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UNITED STATES DISTRICT COURT

DISTRICT OF OREGON

STATE OF OREGON, et al. Plaintiffs, v. JOHN ASHCROFT, in his official capacity as United States Attorney General, et al. Defendants.	Case No. CV 01-1647-JO **CLASS ACTION** **BRIEF OF AMICI CURIAE AUTONOMY, INC., CASCADE AIDS PROJECT, GAY MEN'S HEALTH CRISIS, AND THE SEATTLE AIDS SUPPORT GROUP: On Behalf Of Their Members or Supporters With Disabilities and Terminal Illnesses; and SECRETARY OF STATE BILL BRADBURY AND OTHER INDIVIDUALS WITH DISABILITIES: Evan Davis, Michael Stein, Hugh Gregory Gallagher, and Camilla Lee IN SUPPORT OF PLAINTIFFS (hereafter "The AUTONOMY Disability Brief")** Judge: Robert E. Jones Hearing Date: Time: 9:00 am Place:

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INTERESTS OF AMICI CURIAE

Amici represent people with disabilities who support the right of mentally competent, terminally ill individuals to choose to end their suffering with medications prescribed by their physicians to achieve a humane and peaceful death. While certain members of the disability community have been quite vocal in opposing this choice, Amici believe that the substantial majority of people with disabilities support it. We believe that, in a pluralistic society, the best means to address this issue is through the democratic process, as the people of Oregon have done in passing the Oregon Death with Dignity Act (hereafter, "the Oregon Act" or "the Act"), Or. Rev. Stat. § 127.800-127.995 (2001).[1] We are deeply offended by the decision of Attorney General Ashcroft to prosecute physicians who comply with the Oregon Act (hereafter, "the Ashcroft directive")[2], and believe that it is at direct odds not only with the Supreme Court's ruling in Washington v. Glucksberg, 521 U.S. 702

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[1] The Oregon Death With Dignity Act was a citizen's initiative first voted into law by Oregon voters in 1994. Implementation was delayed by a legal injunction, which was ultimately lifted by the Ninth Circuit Court of Appeals. In 1997, Oregon voters were asked to repeal the Act, but they declined to do so by a margin of 60% to 40%.

Since 1997, the Act has allowed terminally ill Oregon residents to request and obtain a lethal prescription from their physicians if they are diagnosed to have less than six months left to live. The Oregon Act is limited only to adults in the late stage of terminal illness, and a prescription will not be granted based on the patient's age, or the existence of a non-life threatening disability. The Act contains numerous safeguards that ensure the Act will be used only for its limited intended purpose. To qualify under the Act, patients must make two oral requests, separated by at least 15 days, to their physicians; submit a written request, witnessed by two witnesses, to their physician; obtain confirmation of his diagnosis and prognosis, as well as his capacity, from his prescribing physician and a consulting physician; be referred for a psychological examination if either physician suspects mental illness; and be informed by his physician of feasible alternative to assisted dying.

Physicians must provide the Oregon Health Division ("OHD") with extensive information relevant to the procedures followed and results of the assisted dying. In 1999, the Oregon legislature added a requirement that the pharmacist be aware of the prescription's purpose. If physicians and their patients comply with these requirements, they will not be criminally prosecuted for their actions.

[2] On November 6, 2001, Attorney General Ashcroft announced that he was reversing the decision of his predecessor, stating that "assisting suicide is not a 'legitimate medical purpose' within the meaning of 21 C.F.R. § 1306.04 (2001)" and "prescribing, dispensing, or administering federally controlled substances to assist suicide violates the CSA [Controlled Substances Act]." As such, Ashcroft directed that "[s]uch conduct by a physician registered to dispense controlled substances may 'render his registration . . . inconsistent with the public interest' and therefore subject to possible suspension or revocation under 21 U.S.C. 824(a)(4)." Mem. from Ashcroft to Hutchinson, published at 66 Fed. Reg. 56,607 (Nov. 9, 2001).

(1997), but also with the views of the majority of citizens with disabilities. The personal beliefs of a few federal government officials should not be imposed arbitrarily to supercede the democratic will of the people of Oregon.

Amici are organizations and individuals representing people with a broad array of disabilities who share the common belief that individuals with disabilities, as well as those without disabilities, should have control over the decisions affecting their lives. We are committed to ensuring that distorted representations concerning the interests of people with disabilities are not used as a tool to help override the democratic will of society. To that end, we strongly support the people of Oregon, both in their choice to protect their autonomy related to perhaps the most personal decision of all, as well as to their use of the democratic process to reach this choice. The attempt by certain parties to use disability issues as a justification for federal obstruction of a valid, narrowly-tailored state law is objectionable to Amici and to the many thousands of people with disabilities whose interests they represent.

Several organizations join this brief as Amici. AUTONOMY, Inc. (hereafter, "AUTONOMY") is a national disability rights organization incorporated and based in Oregon representing the interests of individuals with a broad array of disabilities who believe that people with disabilities should be able to exercise choices in all aspects of their lives. The Board of Directors of AUTONOMY includes some of the most prominent individuals in the disability community, including a former executive director of the National Council on Disability, one of the world's foremost rehabilitation physicians, a noted Oregon disability rights activist, an award-winning author and historian, the former director of the National Institute on Disability and Rehabilitation Research, and a former editor of the Harvard Law Review who has served as the president of the National Disability Bar Association. All have substantial disabilities.[3]

Other Amici organizations represent people with terminal illnesses, who are also considered people with disabilities under federal law. Cascade AIDS Project is dedicated to helping individuals in

[3] See http://www.AUTONOMY-NOW.org.

the northwest United States who have HIV/AIDS. Gay Men's Health Crisis is a New York based organization dedicated to providing compassionate care to individuals with AIDS, educating the public, and advocating for fair and effective public policies. The Seattle AIDS Support Group is an organization that provides free, confidential, emotional support for people with HIV/AIDS. Each of these organizations firmly supports the continued implementation of the Oregon Act.

The leaders of these organizations have submitted letters of support and statements of interest, which are provided in Appendix II.

In addition, several Amici from the disability community have volunteered to join this brief in their individual capacities and support the people of Oregon in this case. Bill Bradbury is the Secretary of State of Oregon. Evan Davis is a partner with a major national law firm who had polio at age five. Hugh Gregory Gallagher, who is also a survivor of polio, is a pioneer of the disability rights movement, one of the world's foremost authorities on the Nazi "Euthanasia" Program, and Vice President of AUTONOMY. Michael Stein is a person with paraplegia who was the former president of the National Disability Bar Association and is a member of the Board of Directors of AUTONOMY. Camilla S. Lee is a woman with Chronic Progressive Multiple Sclerosis who is a supporter of AUTONOMY. All have disabilities but not terminal illnesses. All are outraged by the decision of the Attorney General to effectively nullify the Oregon Act in a manner that did not even allow them the opportunity to comment on the illegality, inappropriateness and imprudence of the Ashcroft directive prior to its implementation. Their personal statements are also attached in Appendix II.

A. The Disability Rights Movement

The ultimate goal of the disability rights movement is to help people with disabilities secure autonomy and independence in all aspects of their lives.[4] Judy Heumann, one of the pioneers of the movement and co-founder of the World Institute on Disability, expressed the driving spirit of the

[4] The terms "disability rights movement" and "independent living movement" are often used interchangeably by members of the disability community. Whether they are two separate social movements or two names for basically the same movement is a matter of debate. For purposes of this brief, the broader term "disability rights movement" is used to refer to both.

movement best in an early policy report: "To us, independence does not mean doing things physically alone. It means being able to make independent decisions. It is a mind process not contingent on a 'normal' body."[5] Over time, the movement has been successful in recognizing a broad array of rights for people with disabilities and establishing a presumption in our society that individuals with disabilities should be allowed to make their own independent choices about their lives.[6] After decades of political struggle, the Americans with Disabilities Act of 1990 (the "ADA")[7] was enacted, demonstrating the progress and commitment of society in respecting the right of people with disabilities to exercise control over their lives in the mainstream of society.

