. Patients must manifest a durable, verifiable desire for assistance: The patient must make two oral requests for assistance, separated by at least fifteen days, and one written request, signed in the presence of two witnesses. Moreover, physicians are required to inform the patient of alternatives to a hastened death, such as comfort care, hospice care, and enhanced pain control. There are various other safeguards to ensure that the patient's request is informed and truly voluntary, including a confirming diagnosis by a second physician. A patient must be referred to counseling if either the prescribing or the consulting physician believes he might be suffering from a psychological disorder that can cause impaired judgment. The patient need not fill the prescription he receives from his physician, nor must he take the medication once he fills the prescription. The patient maintains control

of the process throughout. The patient must ingest the prescribed drug; the physician may not administer it. Furthermore, physicians must maintain detailed records of the process leading to the prescription and these records are shared with the Oregon Department of Human Services. These records provide the basis for an annual, public report that describes in detail the number of patients receiving assistance, the number of patients using the prescribed medication, their medical condition and various other relevant data.

These records are important for assessing the dangers posed by legalization of assistance in dying. Prior to legalization, opponents of legal assistance in dying predicted thousands would seek assistance each year and physicians would place their patients on a fast track to death, many patients would be coerced into requesting assistance, and the poor, women, and minorities would be disproportionately represented among those who were coerced. Not one of these predictions proved accurate.

Since the inception of the ODWDA a decade ago, approximately 500 patients have received a prescription for medication that would assist them to die and about 300 patients have actually ingested the lethal dose of medication that was prescribed for them (Oregon Department of Human Services 2007; Oregon Department of Human Services 2006). There is no evidence that anyone who has requested assistance under the ODWDA did not have a terminal condition. There is no convincing evidence that any patient has been coerced into requesting assistance in dying. About 97 percent of those who ingested the medication have been white, and about half male. Overall, patients are well-educated; 41 percent had a college degree or higher, far in excess of the percentage of those with higher education in the general population. Only three of the patients, or

about 1 percent, were uninsured and only seven, or about 2 percent, mentioned financial concerns as a motivation for seeking assistance in dying.

In addition, there is substantial evidence that the quality of palliative care has actually improved in Oregon since implementation of the ODWDA. Again, these results are directly contrary to the dire predictions of opponents of legal assistance in dying, who argued that physicians and other healthcare workers would expend little effort to alleviate the symptoms of the terminally ill because these patients could just go ahead and die. The reality is that in a state where assistance in dying is legal, physicians and other healthcare workers are motivated to spend more time with patients in discussions about end-of-life choices, carefully exploring options and arranging for palliative care as an alternative to hastening death. Few treating physicians want their patients to choose hastened death as the first option. It is striking that fully 86 percent of the patients who have availed themselves of assistance in dying under the ODWDA were enrolled in hospice, usually considered the gold standard for palliative care (Oregon Department of Human Services 2007).

Oregon demonstrates that the problems associated with a Kevorkian-style approach to assistance in dying, such as hurried decisions, little interaction between patient and physician, no meaningful consideration of alternatives such as palliative care, no assurance of the patient's competency or the strength of his desire to hasten death, are products of a ban on assistance in dying, *not* of legalizing assistance in dying. If we really want to eliminate Jack Kevorkian's "practice," then let's make assistance in dying legal.

A determined opponent of legal assistance in dying may argue at this point that even if the experience in Oregon has shown that the worst feared harms and abuses have not materialized so far, there is no guarantee that they will not materialize in the future. Moreover, there is no guarantee that these abuses would not materialize in other jurisdictions were they to legalize assistance in dying.

These observations are technically correct. The past does not guarantee the future, and conditions in other states may be materially different from the conditions in Oregon. In addition, any objective observer must acknowledge the likelihood that at some point there will be at least one patient whose decision to request assistance in dying will have been the product of manipulation or coercion, by relatives, healthcare workers, or others. No regulatory system is perfect. Although one or two cases of manipulation or coercion may not be decisive evidence against the benefits of legalization, if there were dozens of cases of coerced choices for every hundred or so cases of requests for assistance in dying, one would have to possess an impaired moral compass not to question the wisdom of legalizing assistance in dying. Accordingly, we need to consider how to assess the risks of abuse and how these risks might be balanced against the benefits derived from legalization.

However, before addressing the issue of abuse and harm to others, we will address briefly the “mistake” argument against legalization, namely that some patients will receive a mistaken diagnosis and even though their request for assistance may be truly voluntary, they will die for no reason.

Mistaken Diagnoses

A mistaken diagnosis is a possibility, but the probability of this is negligible. As indicated, there is no evidence that anyone in Oregon has received a mistaken diagnosis. Bear in mind that the diagnosis must be confirmed by two physicians.

Granted, there is some evidence that a few patients who were diagnosed as terminally ill and eligible to receive assistance—that is, their deaths were projected to occur within six months—lived significantly longer than expected. In one case, a patient who requested assistance in dying lived for over two and one-half years after being diagnosed as terminally ill (Oregon Department of Human Services 2006, p. 24). Predicting when someone will die is far from an exact science.

However, the unavoidable uncertainty about precisely when someone's death will actually occur does not provide a substantial reason against legalization. Recall that the patient remains in control of when to ingest the lethal medication. If the patient does not decline as rapidly as her physician predicted, the patient can simply put off taking the medication.

More importantly, the contention that the possibility of a mistaken diagnosis requires us to ban assistance in dying is an argument for a paternalism that is inconsistent with the discretion we have to make other choices. Any important choice carries with it some risk, including, for some choices, the risk of death or serious injury. Consider the risks attendant on choosing a spouse. Our divorce rates demonstrate that “mistakes” are made frequently. Moreover a mistaken choice of spouse or other intimate partner exposes a person to the risk of serious physical injury, not just emotional harm or financial ruin. Leaving aside the numerous cases of battering by spouses or partners, a mistaken choice

of spouse or partner can be fatal. Roughly ten percent of all murders annually (about 1,400 murders) are committed by spouses, ex-spouses or other intimates (Federal Bureau of Investigation 2006, table 9; Rennison and Welchans 2000). How many lives would be saved if we abridged the freedom to marry or enter into a relationship and insisted that prospective spouses and partners submit to a complete background check, psychological evaluation, and financial assessment and also provided the State with a veto power over any proposed marriage or other intimate relationship? Presumably, we would save many from death and injury, but no one would accept such an intrusion on a decision that is so significant and personal.

More to the point, consider the latitude we allow patients with respect to decisions about refusing medical treatment. Competent patients have virtually an absolute right to decline treatment. Their decisions, of course, are supposed to be informed by a physician's assessment, but whether they are so informed or not, the patient decides what treatment, if any, to receive. Mistaken decisions are made, sometimes with fatal consequences.

Of course, we should adopt reasonable measures to reduce the risk to patients of mistaken diagnoses, but the possibility of a mistake is not an argument against assistance in dying, provided we allow competent patients to evaluate these risks and make their own decisions. Depriving everyone of a right to make a choice because some may make a mistake when they choose makes no more sense in the context of requesting assistance in dying than it does in the context of refusing medical treatment, decisions about marriage, or in any other significant decision in life. No set of regulations, no matter how rigorous, can altogether guarantee that medical mistakes will not be made. But we should not deny

patients the right to make critical choices about their care merely because the information on which they base their decision may be incorrect.