B. The Interests Of People With Disabilities

The interests of Amici reflect the interests of millions of people with disabilities, including people with terminal illnesses, throughout the country.[8] Although the personal circumstances of people with disabilities vary substantially, they share a common interest in having choices in all aspects of their lives and being able to maintain control over their lives.

The conditions of most individuals with disabilities are not life-threatening and will never reach a terminal phase. To these individuals, issues concerning assisted dying are the same as those for anyone else, except that some have a greater need for assistance due to functional limitations.[9]

[5] Susan Stoddard Pflueger, Independent Living: Emerging Issues in Rehabilitation, foreword ii (Dec. 1977) (unpublished report, on file with the Institute for Research Utilization).

[6] See Youngberg v. Romeo, 457 U.S. 307 (1982); the right to be free of involuntary sterilization, Relf v. Weinberger, 372 F. Supp. 1196 (D.C. Cir. 1974); the right to raise a child, In re Marriage of Carney, 598 P.2d 36 (Cal. 1979); the right to have access to public streets, public transportation, schools, public services, privately owned places of public accommodation and places of employment, 42 U.S.C. §§ 12111-12181; the right to a free and appropriate education, 20 U.S.C. §1400 et seq., and the right to be free from unjustified institutionalization and to live in the community; Olmstead v. L.C. ex rel. Zimring, 527 U.S. 581, 596 (1999).

[7] The Americans with Disabilities Act of 1990, 42 U.S.C. § 12101 et seq.

[8] The ADA defines "disability" very broadly as "(A) a physical or mental impairment that substantially limits one or more of the major life activities of such individual [e.g., seeing, hearing, speaking, walking, dressing, feeding oneself, working, learning, etc.]; (B) a record of such an impairment; or (C) being regarded as having such an impairment." 42 U.S.C. § 12102(2). In Bragdon v. Abbott, 524 U.S. 624, 631 (1998), the Supreme Court found that courts must (1) determine whether the plaintiff's condition is an impairment; (2) "identify the life activity upon which the [plaintiff] relies"; and (3) "ask whether the impairment substantially limited the major life activity." Because virtually all terminal illnesses impose a substantial limitation in at least one major life activity, people with terminal illnesses are included as people with disabilities under the ADA.

[9] Andrew I. Batavia, The Ethics of PAS: Morally Relevant Relationships Between Personal Assistance Services and Physician-Assisted Suicide, Archives of Physical Med. and Rehab. (2001);12 Suppl. 2:S25-31 (discussing the

(footnote continued)

Other individuals with disabilities have conditions that are or may become life-threatening, such as the individuals with AIDS represented by several Amici organizations.

All Amici, however, want a wide range of end-of-life choices if they someday become terminally ill, including the right to hasten death if they determine that life during their remaining few days is no longer bearable. Further, they want the security of knowing that they can exercise this choice safely, effectively, and legally with the professional assistance of their physicians. They do not want to be deprived of this right simply because they have disabilities. Nor do they want their disabilities to be used by others to justify a wholesale denial of this right to other people with terminal illnesses. Amici believe that this is a uniquely personal, moral and religious decision, one that would primarily impact themselves and their loved ones – a decision that they should have the right to make for themselves without undue government interference.

SUMMARY OF ARGUMENT

This AUTONOMY Disability Brief expresses the interests of people with disabilities, represented by Amici, who support the continued implementation of the Oregon Act and a permanent injunction against the Attorney General's interference with the democratic will of the people of Oregon. The purpose of this brief is offer a disability rights perspective in support of the Oregon Act and in opposition to the Ashcroft Directive. Amici fully subscribe to and support the legal arguments of the State of Oregon and the other Plaintiffs, and this brief makes no attempt to reproduce their legal arguments, which are already before the Court.[10]

The Citizens of Oregon passed by a 60% majority vote the Death With Dignity Act, which recognizes that persons in the final stages of terminal disease have the right to the assistance of their physicians in hastening their deaths and eliminating their suffering. The Oregon Act provides that only individuals facing imminent death may seek assistance from physicians; people with non-terminal

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implications for some individuals who, due to their disabilities, cannot use their hands and arms or who cannot swallow pills).

[10] See Brief of the State of Oregon and other Plaintiffs' Briefs.

illnesses or disabilities fall outside the scope of the Act. Notwithstanding the narrow tailoring of the Oregon Act, the United States Attorney General and others objecting to the Act have hijacked unrelated federal statutes, to wit, the Federal Controlled Substances Act ("FCSA") and the ADA, in an unwarranted attempt to thwart the will of the Oregon people and the people whose interests are truly at stake – persons facing imminent death due to their terminal illnesses.

In Part I of this brief, Amici discuss the substantial autonomy and liberty interests that people with terminal illnesses have in the right to die without undue government interference and present evidence demonstrating that the substantial majority of people with disabilities support the right of terminally ill individuals to hasten death with the assistance of their personal physicians. Some of those who object to the Oregon Act claim to represent the interests of most or all people with disabilities on these end-of-life issues. The available data on this issue do not support their claim. See Appendix I. These objectors confound the essential autonomy concerns of people with disabilities and terminal illnesses with issues that are either irrelevant to the Oregon Act or that are outweighed by the substantial interests of people dying with terminal illnesses.

In Part II, Amici demonstrate that the Oregon Act is narrowly tailored in a manner to dispel all concerns expressed by opposing amici, such as Not Dead Yet ("NDY"). Their contentions include a variety of examples concerning people with disabilities, most of whom were not terminally ill, who sought the right to die in states that did not enact the safeguards of the Oregon Act or whose circumstances were dramatically different from those addressed by the Oregon Act. This specious "parade of horribles" has no direct relevance to the issues under consideration by this Court and must not be allowed to confuse the real issues being considered concerning the legitimate rights of dying individuals with terminal illnesses.

In Part III, Amici assert that the U.S. Attorney General's attempt to nullify the Oregon Act through an administrative action, without even providing opportunity for notice and comment, is impermissible as a matter of law and constitutes poor public policy. The State of Oregon has an important sovereign dominion over the health and safety of its citizens and has exercised this authority in a highly responsible manner. The federal power to regulate controlled substances is not unbound,

but is limited by a state's interpretation of a "legitimate medical purpose." Upholding the Attorney General's usurpation of the state's traditional authority to define "legitimate medical purpose" will not only deny autonomy to dying individuals, it will discourage their physicians from providing the effective pain treatment they need.

In summary, the Ashcroft directive is a misguided and unpersuasive effort by a few federal officials who are ideologically and religiously opposed to the right to assisted dying to supplant state law. Most offensive to Amici, they have usurped the traditional authority and prerogatives of the states using unfounded disability-related justifications to subvert the real interests of people with disabilities and terminal illnesses. These public officials did so without offering such individuals the slightest opportunity to comment on the administrative action that would affect their interests fundamentally. If implemented, the Ashcroft directive will harm people with terminal illnesses both directly and indirectly by limiting their autonomy during their final days, and deterring their physicians from giving them the pain relief they need.

The Ashcroft directive must not stand.

ARGUMENT

I.

OREGON'S DEATH WITH DIGNITY ACT RECOGNIZES THAT TERMINALLY ILL INDIVIDUALS HAVE A STRONG INTEREST IN THE RIGHT TO HASTEN IMMINENT DEATH WITH THE ASSISTANCE OF THEIR PHYSICIANS

> *There is no reason to think the democratic process will not strike the proper balance between the interests of terminally ill, mentally competent individuals who would seek to end their suffering and the State's interests in protecting those who might seek to end life mistakenly or under pressure.*
>
> Justice O'Connor in Glucksberg, 521 U.S. at 737.

A. Competent Terminally Ill Adults Have A Strong Liberty Interest In The Right To End Their Suffering By Hastening Their Own Imminent Deaths

The United States Constitution confers on individuals, "as against the [G]overnment, the right to be let alone—the most comprehensive of rights and the right most valued by civilized men." Olmstead v. United States, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting). The right of any individual to choose the circumstances of his own death when that death is imminent is perhaps the most personal incarnation of the right to be left alone. This right of an individual to determine his own destiny free from the undue interference of government is what is at stake in this case.

In Glucksberg, while the Supreme Court did not go so far as to recognize a constitutionally protected right to physician-assisted dying, it did acknowledge that there are important elements of individual freedom involved in end-of-life decisions.[11] Justice Stevens noted in his concurrence that the state's "interest in the preservation of human life . . . is not a collective interest that should always outweigh the interests of a person who because of pain, incapacity, or sedation finds her life intolerable, but rather, [is] an aspect of individual freedom." 521 U.S. at 746 (citation omitted). He

[11] The U.S. Supreme Court has also recognized that a liberty interest is implicated when a state inflicts pain and suffering (as prolonging a terminally ill patient's life against his will would do) and when a competent adult refuses life-saving medical treatment. See, e.g., Ingraham v. Wright, 430 U.S. 651, 674 (1977); Cruzan v. Director Missouri Dep't of Health, 497 U.S. 261 (1990).

also stated that "[t]here are situations in which an interest in hastening death is legitimate . . ." and that "there are times when it is entitled to constitutional protection."

The Supreme Court was aware of the importance of their decision to individual liberty and was very careful to issue an opinion that would leave the choice of whether to grant a right to physician-assisted dying up to the individual states. The Ashcroft directive not only ignores the Supreme Court's decision to leave this determination to the states, but it directly deprives the people of Oregon of their state sovereignty by circumventing the results of two state referenda. The directive is therefore both undemocratic and arguably unconstitutional in violation of state rights and prerogatives under our federal system.

The Amicus brief filed by NDY for the TRO proceedings addresses and justifiably criticizes the systemic and pervasive societal discrimination against people with disabilities, a phenomenon that has existed and to some extent continues to exist in society with detrimental effects on people with disabilities. NDY's concerns, however, have no bearing on the Oregon Act. The Oregon Act addresses competent individuals with *terminal illness*, defined as individuals with less than six months to live, and empowers those people to make their own choices regarding the circumstances of the imminent deaths. The Oregon Act does not apply to people with non-life-threatening disabilities, however substantial. While societal discrimination against the people with disabilities continues to be a problem, it does not serve as a justification for limiting individual rights, nor should it be used to obscure the real issue in this case – self-determination for terminally ill people. Indeed, the Oregon Act specifically protects individuals with disabilities from the abuses that NDY suggests.

B. The "Public Interest" Is Better Served By Continuing To Permit Physician Use Of The Medications Necessary To Allow Their Patients With Terminal Illnesses To Exercise This Liberty Interest Than By Denying Such Use

Prohibiting physician assistance in dying for terminally ill individuals will not serve the public interest. In most cases, such governmental interference will only prolong pain and suffering, both on the part of the terminally ill individual and on the part of the individual's family who will be forced to bear witness to the slow and agonizing death of a loved one. In other cases, such a prohibition will not prevent terminally ill people from taking their lives at all; it will merely force them to do so without

the help of physicians. In many cases, people will seek assistance from nurses or family members, and in other cases, they will resort to other methods such as "hanging, suffocation, and shooting."[12] Forcing people to choose between prolonged suffering ending in death and desperate attempts at alleviating their own suffering is not in the public interest; offering the additional choice to end suffering in a humane and dignified way is. The right to assisted dying may even allow some terminally ill people to postpone or cancel suicide plans, knowing that they can receive assistance when they want it.

Permitting physician-assisted dying under the Oregon Act benefits our nation. An important attribute of our federalist system is that, in the absence of a federal regulation, individual communities are left free to experiment with solutions to the difficult problems our society faces from time to time. See New State Ice Co. v. Liebmann, 285 U.S. 262, 311 (1932) ("It is one of the happy incidents of the federal system that a single courageous state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.") (Brandeis, J., dissenting). Allowing the federal government to interfere with state implementation of assisted dying legislation such as the Oregon Act – a power that the Supreme Court expressly recognized belongs to the states – will impede the potential for progress in the field of end-of-life care for all Americans.

C. The Death With Dignity Act Strikes The Appropriate Balance Between The Interests Of Terminally Ill Individuals And The Legitimate Interests Of The State Without Denying Persons With Disabilities Any Rights Or Protections Under The Constitution Or The ADA

The people of Oregon drafted the Oregon Death With Dignity Act to recognize and balance the twin interests enunciated by Justice O'Connor in Glucksberg – those of the terminally ill in ending their suffering and those of the state in protecting individuals who might seek to end their lives mistakenly or under pressure.[13] They narrowly tailored the Act to ensure that the touchstone of a

[12] See Jeremy A. Sitcoff, Death With Dignity: AIDS and a Call for Legislation Securing the Right to Assisted Suicide, 29 J. Marshall L. Rev. 677, 687 (1986); see also David A. Asch, The Role of Critical Care Nurses in Euthanasia and Assisted Suicide, 334 New Eng. J. Med. 1374-75 (1996).

[13] Justice O'Connor's concurring opinion qualifies the majority opinion, since her concurrence was the crucial fifth vote necessary for majority. Further, two justices who did not join the majority opinion, Justices Ginsberg and Breyer, did join Justice O'Connor's concurring opinion.

request for life-ending medication is terminal illness entailing imminent death, not disability generally. See discussion of the Oregon Act's safeguards, infra II.A. The Oregon Act protects against discrimination, coercion, and mistake, while also recognizing the legitimate and unique interests that terminally ill people have in exercising control over their final days.

1. The Interests Of Terminally Ill People Are Distinct From Those Of Non-Terminally Ill People Under The Oregon Act

The Oregon Act recognizes the unique interests of people at the end stage of a terminal illness, including their interest in controlling the manner and time of death when death is imminent, ending the progression of suffering, avoiding intolerable pain and the indignity of living one's final days in a drug-induced stupor, and preserving the dignity of death and the memory of life in the eyes of friends and loved ones.[14] These are important interests, which we recognize must be balanced against competing societal interests. But Courts must be vigilant not to permit specious and extraneous claims of societal interest to find their way onto the scales and tip the balance against the essential interests of the dying individual. Where there is carefully crafted legislation enacted through the democratic process, there is minimal societal interest in preserving and prolonging the life of a suffering person against his will in his final days.

A few leaders in the disability community, including members of NDY, have advanced these extraneous claims based on the unfounded fear that the Oregon Act independently targets or disproportionally affects people with disabilities who are not terminally ill. To demonstrate this alleged discrimination, they present examples of alleged abuses relating to people with non-terminal disabilities who would not have been entitled to assistance in dying under the Oregon Act. The use of these examples is nothing more than an effort to confound the interests of people with non-terminal disabilities with the unique interests of people with terminal illnesses.[15] While the NDY brief purports

[14] See Washington v. Glucksberg, 521 U.S. 702, 745 (1997) (STEVENS, J., concurring) (interest in avoiding intolerable pain and indignity of living one's final days incapacitated and in agony) (citing Planned Parenthood of Southeastern Pa. v. Casey, 505 U.S. 833, 851 (1992)); Cruzan v. Director, Missouri Dep't of Health, 497 U.S. 261, 344 (1990) (STEVENS, J., dissenting) (interest in how one will be thought of after death by loved ones).