The Risks of Abuse

Allowing individuals to incur risks that affect only themselves is one thing, of course, and allowing them to make choices that expose others to risks is something else entirely. We do not allow individuals to engage in target practice in public parks, however convenient such a location may be for them, and we stringently regulate the amount of alcohol someone can have in their bloodstream while operating a motor vehicle not because of the harm they might do to themselves but because of the harm they may cause others. An intolerable risk of harm to those who do not want assistance in dying is a legitimate objection to legalization if in fact the level of risk is unacceptable compared with the benefits obtained through legalization. The principal harm in question is being coerced or manipulated into making a request for assistance and/or being coerced or manipulated into ingesting the lethal medication once it has been obtained. In other words, it is a risk of death that is not truly voluntary.

How does one balance the benefits to be gained from legalization of assistance in dying against the risks to some resulting from the possible abuses of the practice? Although a strict utilitarian may disagree, there is no reliable way to make precise interpersonal comparisons between benefits and harms. The principal problem, of course, is assigning an exact “value” to these benefits and harms. We have no way of assigning a dollar value to the importance of self-determination, and although dollar values are assigned to lives in wrongful death litigation (usually someone’s earning power

multiplied by years remaining of active life, plus some indeterminate amount of money to compensate others for emotional damages, etc.), that sort of calculation seems ill-suited to this context. Among other things, it may well understate the value of the life of someone who is terminally ill.

Another problem in connection with evaluating benefits and harms in this context is deciding what counts as impermissible coercion or manipulation, which obviously are vague characterizations. Is it manipulation if a spouse says, “Gee, dear, you seem to be in a lot of pain, perhaps you should discuss you options with Dr. Smith”?

In any event, even if we were to agree on what constitutes manipulation or coercion and what constitutes a manipulated or coerced death, what percentage of requests have to be coerced or manipulated before we can justify a ban on assistance in dying? Some adamant supporters of individual autonomy might maintain that only a one-to-one ratio of coerced requests to voluntary deaths might justify a ban; on the other hand, rigid opponents of assistance in dying would argue that even one instance of a coerced request is one too many. Both positions are extreme and insupportable. If we believe that we can abridge an individual’s freedom to protect others from serious harm (and this appears to be one of our commonly accepted moral norms), then if a substantial number of requests for assistance in dying are coerced or manipulated, this would argue against legalization. What constitutes a “substantial number” probably cannot be determined in advance of evidence that abuse is not limited to an isolated occasion or two, but a ratio of ten to fifteen coerced requests to every one hundred truly voluntary requests may constitute an unacceptable ratio. Fortunately, given the record from Oregon

we do not have to determine definitively—at least at this stage—how many abuses are “too many.”

Because it is difficult to draw a definitive line between a tolerable and an intolerable percentage of coerced and manipulated requests, some might argue that we cannot decide what policy we should have on assistance in dying based on the consequences of the policy. This view just plays into the hands of extremists on both sides. (“I have an absolute right to assistance in dying” versus “Assisted suicide is always wrong.”) Moreover, it is a view derived from faulty reasoning. Simply because we do not know exactly where to draw a line does not mean that most situations do not clearly fall on one side of the line.

In thinking about the tolerable level of abuses from legalizing assistance in dying, it is helpful to bear in mind two things: One, a ban on legal assistance will not eliminate abuses. Some individuals will still receive assistance in dying from physicians and they will do so under circumstances where it is difficult to confirm whether their choice is truly voluntary. Indeed, if the Kevorkian example suggests anything, it suggests there may be more abuses if the ban on assistance in dying is maintained. Two, for almost any type of choice there is always the risk that some will be harmed as a consequence of allowing individuals to make the choice instead of having the State make the choice for them. In determining what percentage of coerced or manipulated requests from physician assistance in dying is tolerable, we should put this practice in context. In other words, we should consider what level of harm to others we are willing to accept when we allow individuals to make decisions on other issues.

To reply that assistance in dying is different because here a coerced or manipulated choice results in death displays an ignorance of the consequences of some of our policies. Indeed, even with respect to relatively unimportant choices, such as the speed at which we allow individuals to drive, we tolerate a large number of deaths and other serious harms for benefits that are not very significant. Studies have shown that mandating (and enforcing) a nationwide speed limit of fifty-five miles per hour on all highways would save over 6,000 lives annually and tens of billions of dollars in healthcare costs (Phillips 1995). Yet we have decided that these serious harms are tolerable so individuals in some locales can have the freedom to drive seventy miles an hour and arrive a few minutes earlier at their destination

Moreover, allowing individuals the freedom to make critical life choices comparable in their significance to the decision to request assistance in dying, such as the decision to bear or beget children, *does* result in avoidable deaths and other serious harms.

For example, it turns out that if we established clear limits on who could bear children (and with implantable contraceptives this is a very feasible goal), we could save many children from death and disability. Here are the facts: Child abuse, up to and including murder of children by their parents, is a very serious problem in this country. The most comprehensive study to date on this problem determined that approximately 1,500 children die annually as the result of abuse or neglect by their parents (U.S. Department of Health and Human Services 1996, p. 3–12). Some experts believe the numbers of deaths are significantly underreported and that at least 2,000, and perhaps as many as 5,000 children die annually as the result of abuse and neglect (U.S. Department

of Health and Human Services 1995, pp. 9, 18–19). Moreover, in addition to fatalities, approximately 18,000 children per year are permanently disabled by abuse or neglect. In fact, “a staggering 9.5 to 28 percent of all disabled persons in the United States may have been made so by child abuse and neglect” (p. 17). These disabled children suffer tremendous disadvantages in life, and, of course, part of the cost of helping them overcome their disabilities is borne by the community as a whole.

Although persons of all social classes abuse and kill their children, there is a very significant, undeniable correlation between family income and child abuse. Poor couples abuse their children far more often than middle-class or upper-class couples. Government studies have demonstrated that “higher incidence rates [of abuse] were directly associated with lower income levels, and all differences among the income groups were statistically significant” (U.S. Department of Health and Human Services 1996, p. 5–4). “Children in families with annual incomes lower than \$15,000 [in 1993 dollars] had the highest rate of abuse” with their rate being “more than two and one-quarter times the rate for children in families with annual incomes of \$15,000 to 29,000 . . . and nearly 14 times the rate for children in families with annual incomes of \$30,000 or more.”

One conclusion from this impressive body of empirical evidence is inescapable: if the State were to prohibit persons from having children until they reached and maintained a certain income level, the number of murdered and seriously harmed children would plummet. Thousand of lives would be saved; tens of thousands would be protected against serious injury. But there is no doubt that if some legislature were persuaded to restrict the rights of competent adults to bear and beget children in order to reduce the number of deaths and serious injuries experienced by children, the Supreme

Court would hold such a statute unconstitutional. As the Court stated in *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972), “If the right of privacy means anything, it is the right of the *individual* . . . to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.” As a society we have decided that a certain amount of harm to others must be tolerated if we are to allow individuals the right to make important decisions about the shape and direction of their lives.