[15] Interestingly, NDY barely mentions the words "terminally ill" or the Oregon Act by name and otherwise is mostly devoted to attacking a host of unrelated strawmen.

to be devoted to the interests of people with disabilities, it is important to stress that the disability community does not speak with one voice on the issue before the Court and does not share the unique interests in ending life that people with terminal illnesses have.[16] See Appendix I for data indicating the diversity of opinions among individuals with disabilities.

2. The Oregon Act's Recognition Of The Interests Of Terminally Ill Individuals Does Not Constitute Discrimination Against People With Disabilities Under The ADA Or Any Other Law

As noted above, NDY attempts to distract the Court from the legitimate interests of terminally ill individuals by claiming a discriminatory purpose on behalf of legislators, doctors and society at large. It should be clear that granting a right to a group based on terminal illness does not discriminate against people with disabilities generally. If a person with a disability (e.g., spinal cord injury) is in the terminal stage of an illness (e.g., cancer), she can avail herself of the Oregon Act; if she is not in the terminal stage of an illness, she cannot. In short, her general disability status is unrelated to her status under the Oregon Act.

The NDY brief also argues that the Oregon Act discriminates against people with disabilities by denying them "the protection of suicide prevention laws and medical practice standards" afforded non-disabled persons in violation of the ADA. See NDY Brief at 3. This argument also lacks merit and is designed to muddle, not clarify, the Court's task. Nothing in the Oregon Act denies any person with a disability suicide prevention services or any other rights or privileges of citizenship or residency in this country. *Specifically, nothing in the Oregon Act denies anyone any rights under the Constitution, the ADA, or any other law.* The Oregon Act grants rights to people with terminal illnesses; it does not grant rights or deny rights on the basis of disability generally.[17]

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[16] In fact because people with or without disabilities are susceptible to contracting a terminal illness, their interests are similar but secondary to the interests of people who suffer from a terminal illness currently.

[17] Under NDY's perverse formulation, it could be said that the Second Amendment discriminates against people with disabilities because it grants them the right to arms, which they might then use to kill themselves disproportionately. Ironically, if there were a nugget of merit to this formulation, the Second Amendment would be more discriminatory than the Oregon Act, because the right to bear arms is not restricted to people with terminal illnesses, whereas the right to life-ending medication under the Oregon Act is so restricted.

The arguments that the diagnosis and prognosis of terminal illnesses are uncertain, that doctors will target people with disabilities by assuming their lives are not worth saving, and that the potential for error and abuse against people with disabilities is too great are also unpersuasive.[18] The Oregon Act requires confirmation by two physicians of a terminal illness that will, within "reasonable medical judgment," produce death within six months.[19] See Or. Rev. Stat. § 127.800(12). The law does not demand absolute certainty, a standard it knows it cannot deliver. In Glucksberg, the Supreme Court did not counsel that a perfect system must exist, only that the state should strike the proper balance between conflicting interests. The Oregon Act is reasonably calculated to eliminate error and abuse, while maintaining its usefulness to those whom it serves.

There is simply no evidence whatsoever that doctors have abused the Oregon Act by targeting people with disabilities.[20] See discussion infra § II. C; see also Fourth Annual Report on Oregon's Death With Dignity Act (Feb. 6, 2002) (http://www.ohd.hr.state.or.us/chs/pas/ar-index.htm). To the extent that disability would be a factor in a physician's decision to help a person end her life, that

[18] These arguments based on the empirical evidence presented in an article by Carol J. Gill attached to NDY's brief opposing summary judgment are addressed in Andrew I. Batavia, The Relevance of Physician and Disability Data on the Right to Physician-Assisted Suicide: Can Studies Resolve the Issue?, Special Theme Issue: Hastened Death, 6 Psych. Pub. Pol'y L. 546-558 (G. Andrew H. Benjamin et al. eds., 2000). Lacking an adequate substantive response, Dr. Gill replied to this commentary in an unproductive manner that did not shed additional light on this issue. Andrew I. Batavia, A Call for Civility in the Disability/Assisted Suicide Debate, 7 Psych. Pub. Pol'y L. 728 (Letter to the editor).

[19] In its brief opposing summary judgment, NDY appears particularly concerned that a few of the individuals who were diagnosed as terminally ill actually may last somewhat longer than six months. Amici regard this as a positive phenomenon, particularly considering that some of these individuals may have chosen to kill themselves at an early stage if not for the existence of the Oregon Act. The fact that physicians cannot predict with complete certainty the life expectancy of a terminally ill person does not invalidate the law in any way. In fact, research indicates that physicians have a strong tendency to *overestimate* the life expectancy of their terminally ill patients, which would tend to reduce the number of patients declared eligible under the Oregon Act. See Antonio Vigano et al., The Relative Accuracy of the Clinical Estimation of Life for Patients with End of Life Cancer, 86 Cancer 170 (July 1, 1999); Joan Llobera et al., Terminal Cancer: Duration and Prediction of Survival, 36 Eur. J. Cancer 2025 (Oct. 2000). There is no reason to believe that there is any fraud by physicians in making such diagnoses.

[20] In its brief in opposition to summary judgment, NDY also presents a variety of allegations that material facts are in dispute because it is theoretically possible that a person with a disability could have been targeted or abused under the Oregon Act. However, it does not specifically allege a single case of such abuse. In fact, such abuse is substantially less likely to occur in Oregon where there are specific standards and safeguards than in any of the other states. Moreover, the remarkable scrutiny of the Oregon Act's implementation by groups such as NDY substantially increases the likelihood that any such abuse, if it had occurred, would have been exposed publicly. It is likely that no possible reporting requirement would satisfy NDY, which appears to adhere to the notion that physicians in Oregon are eager for the first available opportunity to kill their patients with disabilities. Rather than imposing the impossible task on the State of Oregon of proving a negative—that no person with a disability has been abused—NDY should bear the burden of demonstrating that such abuse has occurred, if it is intent upon continuing to make such unsubstantiated statements. Any such demonstration will lead Oregon to investigate and prosecute such actual abuse.

physician would violate the Oregon Act. Even in the absence of the Oregon Act, such actions would violate pre-existing prohibitions against euthanasia. See Or. Rev. Stat. §127.805. Further, the absence of any potential for abuse has never been a prerequisite to enacting a law or a justification for refusing to recognize a right, even one involving issues of life and death.[21] Rather, society's response to potential abuses is to deter them and to punish the abusers, which Oregon does. Finally, it is important to underscore that the terminally ill individual makes the ultimate decision, not the physicians.

D. Denying Terminally Ill Individuals The Right To Hasten Their Own Imminent Deaths With The Assistance Of Their Physicians Is Inconsistent With The Autonomy Goals Of The Disability Rights Movement

1. The Disability Rights Movement Is Based On Personal Autonomy

The overarching goal of the disability rights movement is to help people with disabilities achieve autonomy and independence in all aspects of their lives. Until recently, however, a paternalistic attitude towards people with disabilities was prevalent in our society, and many people with disabilities were forced to cede control of their lives to other people, often to their detriment. It was only through the bipartisan enactment of the ADA that our nation developed a consensus that competent adults with disabilities can and should exercise control of their lives in the mainstream of our society.[22]

Consistent with these rights, and with the disability rights movement's goal of autonomy for its constituents, is the right to control one's own death when it is imminent. The NDY brief details prejudices against people with disabilities within the medical community and claims that "many doctors conclude that lives of people with severe disabilities are not worth saving . . . ." NDY Brief at

[21] If the absence of any potential for abuse were a prerequisite to enacting legislation, then we would not have a prison system, we would not license people to drive automobiles, we would not permit physicians to prescribe any controlled substances whatsoever, for fear that somewhere, sometime, someone will abuse the system and someone will die unnecessarily. The likelihood of abuse of people with terminal illnesses or other disabilities in Oregon is substantially less than in other states that do not have a right to assisted dying and where suffering individuals have no choice but to accept the assistance of anyone who will offer it.

[22] See generally The Americans With Disabilities Act: From Policy To Practice (Jane West ed., 1991); Implementing The Americans With Disabilities Act (Jane West ed., 1996); Mark Nagler, Perspectives On Disability (2d ed. 1993); Implementing The Americans With Disabilities Act: Rights And Responsibilities Of All Americans (Lawrence O. Gostin & Henry A. Beyer eds., 1993).

7. While Amici certainly do not dispute that prejudice and discrimination exist among physicians and within the medical community, the Oregon Act does not give the decision-making power to physicians. Precisely the opposite—it puts decision-making power in the hands of the dying person with a terminal illness. This is exactly the goal that the disability rights movement has been working towards since its inception.

2. An Individual's Interest In Controlling The Circumstances Of Her Death In The Terminal Stage Of Disease Outweighs Any Governmental Interest In Preserving The Brief Amount Of Her Life Remaining

While the state has a legitimate interest in preserving life, that interest diminishes as the potential for life diminishes. Garger v. New Jersey, 429 U.S. 922 (1976); In re Quinlan, 355 A.2d 647 (N.J.), cert. denied, 429 U.S. 922 (1976). The only situation governed by the Oregon Act is the case of an individual who, based on reasonable medical judgment, has less than six months of life left to live. The state's interest in preserving that life is minimal.

The only legitimate governmental interest in preventing terminally ill individuals from controlling the circumstances of their own deaths is an interest in preventing abuses of this policy that may occur as a result of uninformed decisions, lack of competence, or outright coercion. However, the Oregon Act already protects this interest with exactly the type of narrowly tailored restrictions that due process envisions, i.e., procedural safeguards ensuring that the individual making this decision is fully informed, fully competent, and not under any coercion. Or. Rev. Stat. § 127.800 et. seq. (2001), discussed infra II. Thus, there simply is no governmental interest at issue that would warrant further intrusion into this sphere.

When physically healthy people attempt suicide, in many cases this attempt is a result of mental health problems such as depression. In such cases, the government has an interest in intervening based on the possibility that the individual's action may be a product of mental illness. The Oregon Act requires that the decision to hasten death be made only by a mentally competent terminally ill adult, in consultation with his or her physician, and when necessary, in consultation with a psychologist or psychiatrist. There is no governmental interest in preventing competent people facing imminent death from making such informed decisions in consultation with their doctors.

E. Available Data Demonstrate That A Substantial Majority Of People With Disabilities Supports The Right Of Terminally Ill Individuals To Hasten Death With The Assistance Of Their Physicians

When considered in aggregate, the data available on the extent to which people with disabilities support the right to assisted dying for terminally ill individuals demonstrate that a substantial majority of people with disabilities support this right. A 1994 Harris poll found that 70% of the general population and 66% of people with disabilities favor the right to physician-assisted dying for terminally ill individuals.[23] Other studies show that between 63% and 90% of people with terminal illnesses support the right to physician-assisted dying and want this choice available to them.[24]

A recent in-depth study of 45 individuals with disabilities in Berkeley, California, a stronghold for organizations that oppose a right to assisted dying, suggests that people with disabilities are deeply divided over whether terminally ill individuals should have a right to end their lives with the assistance of their physicians.[25] The key finding of the study is that "[t]remendous breadth and diversity of opinion exists with respect to attitudes toward death with dignity legislation."[26] Specifically, 27% of the disabled people interviewed supported assisted dying legislation, 24% opposed such legislation, and 49% were ambivalent on this issue. Virtually all respondents advocated self-determination and autonomy in how people with disabilities live and die. Disturbingly, many respondents indicated that they felt significant social pressure not to support the right to assisted dying, and many received misleading information from opponents of this right.

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[23] Table available from Louis Harris and Associates, Public Opinion Online, Question 004 NEW06090 (Release Date 1995). The statistic of 66%, which is based on a small sample, is presented because it is offers the earliest insight from national data available and may be compared with similar statistics from the 1997 Harris survey and the most recent 2001 Harris survey, discussed infra and presented in the Appendix I, which presented similar results and suggests that a substantial majority of people with disabilities support the right to assisted dying for terminally ill individuals.

[24] Studies cited in Batavia, The Relevance of Data on Physicians and Disability on the Right to Assisted Suicide, 6 Psych. Pub. Pol'y L., at 552-53 (citing W. Breibart et. al., Interest in Physician Assisted Suicide Among Ambulatory HIV Infected Patients, 153 Am. J. Psychiatry, 238-42 (1996), B. Trindall et al., Attitudes to Euthanasia and Assisted Suicide in a Group of Homosexual Men with Advanced HIV Disease, 6 J. of Acquired Immune Deficiency Syndrome, 1069 (1993)).

[25] Pamela Fadem et al., Attitudes of People with Disabilities Toward Death with Dignity/Physician Assisted Suicide Legislation: Broadening the Dialogue (Berkeley, California 2001).

[26] Id.

A member of the study's community advisory committee, comprised of six people with disabilities, summarized the study results as follows:

> There seems to be one public position on behalf of people with disabilities about death with dignity legislation put forward by disability community spokespersons and groups, but when you go deeper into the community there are many different opinions. An individual's opinion seems to depend on their own character, personal experience (of self or a loved one) with near-death or death, among many other things.[27]

The most recent Harris poll data from December 2001 provide the most compelling evidence that a substantial majority of Americans with disabilities support the right to assisted dying generally and the Oregon Act in specific. See Appendix I. It found that Americans with disabilities support the right to physician assisted dying by more than a two-to-one majority. Specifically, 68% of adults with disabilities believe "the law should allow doctors to comply with the wishes of a dying patient in severe distress who asks to have his or her life ended."[28] When read a description of Oregon's assisted dying law, 68% of people with disabilities indicated that they favored implementation of such a law in their own state.[29] When told of Attorney General Ashcroft's action to nullify the Oregon Act, 63% said they believed he was wrong in doing so. See Appendix I.

Such large majorities of people with disabilities would not indicate that they support the right to assisted dying or the Oregon Act if they felt threatened by them.

[27] Id. If only 24% of respondents in the Berkeley study oppose the right to assisted dying, it is likely that a substantial majority of people with disabilities support the right in other communities in which there is less indoctrination against such right. This conclusion is supported by the consistent results of the 1994, 1997 and 2001 Harris surveys discussed in this AUTONOMY disability brief. See Appendix I.

[28] This figure of 68% support in the 2001 Harris poll may be compared with 73% support by people with disabilities based on the same question asked in a 1997 Harris poll. See Appendix I. The slight reduction in 2001 may be the result of scare tactics used by some groups like NDY. Andrew I. Batavia, Don't Use Scare Tactics in Assisted Death Debate, *Times Union*, March 30, 2001 (Letter to the editor).