Choosing when to die fundamentally affects a person as much, if not more than, the decision whether to bear or beget a child. Unquestionably, we should adopt reasonable measures—as Oregon has—to ensure that as far as possible the choice of assistance in dying is truly voluntary. But to maintain that we must ban assistance in dying completely because we cannot guarantee that *every* request for assistance in dying has not been improperly influenced is starkly inconsistent with the latitude we allow individuals with respect to other critical life choices.

The fact of the matter is that persons are subject to manipulation and pressure from others at all times, but especially with respect to critical life choices such as which career to pursue, whom to marry, whether to have a child, etc. It cannot be a sufficient justification for denying all individuals the right to make such choices that the decisions of some are the product of pressure or manipulation. Not only would such an overbearing, all-encompassing paternalism lead to a denial of the freedom to choose in all critical situations, but if the point of taking certain decisions away from individuals is to eliminate the possibility of their decision being coerced or manipulated, then such a policy would be self-defeating. Turning over all important decisions to the State

substitutes the *certainty* of coercion backed up by the machinery of government versus the *possibility* of coercion from individuals trying to advance their own interests. This does not seem like an advantageous trade-off.

Finally, to drive home the point that denying the right to request assistance in dying because of possible abuses is inconsistent with our other policies, we should consider an example from the context of end-of-life choices, namely the freedom we allow competent patients to refuse treatment, even when this refusal is likely to result in their deaths. Competent patients have virtually an absolute right to decline treatment. As one leading treatise on health care law states, “competent adults will have virtually no difficulty asserting their right to ... refus[e] medical care, including life-sustaining medical treatment” (Obale 1997, p. 8–3). Unlike the requests for assistance in dying under the ODWDA, there is scant regulation of the withdrawal or withholding of life-sustaining treatment for competent patients. Relevant information, including notes regarding consultation with physicians, is supposed to be recorded on hospital charts and similar documents, but oversight of this process is negligible. Moreover, no law requires the patient refusing treatment to make a series of oral and written requests and to have these requests witnessed. No investigation is carried out to determine whether the patient is being improperly influenced by relatives or friends who are concerned about long-term care obligations or financial burdens. No one is required to probe the patient’s reasoning to determine whether he wants treatment stopped because he finds it burdensome or because he simply wants to die.

One of the arguments often found in the literature opposing assistance in dying is the contention that patients, especially terminally ill patients, are too vulnerable and

dependent on their physicians to make a truly independent, voluntary decision. This statement by Leon Kass is indicative of this argument: “To alter and influence choices, physicians and families need not be driven by base motives . . . Well-meaning and discreet suggestions, or even unconscious changes in expression, gesture, and tone of voice, can move a dependent and suggestible patient toward a choice for death” (Kass 2004, p. 24). Leaving aside the point that these assertions lack empirical support and are demeaning toward the terminally ill (in Kass’s view, their terminal illness has somehow rendered them infantile), this argument proves too much. If the terminally ill are not capable of making informed choices and are so easily manipulated, why then do we allow patients to refuse life-sustaining treatment? The number of patients who refuse such treatment dwarfs the couple of hundred of patients who have availed themselves of assistance in dying under the ODWDA. Surely given the alleged suggestibility of these patients, there must be thousands of persons each year who are manipulated into an early death by physicians, families, or friends. If we really wanted to prevent manipulated and coerced requests that end in a patient’s death, we would either deny competent patients the right to refuse treatment or, at a minimum, we would subject all patients refusing treatment to the same rigorous procedures that patients must follow under the ODWDA.

Of course, we do neither, nor, except in some extremist religious circles, is there any demand that we impose such restrictions. This inconsistency in the level of concern between assistance in dying and refusals of life-sustaining treatment cannot be explained by the risk of harm to others. As indicated, the risk of harm to others is greater in the latter set of circumstances than the former. As Kass to his credit admits, this inconsistency is based on a “taboo,” that is, the taboo against assistance in dying (2004,

p. 29). This taboo persists largely because of religious dogma. To the extent that it has a secular justification, it is based on the illogical, unsupported claim that assistance in dying always constitutes intentional “killing” whereas withdrawal or withholding of life-sustaining treatment does not. (We will explore this issue further and demonstrate why it is illogical in the next section of the paper.)

To sum up: When a competent person who is terminally ill decides that she no longer wishes to live in a condition she finds intolerable, allowing her to receive assistance in dying is morally permissible (arguably even morally obligatory). Denying her assistance effectively forces her to remain alive against her will and strips her of any ability to direct her own life. What limited choices she has left (for example, whether to have orange juice or apple juice while she is confined to her hospital bed) are all effectively compelled because she no longer desires to engage in *any* activity. When the State both controls access to medications that this person could use to end her suffering and also legally prohibits physicians and others from providing effective assistance to this person, then the State has appropriated her life. This represents a substantial infringement, if not a total denial, of this person’s liberty. Under some circumstances, the State might be able to justify such a substantial interference with a person’s liberty interests. If respecting this person’s liberty interest would cause a significant risk of imminent, serious harm to many others, then the State may curtail this person’s freedom. However, in the context of assistance in dying, as demonstrated by Oregon’s experience, legalizing assistance in dying does *not* pose an intolerable risk of harm to others. In fact, the evidence indicates that with appropriate regulation assistance in dying does not pose even a negligible risk of harm to others. Furthermore, when we compare assistance in

dying with other practices, we find that we are willing to accept far greater risks of harm for the sake of individual liberty. Accordingly, we should legalize assistance in dying, with procedures similar to those used in Oregon, in the rest of the country.

As I have acknowledged, the argument that we should not legalize assistance in dying because it would cause many persons to be put to death involuntarily, through coerced or manipulated requests for assistance, is a legitimate argument. There is no evidence to support this argument, however. But in addition to this argument, opponents often resist legalization based on the argument that physician assistance in dying violates the “sanctity of life.” It is now time to address this argument

Opposition to Assistance in Dying Based on the Sanctity of Life

There is little doubt that much of the opposition to legalizing assistance in dying derives not from concerns about possible abuses of the practice, and the risk of harm to others, but from the conviction that assisting someone to die is itself an inherently immoral act. Moreover, some believe this act is so gravely immoral and is so threatening to our social fabric that the law must prohibit it. This conviction is in turn based on the sanctity-of-life principle. In arguing against assistance in dying, the late Pope John Paul II stated, “The deliberate decision to deprive an innocent human being of life is always morally evil and can never be licit either as an end in itself or as a means to a good end” (1995, p. 102).

But what does this verbiage mean exactly? For example, what does it mean “to deprive” someone of life? Can one “deprive” a person of life when that person expressly requests—even pleads—for an end to suffering? Do we “deprive” someone of pain when

we provide them with an analgesic at their request? And what does it mean for something to be “an end in itself or as a means to a good end”?

As we will see, the sanctity-of-life principle is less a carefully articulated moral view than a welter of confused and contradictory attitudes. In particular, there are two principal flaws in the claim that we cannot permit assistance in dying because it violates the sanctity of life. First, it is not possible to draw a distinction between assistance in dying (supposedly impermissible) and refusals of treatment (considered permissible) on the ground that the former always constitutes an intentional killing, nor does such a distinction make any sense from a policy perspective. Second, banning assistance in dying fails to promote the underlying rationale of our norms against killing others. We condemn killing others because almost always such actions are very harmful to the interests of others. Hastening the death of a terminally ill person may not be harmful to that person’s interests, however; certainly if the person requests such assistance there is a presumption that this assistance furthers his interests. In applying our moral norms sensibly, it is critical to understand the rationale and objectives of these norms.