[29] Interestingly, based on the results of the 2001 Harris survey, the support among the disability community for the right to assisted dying is even slightly higher than support among the general population, which is still a substantial majority of 61%. See Appendix I.

II.

THE DEATH WITH DIGNITY ACT IS NARROWLY DRAWN SO THAT ONLY INDIVIDUALS WITH TERMINAL ILLNESSES MAY AVAIL THEMSELVES OF ITS PROVISIONS FOR ENDING SUFFERING

A. The Act Is Narrowly Tailored To Protect Individuals In The Terminal Stage Of Disease And Expressly Excludes Disability Without The Presence Of Terminal Illness As A Basis For Granting Physician Assistance To End Their Suffering

The Oregon Act permits terminally ill individuals the opportunity to request and receive from their physicians a prescription for medication that they may use, at their own discretion, to hasten imminent death in a "humane and dignified manner." Or. Rev. Stat. § 127.805. The Oregon Act also expressly provides that "[n]o person shall qualify under the provisions of [the Act] solely because of age or disability." Or. Rev. Stat. § 127.805. The drafters narrowly tailored the Act to ensure that only competent adults with terminal illness, and not people with general non-terminal disabilities, will be able to avail themselves of the Act.

Very few people qualify for assistance under the Act, only to a precisely defined group of people with very little time left to live. Physicians may grant a prescription to individuals who satisfy the Act's narrow criteria only after the individual completes an extensive approval process involving consideration of his mental and physical condition.[30] As a result, in the first three years of its existence, the Act has been used infrequently. In 2000, an estimated 9 out of every 10,000 deaths in Oregon resulted from the ingestion of medications prescribed under the Act. Data from previous years provide similar percentages.[31]

Due to the rigorous procedures for obtaining a prescription under the Oregon Act, the rights granted to terminally ill individuals in Oregon are less prone to abuse than the rights of individuals

[30] Only competent adults with less than six months to live may request a prescription, and they must make two oral request separated by at least 15 days, as well as one written request signed by two witnesses. At this point, two physicians must confirm the diagnosis and prognosis, and refer the individual for a psychological examination if they believe the patient's judgment is impaired. In addition, the prescribing physician must inform the individual of other feasible alternatives to hastening death, and request that the individual notify their next-of-kin of the request. In 1999, an additional safeguard was added to the legislation, requiring that the pharmacist be notified of the purpose of the prescription, providing a final check by an objective party. Or. Rev. Stat. §§ 127.800-127.897.

[31] Fourth Annual Report at 9 (Feb. 6, 2002).

seeking palliative care or withdrawal of life support in other states. In the case of aggressive palliative care, which in many states results in *de facto* physician-assisted dying, procedures for evaluating the individual's capacity are lacking and often the exact desires of the parties involved are left ambiguous. A family member's decision to withdraw life support of a person in a coma or permanent vegetative state is also more susceptible to abuse because the individual is unconscious and therefore unable to express his desires.[32]

Although any legal right can be abused, there is no reason to believe that the Oregon Act will be extended to persons or situations for which it was not intended. Well-crafted legislation provides adequate safeguards to prevent the rights it grants from being used for unintended purposes, and the Oregon Act does just that. Its precise definitions of who can request a physician's assistance in hastening imminent death, together with its substantial procedural requirements for the fulfillment of a request, ensure that the Act will be used for its intended purpose and will provide the citizens of Oregon the freedom to choose to end intolerable suffering when appropriate.

B. Examples Of People Without Terminal Illnesses In Other Jurisdictions Are Irrelevant To The Oregon Act

Opponents of the Oregon Act equate the hastened deaths that may occur under the Act with a wide variety of illegal physician-assisted deaths that have occurred in other jurisdictions. The examples used, ranging from the forced "euthanasia" program employed by the Nazis, to the controversial actions of Dr. Kevorkian, are not directly relevant to the function, purpose, and reality of the Oregon Act, and the Court should be careful not to allow opposing amici to confuse these very different situations.

The execution of individuals with disabilities by physicians under the Nazi regime could not be more different from the situation in Oregon today.[33] The Nazis engaged in a program of involuntary

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[32] See Kathryn Tucker, The Death with Dignity Movement: Protecting Rights and Expanding Options after Glucksberg and Quill, 82 Minn. L. Rev. 923, 931 n.41(1998); David Orentlicher, The Supreme Court and Terminal Sedation, 24 Hastings Const. L.Q. 947 (1997).

[33] Hugh Gregory Gallagher, What the Nazi 'Euthanasia' Program Can Tell Us About Disability Oppression, Journal of Disability Policy Studies 12(2) (Fall 2001) (drawing fundamental distinctions between the Nazi situation and

(footnote continued)

euthanasia under which a totalitarian state gave physicians the authority to kill individuals with disabilities against their will.[34] The Oregon Act is a carefully tailored statute granting its citizens choice and control over the end of their lives while limiting its application to those who are truly facing the end of life. Although there may be some superficial resemblance, in that both involve physicians intervening at the end of life, in fact they are complete opposites. In dispelling this anomalous analogy, we must recognize that "[i]n one case, the state has all the power, and in the other case, the individual has all the power."[35]

NDY also analogized the Oregon Act to killing infants under 30 days old due to disabilities. This is again far off-point. Oregon's Act allows *competent, terminally ill adults to determine their own fate.* It does not allow any individual to make any decision about any other individual's life, and it is never applicable to infants.

A comparison of the Oregon Act with the actions of Dr. Jack Kevorkian is similarly misguided. Kevorkian did not operate pursuant to a narrowly tailored statute, but instead worked in the extra-legal sphere outside the scrutiny of the state and its oversight of the medical profession. His acts violated the law of the states where he practiced and typically would have violated the Oregon Act as well. As the NDY brief points out, "[s]eventy percent of Dr. Jack Kevorkian's [patients] were . . . not terminally ill under accepted medical definitions." See NDY Brief at 7 and 13. Those individuals would not have qualified for lethal medication under the Oregon Act because they were not terminally ill and in the last six months of life.[36] Therefore, these examples are irrelevant to the narrow question

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that of the United States). The Court should be aware that Mr. Gallagher, who is a person with a disability and one of the world's foremost experts on the Nazi program, serves as Vice President of AUTONOMY, Inc. Obviously, he would not have taken a leadership role in this organization if he believed that NYD's analogy had any credibility.

[34] Hugh Gregory Gallagher, By Trust Betrayed: The License to Kill in the Third Reich, (rev. ed. Arlington, Vandamere Press 1995).

[35] Andrew I. Batavia, Disability and Physician-Assisted Suicide, 336 New Eng. J. Med. 1671, 1672 (1997).

[36] See NDY Brief at 8-11 ("Ms. Bouvia . . . had . . . a . . . nonterminal disability . . . . Rivlin . . . had no terminal illness . . . .") and 14-15 (listing examples of people with "years of productive life ahead" and "no apparent illness," etc., who received physician assistance to die outside of Oregon). It seems that NDY's central concern is that people with disabilities do not receive the essential services they need and deserve to maintain their autonomy, and that this lack of services drives some to seek an end to their lives. Amici share NDY's concerns in this regard, but these concerns do not in any way justify nullification of the Oregon Act, which provides an important right for terminally ill people.

of whether the Oregon Act results in harm to the public good. The example of Dr. Kevorkian does illustrate, however, that physician-assisted dying without state regulation and oversight is the true danger, and emphasizes the importance of the Oregon Act. Many individuals with disabilities, including Amici, oppose his actions, including his assistance to people with disabilities who did not have any terminal disease. Even those who believe most strongly in the right to physician-assisted dying understand that the right is a benefit to society only if exercised in a controlled and responsible manner.