Our analysis of the arguments derived from the sanctity-of-life principle begins by examining the allegedly profound moral distinction between the withdrawal and withholding of life-sustaining treatment and assistance in dying. Those who reject physician assistance in hastening death often attempt to distinguish between permissible cessation of treatment and what they characterize as the immoral act of assisting in a suicide. They attempt further to ground this distinction in what they describe as the difference between “letting die” and “killing.” Withdrawals or withholdings of treatment have usually been classified in the “letting die” category. This distinction between letting

die and killing has long been the most critical one in attempts by opponents of assistance in dying to distinguish appropriate from inappropriate means to death.

In fact, this distinction between letting die and killing formed the principal basis for the Supreme Court's companion decisions in *Washington v. Glucksberg*, 521 U.S. 702 (1997) and *Vacco v. Quill*, 521 U.S. 793 (1997), the two 1997 cases in which the Supreme Court ruled that patients did not have a constitutional right to assistance in dying. In so ruling, the Court unambiguously stated that while "*Everyone . . . is entitled, if competent, to refuse unwanted lifesaving medical treatment; no one is permitted to assist a suicide*" (*Vacco*, p. 800). Note that in describing the legality of cessation of treatment, the Court focused on authorization by the patient. All competent patients may insist the physician stop treatment, even if it results in death. Nonetheless, when the Court distinguished assistance in dying, it focused not on the patient's right to make a decision about his treatment, but on vague notions of causation and intent.

Thus, according to the Court, while in a case of assisted dying the medication prescribed by a physician causes the patient's death when the patient ingests it, when "a patient refuses life sustaining medical treatment, he dies from an underlying fatal disease or pathology" not the physician's actions in stopping treatment. With respect to intent, the Court stated that when a physician withholds or withdraws treatment, the physician "purposefully intends, or may so intend, only to respect the patient's wishes," whereas a physician "who assists a suicide, however, 'must, necessarily and indubitably, intend primarily that the patient be made dead'" (*Vacco*, pp. 801-02, quoting U.S. House Committee on the Judiciary 1996, p. 367). Similarly, the Court concluded that a patient seeking assistance in dying "necessarily has the specific intent to end his or her own life,

while a patient who refuses or discontinues treatment might not.” Therefore, according to the Court, both in terms of the cause of death and the intentions of the physician and patient, cessation of treatment can be sharply distinguished from assistance in dying.

With all due respect to the High Court, these distinctions are totally untenable. About the only favorable thing that can be said about the Court’s analysis is that it mercifully spared us the even more specious distinction between omission and act, which some scholars and prior court decisions had seized upon as the key distinction between cessation of treatment and assistance in dying. The argument for this distinction is essentially this: Cessation of treatment is merely omitting something, whereas providing assistance in dying is an action, so cessation of treatment may be permissible whereas assistance in dying is not. But the distinction between omission and action cannot bear the moral weight placed upon it by opponents of assistance in dying. To begin, “omissions” can cause harm as much as “actions.” (If I stand by and calmly watch you choke on some food when I could have applied the Heimlich maneuver or called for help, my “omission” has certainly contributed to your death.) Moreover, in the context of end-of-life care, the distinction between omission and action is a mere semantic distinction at best. Contrast a physician who yanks a ventilator from a patient, who then dies within a couple of minutes, and a physician who writes a prescription that the patient may use—if at all— weeks later. Which of these is best described as an “action” directly connected with the patient’s death? Stopping treatment is clearly as much of an action as writing a prescription.

The foregoing rhetorical question also helps to illustrate why the causation distinction invoked by the Supreme Court is faulty. To say that an act (or omission) is the

cause of a patient's death is to reason backwards from our conclusions about the proper assignment of fault or responsibility. If a neighbor's child falls in my swimming pool and drowns, did I help cause the child's death? The law may, in fact, hold me liable if I was aware that children are in the neighborhood and made no effort to inhibit access to my pool. What if I build a fence around my yard, but a child climbs the fence anyway? I probably would not be held liable, because the law will reward me for taking precautionary measures, but the relevant sequence of events is the same. I build a pool; child is attracted to the pool; child falls in the pool; child drowns. In other words, "causation" in the law is a readily manipulated concept that is used to advance policy objectives. We want swimming pool owners to take precautions, so we relieve them of causal liability when they take those precautions. We want to have physicians respect patients' desires concerning treatment, so we say that the physician's removal of the respirator does not cause the patient's death. But, of course, given the patient's condition, the removal of the respirator is likely both a necessary and a sufficient condition for the patient's death. The patient would not have died but for the physician's removal of the respirator.

By contrast, under the ODWDA, a physician who prescribes a lethal medication at a patient's request is simply writing a prescription. That act no more "kills" a patient than does the writing of a prescription for sedatives or analgesics for a patient who is undergoing withdrawal of treatment. Under the ODWDA, the patient must make a conscious decision to use the drug. As indicated previously, about one-third of the patients who obtain a prescription under the ODWDA never ingest the lethal drug; others ingest it months after it has been prescribed. For those who do take the drug, the

physician's writing of the prescription is a necessary step in the process that leads to the patient's death, but it is not the determinative or even the final step. Given this background, to say that the physician who assists a patient's death under the ODWDA causes the patient's death whereas a physician who removes life support does not cause a patient's death is simply another way to say that we should not allow the former type of conduct whereas we should allow the latter type of conduct. Significantly, even some scholars such as Gorsuch who strongly oppose legalization of assistance in dying concede that "causation may be an imperfect basis" for distinguishing between cessation of life-sustaining treatment and assistance in dying (2006, p. 52).

Gorsuch does endorse the use of intention to distinguish between cessation of treatment and assistance in dying. Gorsuch argues that assistance in dying (which, of course, he refers to as assisted suicide) "*always* involves, on the part of the principal, an intent to kill and also requires that the assistant intentionally participate in a scheme to end life," whereas cessation of life-sustaining treatment need not involve an intent to end life (2006, p. 66). This argument is based on the observation that patients refusing treatment may simply want to be free of the burdens of medical care or, as Gorsuch puts it, "they are tired of the invasive treatments and tubes and the poking and prodding that have come to characterize much of the modern medical care" and they may wish to maintain their sense of dignity and privacy and die peacefully at home with their loved ones.

It is undoubtedly true that many patients refuse treatment for precisely the reasons Gorsuch notes. However, they do this with the understanding that the cessation of treatment will almost surely result in their death. Therefore, their situation is not in any

way distinct from the terminally ill patient who, for similar reasons (desire to avoid burdensome treatment and suffering, maintain dignity, die peacefully with loved ones) takes a medication with the understanding that the medication will almost surely result in her death. What is the difference here? Those who argue for a distinction usually emphasize that the patient who refuses treatment does not necessarily want to die, but merely wants to be freed from the degrading intolerable condition in which she finds herself. Were she to recover after treatment was stopped, she would not be disappointed. However, exactly the same can be said for the patient who ingests a medication that is likely to cause death. If through some improbable and unanticipated chemical reaction the barbiturate did not result in death but rather in a remission of the cancer or other terminal condition, the patient would be overjoyed, not disappointed. If we determine intent not by examining the patient's understanding of what is likely to happen, but rather the motivations and desire of the patient, there is nothing to distinguish the terminally ill patient who dies as a result of stopping treatment and the terminally ill patient who dies as a result of ingesting a barbiturate. Both patients are knowingly taking actions that almost certainly will result in their deaths and their motivations and desires may be, and probably are, identical.

The only reason there is a superficial appeal to the distinction based on intention is that those who employ this distinction typically shift their focus when they move from discussing cessation of treatment to assistance in dying. In discussing cessation of treatment, they focus *not* on what the patient knows will happen, but rather on the patient's motivations and desire. Then, when discussing assisted dying, they switch their focus to what the patient knows will happen and ignore the patient's motivations and

desires. This shift in focus is not made explicit and, therefore, often passes unnoticed. Using two different meanings of “intention” to distinguish cessation of treatment from assistance in dying reduces the debate to a shell game—sadly, with the American public and suffering patients as the victims of this sophistry.

As the foregoing argument demonstrates, distinctions based on causation and intention fail to distinguish cessation of life-sustaining treatment, which is considered morally and legally permissible, and assistance in dying, which is condemned by many and legal only in Oregon. These distinctions are unsatisfactory for a number of reasons, not least because they tend to mask, rather than promote, consideration of the relevant factors that ought to be considered in determining permissible conduct. The key consideration in determining the permissibility of both cessation of treatment and assistance in dying is whether the decision of the patient is informed and voluntary. Withholding or withdrawing treatment from a competent patient is morally and legally justifiable if the patient has made an informed, voluntary decision authorizing the cessation of treatment. The physician is not the relevant cause of death and does not act wrongly if he or she has valid authorization for withholding or withdrawing treatment. By contrast, if a physician removes a respirator from a patient who needs it and wants to continue to use it, the action is wrong, even though the physician has only removed artificial life support and let “nature” take its course. Absent the patient’s authorization, such “letting die” is simply killing. The lack of authorization by the patient is the relevant consideration in determining the act is unacceptable.

Similarly, when a patient requests a physician to assist him in hastening his death by facilitating access to a barbiturate, the key consideration is whether the physician’s

action is authorized by an informed, voluntary decision of the patient. If that is the case, then there is no sound reason for thinking the physician's or the patient's action is morally impermissible. The physician merely provides the patient with the means to escape the ravages of a fatal illness, exactly as the physician does when he disconnects life support. Furthermore, there is no legal justification for distinguishing between the two types of actions, assuming there is no difference in the risk of harm posed to others by these actions (and we have shown there is no such difference).

Why then do scholars, jurists, and physicians who clearly are not unintelligent persist in arguing for a distinction? To the extent they are not mistakenly swayed by the argument that legalization of assistance in dying will result in too many abuses, it is likely they are motivated by the view that assistance in dying is somehow inherently wrong. In other words, such conduct violates the sanctity-of-life principle. Logically, this should lead them also to oppose cessations of life-sustaining treatment, for the reasons stated, but most of us cannot accept the notion that somehow we are permitted to force a ventilator down a resisting patient's throat in the name of preserving the sanctity of life. There is an instinctive revulsion to the idea of restraining a patient to hook her up to machines, even if doing so is necessary to keep her alive. (This revulsion is reflected in tort law, which has long made unwanted "touchings" actionable; you have a personal space that I cannot invade absent your consent.) The same instinctive revulsion is absent from the situation in which a patient is not forcibly attached to machines, but is merely dying a slow, painful death from cancer or some other terminal condition. In the latter situation, because we are not required to take "hands-on" action to compel the patient to live, some are more comfortable with insisting on maintaining the sanctity of life.

But now we need to dig deeper. We have shown that it is inconsistent to object to assistance in dying because of the sanctity-of-life principle while raising no objection to cessation of life-sustaining treatment. Nonetheless, there still will be some who maintain that there is a significant difference in the patient's intent in the two situations. Moreover, a determined opponent of assistance in dying can adjust his beliefs and eliminate the inconsistency by arguing that we should prohibit cessation of life-sustaining treatment as well. A few have taken such an extreme step. To complete our argument, we need to take a close look at the sanctity-of-life principle to determine whether it has a sound basis or whether it is a principle that represents an overgeneralization or misstatement of the rationale of other moral norms.

The sanctity-of-life principle holds that intentionally bringing about the death of a human being (including oneself) is always morally impermissible. Its defenders see it as independent of any other moral norm; in other words, bringing about the death of a human being is wrong regardless of whether this death produces bad consequences, violates a special obligation towards that person, etc. Usually exceptions are grafted on to the principle so that the principle applies only to "innocent" human beings (thereby allowing killing of criminals, combatants, etc.), but that is a complication we need not worry about for our purposes.

The principle has some intuitive appeal, but we need to ask ourselves, *why* do we prohibit bringing about the death of others? If morality has a point, and it is not simply some ingrained set of instinctive reactions, our moral rules and norms must serve some purpose. So why do we condemn killings?

The answer is suggested by the universal, or nearly universal, acceptance of the prohibition of killings. Although much is often made of the fact that different societies follow different moral norms, there are certain core moral norms that one can find across almost all cultures, such as norms prohibiting stealing and deceit. One such core norm is the rule prohibiting bringing about the death of another member of the moral community, a/k/a killing. (Determining who is protected by this prohibition is an entirely separate question, and has been answered in different ways by different cultures; see Lindsay 2005).

Universal acceptance of this norm suggests that this rule is critical for people to live together peacefully. A moment's reflection will show why the prohibition on killing serves the needs of the moral community. Killing harms others. If we are to maintain peace within the moral community, we cannot allow people to injure, thwart, or defeat the interests of others without appropriate justification, and physically harming a person is a very effective way of injuring or thwarting another's interests. Killing that person is usually the most effective way. Therefore, typically, we regard killing as a grievously wrong action.

All of this should be fairly straightforward. Only the morally deranged believe they are permitted to kill with impunity, and we all recognize that killing is normally the most serious harm we can inflict on another, so we condemn killing morally and punish it legally.

But notice that even though we condemn the harming of others, we tolerate and even applaud the infliction of harm in some cases (even beyond the special situations of combat or criminal executions). Moreover, the principal reason we tolerate the infliction

of harm in some cases is that the person upon whom the harm has been inflicted has authorized the imposition of harm and the person is competent to make such an authorization. This consensual infliction of physical harm takes place countless times each day—for instance, in doctors’ offices, dentists’ chairs, hospitals, and gymnasiums. Persons authorize harm to themselves because they want to accomplish certain ends that cannot be achieved except via the infliction of this harm, whether it is the removal of a tumor, a pretty smile, slim body, etc. Slicing open someone’s abdomen is normally a grievous wrong; it ceases to be a wrong when the knife is wielded by a surgeon and the surgery is authorized by a competent patient.