The NDY brief also contains several examples of people in other states and countries who sought out physician-assisted dying. Some of them received assistance, others did not, and the appropriateness of some of their requests was questionable. Once again, Amici emphasize that these cases have absolutely no bearing on the Oregon Act. At most they serve as evidence for why such legislation drafted with attention to detail is needed, and why adequate procedural safeguards are essential. Some of the examples show once again the arbitrary fashion in which assistance is granted when it is prohibited by the state and doctors carry out their patients' will in secret.

Amici believe that there is grave danger in allowing Attorney General Ashcroft to nullify the Oregon Act because experience has taught us that terminally ill individuals will take steps to hasten their deaths when life truly becomes unbearable, irrespective of the availability of legal means for doing so. The Oregon Act strikes a proper balance between the legitimate interests of people with terminal illnesses and the state's interest in protecting its citizens from discrimination, coercion, and mistakes. The NDY brief attempts to obfuscate this simple formulation through fearful examples and arguments unrelated to the merits of the Oregon Act. In short, the Act deliberately and effectively safeguards against those very abuses NDY identifies.

C. There Is No Evidence That People With Disabilities Have Been Harmed In Any Way Under The Oregon Act

There are no known instances of discrimination against people with disabilities under the Oregon Act. Nor is there any evidence of any abuse occurring under the Act during its first four

years.[37] Detailed reports of the Act's procedures and results have been published since its inception, and the fierce scrutiny of the Act by its opponents offers assurance that any misuse of the Act's provisions would not go unnoticed.

The Oregon Health Division ("OHD") is required by the Act to develop a reporting system for monitoring and collecting information on hastened deaths under the Act.[38] The data collected are intended to help evaluate concerns that the option of physician-assisted dying would be forced upon the poor, uneducated, uninsured or otherwise disadvantaged people. The OHD annual reports offer no indication of discrimination against people with disabilities. In fact, the OHD data have consistently shown that individuals who hasten their imminent death under the Act are demographically comparable to other Oregonians dying of similar diseases.[39]

The only notable demographic difference is that those who have made use of the Act's option tended to be more educated than those who do not seek assistance under the Act, placating concerns that people will choose to hasten their deaths under the Act due to ignorance of other options for dealing with the end of life.[40] As an additional precaution, the prescribing physician is required to inform every individual requesting a prescription of additional options for end of life care, to ensure that his request is in fact a choice and not a decision forced upon him for lack of other options. Information gathered from prescribing physicians also indicates that people who choose to request physician assistance in hastening death tend to be knowledgeable and demanding. "When you talk to

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[37] See Dr. Timothy Quill, Op-Editorial, Ashcroft's Ruling Usurps States' and Voters' Rights, Rochester Dem. Chron., Dec. 12, 2001; Fourth Annual Report on Oregon's Death With Dignity Act (Feb. 6, 2002).

[38] Pursuant to this requirement, the OHD requires each physician who writes a prescription for lethal medication to submit information documenting his or her compliance with the law. The OHD then reviews all physician reports and contacts physicians if any data is missing. The OHD collects the death certificates that correspond to the physicians' reports to confirm that the deaths actually occurred and to collect demographic information about the patients. For the third and fourth year reports, the OHD also conducted telephone interviews with all of the prescribing physicians. Oregon's Death with Dignity Act. See Three Years of Legalized Physician Assisted Suicide at 8 (Feb. 2001); Fourth Annual Report at 7 (Feb. 6, 2002).

[39] The most common underlying illness is cancer (86% in 2001), followed by heart and lung disease. Fourth Annual Report, Table 1 (Feb. 6, 2002).

[40] People with a college education were eight times more likely to seek assistance in dying than people without a high school education. Patients with post-baccalaureate education were 19 times more likely to seek assistance than people without a high school education. Three Years of Legalized Physician Assisted Suicide at 4.

doctors, what comes through is, this is an unusual group of people. They place a high value on control and independence. Compromise is not in their vocabulary. Nobody who knows them is surprised by the request."[41]

In its *amicus* brief, NDY makes conclusory statements based on its interpretation of OHD data on whether the decision to hasten an imminent death is a good choice or a harmful one. In fact, these are value judgments on a dying individual's feelings about the meaning of life and death.[42] People considering the option of hastening imminent death are in the very final stages of life and are likely to experience many interrelated concerns, such as those discussed in the OHD reports. A terminally ill person who is concerned about the potential loss of bodily functions or being a burden on his family is not necessarily choosing to hasten her death for the wrong reasons.[43] Quality of life is an individual determination and the OHD reports should not be used to allow outsiders to sit in judgment of their fellow citizens. The concerns noted in the OHD deal essentially with the ability of a dying individual to exercise control during the final days of his life.

There are significant differences between the effect of loss of mobility or bodily functions on independence in the case of a person with a stable disability and this loss of independence in a terminally ill person. Many people with disabilities maintain very independent lifestyles despite major

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[41] See Susan Okie, "I Should Die the Way I Want To": Oregon Doctors, Patients Defend Threatened Assisted Suicide Law, Wash. Post, Jan. 1, 2002 (citing survey conducted by Linda Ganzini, professor of psychiatry at the Oregon Health Services University).

[42] The most common concerns cited by patients receiving a prescription were: losing autonomy (94% in 2001), decreasing ability to participate in activities that make life enjoyable (76% in 2001), losing control of bodily functions (53% in 2001) and becoming a burden on others (24% in 2001). Fourth Annual Report at Table 1. Although patients frequently mentioned not being a burden, prescribing "physicians in 2000 commented that family members were very willing to care for the patients. The fact that patients choosing to obtain a prescription almost always discussed concern about becoming a burden in conjunction with losing autonomy suggests that it might be part of patients' ideas about independence." "No evidence indicates that such pressure has been a primary motivating influence among the 70 Oregon patients to date who have exercised the Act's option." Three Years of Legalized Physician Assisted Suicide at 13.

[43] In its brief in opposition to summary judgment, NDY presents autonomy-related arguments that confuse anti-disability prejudices about the loss of bodily functions due to disability with legitimate concerns about loss of bodily functions for people in the terminal stage of an illness. Specifically, while prejudices and misconceptions about loss of bodily functions and life with a disability should not be allowed in the policy debate, the concerns of dying people about losing control, including control of bodily functions, during their final days are entirely legitimate. People with disabilities, including people with terminal illnesses, should be allowed to assess the quality of their own lives without being told by outsiders what factors they may or may not consider. Notwithstanding NDY's allegations of discrimination, issues of control and autonomy are entirely legitimate factors for these individuals to consider in assessing the quality of their lives.

physical limitations. Although it may not be easy, most individuals with disabilities adjust to their disabilities and maintain what they assess as a high quality of life. Terminally ill individuals, however, have very different challenges. Debilitating terminal illnesses often result in a rapid deterioration of physical capabilities that may present increasing frustration and limitations with each day that passes, culminating in death. This deterioration, often accompanied by extreme pain and the lack of any hope for recovery, puts terminally ill individuals in a very different situation from individuals with disabilities and long lives ahead of them. Those who oppose the right to physician-assisted dying based on concerns about individuals with non-terminal conditions (i.e., stable disabilities) tend to incorrectly equate these two very different situations.