Can the same reasoning be applied in the case of hastening someone’s death? Yes. The reason bringing about someone’s death is a moral wrong in most circumstances is that the death completely deprives the person of the ability to pursue and fulfill his interests. Not only is his current well-being destroyed, but the possibility of his being able to achieve any desired state in the future is also being eliminated. However, a terminally ill patient who seeks to hasten his death because he wishes to avoid existing in a wretched, intolerable condition will not be deprived of any desired future state. There is no impairment of any interest because he has no interest in remaining alive given the conditions in which he finds himself. Accordingly, just as we recognize an exception to the general rule of “inflict no harm” in situations in which the harm, in conjunction with other conditions, does not on balance impair a person’s interests, similarly we can recognize such an exception in the case where the harm in question is death, but, on balance, this harm is in the person’s interest because it delivers the person from an intolerable condition.

Granted, just as with the infliction of any other presumptively serious harm, we will want to establish safeguards that ensure, among other things, that the person requesting the harm is competent to make a decision, that the person who assists in bringing about the harm has the appropriate knowledge and skill to counsel the person, discuss alternatives, and effect the harm in a way calculated to achieve the person's objectives, and that background conditions establish that the person's request to be harmed is not a momentary whim. What is meant by the last condition is that harms are not normally reversible, at least not easily. A dentist will not remove a patient's healthy teeth merely because the patient walks in and asks that this be done. Likewise, no physician is going to assist a patient to die merely because he walks into the physician's office and requests a barbiturate. When a patient is terminally ill, however, background conditions indicate that the person's request for assistance in dying is not necessarily whimsical or irrational. Moreover, if the patient's condition indicates the patient is suffering and the patient considers this suffering to be intolerable, then hastening death can be a rational objective. For the terminally ill then, we should recognize an exception to the general rule that bringing about someone's death is morally impermissible.

In other words, as is true with any moral norm, the general prohibition against bringing about the death of another should not be considered a rigid taboo that we adhere to mindlessly. We need to understand the norm's rationale and the objectives we are trying to achieve by inculcating and following such a norm. Ultimately, this norm, and many others, serve to respect, protect, and further the interests of others. It is almost always morally impermissible to inflict the harm of death because it is prejudicial to the interests of others. But in the exceptional case, where the death in question merely

hastens an already inevitable death and allows someone to escape the ravages of her suffering, death is not necessarily prejudicial to that person's interests. To insist otherwise is to adhere unthinkingly to dogma; it is to follow a rule without any understanding of why we have the rule. But, essentially, that is what the defenders of the sanctity-of-life principle do. They maintain that intentionally causing the death of another is wrong, period. It does not matter whether this principle serves any function related to human interests.

However, out of fairness, let us devote some time to examining the best argument in favor of the sanctity-of-life principle. Some proponents of assistance in dying might claim this is unnecessary because the sanctity-of-life principle is a religious viewpoint, not a secular one. Historically, it is true that the sanctity-of-life principle has rested on certain theological assumptions, including the belief that God has some ownership interest in our lives, and in bringing about a death, including our own death, we act against the Deity's interests. The very use of the term "sanctity," which implies that life is sacred, shows the religious roots of this principle. But many who defend the sanctity-of-life principle have attempted to ground this principle on secular concerns and their arguments deserve consideration. Finally, proponents of this principle represent one of the most powerful forces blocking the acceptance of assistance in dying. To disregard their arguments diminishes the practical value of any discussion of assistance in dying.

This paper will discuss the version of the argument advanced by Joseph Boyle (1989). It is similar to versions offered by Gorsuch and others (2006), but Boyle's argument is both more philosophically sophisticated and clearer. Boyle views the sanctity-of-life principle as codifying in practical terms the implication of recognizing

human life as a “basic good” of human nature. Boyle maintains that a justification of the sanctity-of-life principle, and its application to assistance in dying (which he groups under the category “self-killings”), may be summarized as follows:

1. One should never act with the intention of destroying an instance of a basic good of human nature.
2. Human life is a basic good of human nature.
3. One should never act with the intention of destroying an instance of human life.
4. Intentional self-killing is acting with the intention of destroying an instance of human life.
5. One should never act with the intention of killing oneself (which, again for Boyle, implies that one cannot hasten one’s death, with or without assistance) (1989, p. 232).

Almost all the premises of this argument are questionable. For example, to accept both Premise 1 *and* refusals of life-sustaining treatment, we would have to agree with Gorsuch that patients who stop treatment with the knowledge that they will die do not “intend” their deaths—even though such patients may have the same motivations and desires as those who hasten their deaths under the ODWDA and are equally certain their actions will result in their deaths. As previously discussed, such a malleable notion of intent is unjustifiable and unworkable. Nonetheless, this paper will focus on Premise 2.

Premise 2 is really what makes the sanctity-of-life principle distinctive, as Boyle himself points out (1989, p. 236). If this premise is removed, then one simply has a rule-based ethic condemning killings, including self-killings. No one is going to be persuaded by the mere pronouncement of such a rule.

What then of Premise 2? The key to Boyle's defense of human life as a basic good is his assumption that we can divide goods into basic and "instrumental" ones and his contention that we regard life as a basic or fundamental good. (Boyle uses the terms "basic" and "fundamental" interchangeably.) Instrumental goods are things that are valued only as a means to an end. Sun block is an instrumental good. We do not purchase sun block lotions or creams to display on our bookcases nor do we shape our lives to maximize the acquisition of sun block; sun block can be very valuable, but only as means to protecting our skin. According to Boyle, life must be a basic good because it "certainly is not extrinsic and instrumental" (P. 237). That is to say that we do not value life only because it is a useful means for obtaining other goods. Moreover, because it is not an "extrinsic" good, it has value independent of its relation to other goods. In other words, preservation of life is justified by the preservation of life and nothing further. We do not value life for the consequences it produces, but rather it is desired for its own sake. (Gorsuch similarly observes, "To claim that human life qualifies as a basic good is to claim that its value is not instrumental, not dependent on any other condition or reason, but something intrinsically good in and of itself"; 2006, p. 158). In sum, Boyle maintains that goods can be divided into two exhaustive categories, namely instrumental and basic goods, and that this division, in Boyle's mind, correlates with the distinction between goods that have extrinsic value (that is, their value depends on their relationship with other things) and goods that have intrinsic value (that is, their value depends on nothing else). Life must be a basic good with intrinsic value because it clearly is not a merely instrumental good.

So far, Boyle's argument has some plausibility; at least it seems to be relying on a distinction often made between things valued for their own sake and things valued only as a means to some other good. Moreover, if our only choice is to classify life as something valued for its own sake or as something valued only for the sake of something (that is, an instrumental good), Boyle appears to have a point. It does seem implausible to regard life as an instrumental good in the same way that sun block or money is an instrumental good. Life does not so much produce other goods as it is a necessary constituent of whatever goods we achieve.

However, Boyle's argument has plausibility *only* if we accept that all goods must be divided between intrinsically valuable goods and instrumentally valuable goods and that intrinsically valuable goods are goods that have an unconditional value and should never be "destroyed." These are the critical flaws in his argument. If we introduce a category of goods that are extrinsically valuable, *i.e.*, dependent for their value on other goods, but that can nonetheless serve as an end or goal of human action (that is, they are not valued only as a means to something else), then Boyle's argument collapses.

Human life seems to be such a good, that is, a good whose value is dependent on its relationship to other goods. Admittedly, human life does not seem a mere instrumental good; human life can convincingly be described as something that is valued as an end or goal. Nonetheless, the value of human life is dependent on its relations to other goods, *e.g.*, rationality, cognition, sentience, and when these relations are severed, the value of human life is substantially diminished, if not eliminated. That the value of life is extrinsic, not intrinsic, is supported by the consideration that no one regards living in a persistent vegetative state to be desirable. Yet if we strip away all goods except life itself,

all that would remain would be a bare, biologically human existence, devoid of cognition, emotion or any experience. Bare, biologically human life does not appear to be a good “desired for its own sake.” Life’s value *is* dependent on its relationship to other goods.

The view that we cannot exhaustively divide all goods into intrinsically valuable and instrumentally valuable goods, that is, we can have goods that we value as an end or goal but that nonetheless depend on their value for their relationship to other goods is not original with this paper. A number of philosophers have made similar observations. For example, in an insightful essay, Christine M. Korsgaard has argued that the distinction between final and instrumental goods does not always match the distinction between intrinsic and extrinsic goods (1983). One can value something as an end or goal that has value only in relation to other goods. This does not imply that the thing in question is only a means to an end; it implies the thing in question has value in a certain context. Life is not just a means to an end, but neither is it something necessarily to be preserved as a “fundamental good” when one’s ability to function has all but disappeared.

It’s a pity that Boyle, Gorsuch and others who argue for the sanctity-of-life principle either are unaware of or simply ignore arguments that refute their simplistic classification scheme. Once we reject their simplistic scheme, we can readily understand why human life is not regarded merely as an instrumental good, but, at the same time, is not a good that must be valued unconditionally in the sense that it must always be preserved, no matter what the condition of a person’s life.

Using his metaphysical categories as a shield, Boyle’s sanctity-of-life argument fails to come to grips with the central issue of whether life is worth preserving when it is no longer possible to pursue other goods. Many people believe that the value of life is

explained by reference to other goods. Obviously, the preservation of life is necessary if we are to fall in love, enjoy friendship, obtain knowledge, work on our personal projects, etc. However, this does not imply that life is a basic or ultimate good such that we must preserve it when it no longer bears a relation to these other goods, that is, when someone is in such a wretched condition that there is no longer any possibility of working on one's projects, experiencing joy, etc. Instead of addressing this issue squarely, Boyle, Gorsuch and others circumvent the issue through use of their classification scheme, which allows them to place life in the intrinsically valuable category and then claim that it is wrong under any circumstance to end a life. Provided one does not accept their classification scheme—and they provide no good reason to accept this scheme—their argument for the sanctity-of-life principle is wholly unpersuasive.

At one point, Boyle does concede that “people desire not merely to live but to live well, not merely to survive in a vegetative state but to flourish self-consciously in a wide range of goods” (p. 237). However, he persists in maintaining that life is a basic good because even when a human life is in a persistent vegetative state it “can by itself provide a reason for acting” (pp. 238). He observes, “Family members and health-care workers have chosen to give life-preserving care to [such] persons... Not everyone would make such a choice or consider it correct. But the fact that some have made it gives evidence that life is a basic good” (pp. 238–39). There you have it: the ultimate rationale for the sanctity-of-life principle, according to Boyle. Because *some* choose to treat bare biological existence as a basic good that cannot be destroyed (namely those who share Boyle's outlook), *all* of us must so regard it.

Cutting through all the metaphysical jargon, we can see that what Boyle, Gorsuch and company are really saying is that a terminally ill person who no longer finds existing to be of any value, whose life no longer has any relationship to experiences and goods she finds meaningful, is morally obliged to refrain from hastening her death merely because *they* think she should. The sanctity-of-life principle is a vehicle for imposing the values of some on all; it is a device for appropriating the lives of others. “Sanctity of life” functions as a shibboleth, itself devoid of any coherent meaning, but effective in convincing some that we should deprive terminally ill individuals of the ability to hasten their own deaths. Boyle, Gorsuch and others would have the terminally ill suffer for the sake of a platitude.

So far this paper has shown that the proponents of the sanctity-of-life principle have not been able to develop a positive argument in favor of their view that it is always wrong to bring about the death of a person intentionally. However, anyone familiar with the literature on this issue will know that positive arguments are not the only weapon used by defenders of the sanctity-of-life principle. Instead, they typically raise an alarm about the consequences of what they characterize as the “quality-of-life” view. They argue that we must adhere to a sanctity-of-life ethic, because that is the only way to maintain the position that human lives are worthwhile. If we adopt a quality-of-life ethic, we will need to make judgments about the quality of individuals’ lives and this will place us on the slippery slope to culling human beings based on their capacities or characteristics. Gorsuch goes off on a rant about how those who oppose the sanctity of life must make arbitrary judgments about the worth of individuals, and he speculates that

the autistic, stroke victims, or those with low IQs will lose the protection of the law (2006, pp. 159–62, 172–76).

This argument is essentially a scare tactic. All it really does is to underscore the tensions and inconsistencies within the sanctity-of-life movement. Any defender of the sanctity of life who also agrees that in some circumstances treatment can be withdrawn or withheld from patients who are no longer competent to make their own decisions (and many of the patients who die as a result of the withdrawal of life-sustaining treatment are not competent to make their own decisions) is implicitly making judgments about an individual's quality of life. To agree with a spouse, a relative, or a friend of the incompetent patient that the burdens of treatment outweigh the benefits to be gained from further treatment is to make a judgment about the quality of the patient's life. For example, if an otherwise robust, healthy patient were admitted to the hospital in an unconscious state for treatment of an acute infection, no physician is going to withhold treatment simply because the spouse says the person should be left to die a "natural" death, and no bioethicist would regard withholding of such treatment to be permissible. (We are excluding the situation where the refusal of treatment is based on some religious precept.) But if that patient were in his 90's, with multiple serious health issues, including cardiovascular disease and terminal cancer, the physician likely would respect the decision of the spouse to withhold treatment. What is the difference between the two cases? The difference obviously lies in a judgment about the quality of life of the two patients. For all those defenders of the sanctity-of-life principle who believe that it is permissible to withhold or withdraw treatment in some circumstances because the

burdens of the treatment outweigh the benefits, they are implicitly making judgments based on the quality of life and it is hypocritical of them to deny this fact.

To sum up: We should not use the sanctity-of-life principle to guide our public policy regarding assistance in dying. Applying the principle by its own terms would either require us to prohibit all patients from stopping treatment that would result in their deaths or would force us to resort to distinctions that have no sound, logical basis. Moreover, the defenders of the sanctity-of-life principle are not able to provide any persuasive argument in favor of this principle, and their arguments for this principle are rife with contradictions. Obviously, death is almost always harmful to a person's interests and we should protect people from this harm for that very reason. But when a terminally ill person is in an intolerable condition, then death may not be, on balance, detrimental to that person's interests. We respect both self-determination *and* the obligation to protect people from harm when we allow terminally ill patients to decide for themselves whether they should seek assistance in hastening their death.

Conclusion

We have established that physician assistance in dying for the terminally ill is morally permissible. It is a practice that shows both compassion and respect for the right of individuals to make critical decisions about their own lives. Based on the experience in Oregon, we have also shown that legalization of physician assistance in dying poses no significant risk of undesirable consequences, such as a decrease in the quality of palliative care or uncontrollable abuses. Finally, we have examined the argument against legalizing assistance in dying based on the sanctity-of-life principle. To the extent this

principle has a secular foundation, it is based on indefensible assumptions. Moreover, if the defender of this principle is to be consistent, he must also prohibit competent patients from refusing life-sustaining treatment—a position embraced by only a few extremists.

For the past decade, Oregon has served as a laboratory for physician assistance in dying. The results from that experiment are now in, and it is time to extend to inhabitants of other states the end-of-life choices that at present only citizens of Oregon enjoy. We urge other states to enact statutes that will provide competent, terminally ill patients the right to request assistance from their physicians in hastening their deaths. Such statutes should incorporate the procedural safeguards included within the ODWDA.

With respect to the federal government, its role is principally to stay out of the way. Immediately after the ODWDA went into effect, various members of Congress engaged in a concerted effort to block the operation of the ODWDA (Lindsay 2006). When these efforts failed, and after the installation of the Bush Administration, Attorney General Ashcroft tried to circumvent and gut the ODWDA by issuing a directive preventing physicians from prescribing “controlled substances” (a barbiturate is a controlled substance) to assist in a “suicide.” Since prescribing a controlled substance is the means by which an Oregon physician effectuates the patient’s informed decision for a hastened death, enforcement of this directive would have nullified the ODWDA and put an end to legal physician assistance in dying. This was a blatant attempt to override the democratic choice of the voters of Oregon by the fiat of a Bush Administration official. Fortunately, the Supreme Court, in *Gonzales v. Oregon*, 546 U.S. 243 (2006), rejected the government’s position, reasoning that the Attorney General was not authorized to decide on his own the legitimate boundaries of the practice of medicine.

Hostility to physician assistance in dying will continue. Of that, there is little doubt. However, what we have shown is that this hostility has no logical or empirical basis. As a matter of public policy, legalization of physician assistance in dying is the only reasonable, humane choice.

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APPENDIX

Below is the full text of the Oregon Death with Dignity Act. As noted in the position paper, other states either are currently considering or have recently considered legislation that would allow physician assistance in dying for the terminally ill. These states include Arizona, California, and Vermont. Note also that the state of Washington will hold a referendum in 2008 on the issue of legalizing assistance in dying. All measures under consideration contain safeguards similar to the Oregon Death with Dignity Act.

TEXT OF THE OREGON DEATH WITH DIGNITY ACT

127.800 s.1.01. Definitions.

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

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

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

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

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

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

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

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

(a) His or her medical diagnosis;

(b) His or her prognosis;

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

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

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

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

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

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

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

(12) "Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.

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

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

(2) No person shall qualify under the provisions of ORS 127.800 to 127.897 solely because of age or disability.

127.810 s.2.02. Form of the written request.

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

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

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

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

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

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

(4) If the patient is a patient in a long term care facility at the time the written request is made, one of the witnesses shall be an individual designated by the facility and having the qualifications specified by the Department of Human Services by rule.

127.815 s.3.01.Attending physician responsibilities.

(1) The attending physician shall:

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

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

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

(A) His or her medical diagnosis;

(B) His or her prognosis;

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

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

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

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

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

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

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

(h) Inform the patient that he or she has an opportunity to rescind the request at any time

and in any manner, and offer the patient an opportunity to rescind at the end of the 15 day waiting period pursuant to ORS 127.840;

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

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

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

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

(B) With the patient's written consent:

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

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

(2) Notwithstanding any other provision of law, the attending physician may sign the patient's death certificate.

127.820 s.3.02. Consulting physician confirmation.

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

127.825 s.3.03. Counseling referral.

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

127.830 s.3.04. Informed decision.

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

127.835 s.3.05. Family notification.

The attending physician shall recommend that the patient notify the next of kin of his or her request for medication pursuant to ORS 127.800 to 127.897. A patient who declines or is unable to notify next of kin shall not have his or her request denied for that reason.

127.840 s.3.06. Written and oral requests.

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

127.845 s.3.07. Right to rescind request.

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

127.850 s.3.08. Waiting periods.

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

127.855 s.3.09. Medical record documentation requirements.

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

- (1) All oral requests by a patient for medication to end his or her life in a humane and dignified manner;
- (2) All written requests by a patient for medication to end his or her life in a humane and dignified manner;
- (3) The attending physician's diagnosis and prognosis, determination that the patient is capable, acting voluntarily and has made an informed decision;
- (4) The consulting physician's diagnosis and prognosis, and verification that the patient is capable, acting voluntarily and has made an informed decision;
- (5) A report of the outcome and determinations made during counseling, if performed;
- (6) The attending physician's offer to the patient to rescind his or her request at the time of the patient's second oral request pursuant to ORS 127.840; and
- (7) A note by the attending physician indicating that all requirements under ORS 127.800 to 127.897 have been met and indicating the steps taken to carry out the request, including a notation of the medication prescribed.

127.860 s.3.10. Residency requirement.

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

- (1) Possession of an Oregon driver license;
- (2) Registration to vote in Oregon;
- (3) Evidence that the person owns or leases property in Oregon; or

(4) Filing of an Oregon tax return for the most recent tax year.

127.865 s.3.11. Reporting requirements.

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

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

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

(3) The division shall generate and make available to the public an annual statistical report of information collected under subsection (2) of this section.

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

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

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

127.875 s.3.13. Insurance or annuity policies.

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

127.880 s.3.14. Construction of Act.

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

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

Except as provided in ORS 127.890:

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

(2) No professional organization or association, or health care provider, may subject a person to censure, discipline, suspension, loss of license, loss of privileges, loss of membership or other penalty for participating or refusing to participate in good faith compliance with ORS 127.800 to 127.897.

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

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

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

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

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

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

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

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

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

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

(d) For purposes of this subsection:

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

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

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

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

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

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

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

(7) No provision of ORS 127.800 to 127.897 shall be construed to allow a lower standard of care for patients in the community where the patient is treated or a similar community.

127.890 s.4.02. Liabilities.

(1) A person who without authorization of the patient willfully alters or forges a request for medication or conceals or destroys a rescission of that request with the intent or effect

of causing the patient's death shall be guilty of a Class A felony.

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

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

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

127.892 Claims by governmental entity for costs incurred.

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

127.895 s.5.01. Severability.

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

127.897 s.6.01. Form of the request.

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

REQUEST FOR MEDICATION
TO END MY LIFE IN A HUMANE
AND DIGNIFIED MANNER

I, _____, am an adult of sound mind.

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

I have been fully informed of my diagnosis, prognosis, the nature of medication to be

prescribed and potential associated risks, the expected result, and the feasible alternatives, including comfort care, hospice care and pain control.

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

INITIAL ONE:

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

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

_____ I have no family to inform of my decision.

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

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

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

Signed: _____

Dated: _____

DECLARATION OF WITNESSES

We declare that the person signing this request:

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

(b) Signed this request in our presence;

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

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

_____ Witness 1/Date

_____ Witness 2/Date

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

127.995 Penalties.

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

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