Concerns that the Oregon Act will reduce the availability of health care services to terminally ill individuals are also unfounded. Some have voiced concern that a cost-conscious society would rather have their terminally ill citizens die than provide them with expensive care during their last months of life, or that the existence of a right to hasten imminent death will reduce the availability of other options for end-of-life care. The first three years of the Oregon Act have demonstrated the opposite. According to one physician with extensive experience in end-of-life issues:

> The net positive result [of the Oregon Act] is that morphine prescribing for serious illness is high, the hospice referrals are up and more deaths are occurring at home. The relatively few deaths that are assisted under the new law are subject to safeguards – such as second opinions and waiting periods – and oversight that includes review by the Oregon Health Division. People in Oregon have learned to expect good end of life care, but also have had the comfort of knowing that their choices and values will be honored.[44]

In a survey of Oregon physicians, Dr. Linda Ganzini, a professor of psychiatry at the Oregon Health Sciences University, found that in 68 of 142 cases, a patient's request for a lethal prescription prompted the physician to learn more about end-of-life issues such as pain treatment, hospice care, and treatment for depression.[45]

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[44] Quill, supra note 37.

[45] See Susan Okie, "I Should Die the Way I Want To": Oregon Doctors, Patients Defend Threatened Assisted Suicide Law, Wash. Post, Jan. 1, 2002.

There is substantial agreement that the health care treatment of individuals with disabilities is often far from perfect. Imperfections in the system, however, provide no legitimate basis for denying the right of persons in the terminal stage of illness to control the final phase of their lives. The people of Oregon took these imperfections into consideration when drafting the Act, and enacted a law with extensive procedural safeguards to protect potentially vulnerable groups. In the absence of any evidence that abuses have resulted in the first four years of the Oregon Act's existence, this Court should accept the Oregon Act for what it is – a careful, responsible piece of legislation that creates rights without causing harm to any vulnerable groups of people.

III.

THE CITIZENS OF OREGON HAVE SOVEREIGN AUTHORITY TO DETERMINE THAT ASSISTED DYING FOR TERMINALLY ILL INDIVIDUALS IS PART OF THE LEGITIMATE PRACTICE OF MEDICINE IN THAT STATE, AND THE ATTORNEY GENERAL MAY NOT USURP THIS AUTHORITY BY ADMINISTRATIVE FIAT

The U.S. Supreme Court recognized in Glucksberg that "Americans are engaged in an earnest and profound debate about the morality, legality, and practicality of physician assisted suicide" and encouraged "this debate to continue, as it should in a democratic society."[46] After years of intense debate, the Death With Dignity Act was adopted by a vote of the Oregon people in November 1994. Shortly thereafter, a proposal to repeal the Act was considered and soundly rejected by the state legislature and Oregon voters. The courts also rejected legal challenges to the Oregon Act's constitutionality.[47] The people of Oregon have struggled with, considered and debated this difficult policy question, and have chosen to provide those members of their community who face imminent death with a humane and compassionate way to eliminate their own suffering.

A. Providing Terminally Ill Persons The Opportunity To Control Their Final Days And Eliminate Their Own Suffering Is A "Legitimate Medical Purpose"

Oregon's underlying determination that hastening imminent death to ease suffering for individuals in the terminal stage of an illness is a "legitimate medical purpose" was heavily debated as early as 1991 within the state government and among its citizenry.[48] It is based on years of legislative

[46] Washington v. Glucksberg, 521 U.S. 702, 735 (1997).

[47] Lee v. Oregon, 107 F.3d 1382 (9th Cir.), cert. denied, 522 U.S. 927 (1997).

[48] See, e.g., Hearings before the Oregon Senate Committee on Health Insurance and Bioethics on SB1141 (April 30, 1991) (statement of Richard A. Wise, ACLU of Oregon) (stating that individuals should have the right to control their own bodies and lives so long as they don't harm anyone else and that society should intervene only to make sure that the person has considered all other options) (statement of Peter Goodwin, Department of Family Medicine, Oregon Health Sciences University) (stating that the time has come to address this issue because individuals need a process for making life-ending requests).

testimony, medical opinion and the often painful realities expressed by people experiencing life with a terminal illness.[49]

The regulation of the practice of medicine has always been the province of the states and the Oregon Act is an unambiguous exercise of this traditional state power.[50] It regulates end-of-life medical care and represents the state's discharge of its regulatory obligation to administer, control and govern the practice of medicine within its borders. Oregonians recognized that, in the absence of this law, some individuals facing imminent death would resort to desperate acts of suicide, through the use of guns, knives, ropes, and other undependable means to avert the extreme pain and anguish that they face during the final days of their lives. These acts, if unsuccessful, could result in serious injury, including brain damage, coma or other adverse consequences. See supra note 12 and accompanying text. The Oregon Act is the state's legitimate response to the realities of terminal illness. Indeed, one of the side benefits of the Oregon Act is that, by making assisted dying part of the legitimate practice of medicine in that State, it has encouraged individuals nearing death to consult and seek medical treatment from their physicians and to postpone decisions to end their lives. See generally supra note 36 and accompanying text.

B. The U.S. Attorney General's Interpretation Of "Legitimate Medical Purpose" Is Not Entitled To Deference

No language in the CSA permits the U.S. Attorney General to override the will and better judgment of the people of Oregon in this area of traditional state power. The DEA does not have agency expertise in the specific medical area that the Oregon Death With Dignity Act encompasses: end-of-life medical care. The CSA does not define "legitimate medical purpose" and "public interest," and does not provide any insight as to how these terms apply in the current context, which is a context

[49] See, e.g., Hearings before the Oregon Senate Committee on Health Insurance and Bioethics on SB322 (Jan. 29, 1991); Hearings before the Oregon Senate Committee on Health Insurance and Bioethics on SB1141 (Apr. 30, 1991); Hearings before the Oregon Senate Committee on Health Insurance and Bioethics on SB286 (Feb. 18, 1993); Hearings before the Oregon House Committee of Judiciary, Subcommittee of Civil Law and Judicial Administration on HB286 (Apr. 28, 1993).

[50] See Bristol Myers Squibb Co. v. Shalala, 91 F.3d 1493, 1496 (D.C. Cir. 1996) (noting that the FDA is not authorized to regulate how a physician prescribes a medication once it has been approved under the Food Drug and Cosmetic Act).

1 that was not contemplated by Congress in enacting the CSA. Moreover, because these issues are
2 traditionally within the authority of the state, these terms must derive their definitions from Oregon
3 state law.[51] The Attorney General is thereby bound by Oregon's determination of what constitutes a
4 legitimate medical purpose, and his directive should not be entitled to any substantive weight and
5 cannot be allowed to trump the years of careful consideration of this issue by the state of Oregon.

6 C. Some Opposed To The Act Arrogantly Assume That Oregon Is Less Concerned Than
7 The Federal Government With The Well Being Of Its Citizens With Disabilities

8 In his attempts to nullify the Oregon Act under the Administrative Procedure Act, Attorney
9 General Ashcroft did not afford individuals the opportunity to testify in support of the Oregon Act.
10 Had he done so, many people with terminal illnesses and other people with disabilities, including
11 Amici, would have helped to illuminate why this law is so important. He instead reversed his
12 predecessor's standing directive without formal notice or opportunity to comment, and failed to ensure
13 "that the public interest is served by a careful and open review of the proposed administrative rules
14 and regulations."[52]

15 In contrast, the legislative record for the policy determination underlying the Oregon Act is
16 replete with evidence that the state was guided by Oregon's medical community, disability
17 community, family members of terminally ill people, and bio-ethicists.[53] Unlike the Ashcroft
18 directive, the policy determination underlying the Oregon Act resulted from a participatory process in
19 which the interests of people with disabilities were considered, representing a balance between the
20 need to ease the suffering of terminally ill and the need to provide safeguards against abuse.

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22 [51] Incorporation of state law is commonplace in federal law. For example, when the IRS serves a bank or other third party (the "custodian") with a tax levy on property belonging to a delinquent taxpayer held by the custodian, although the consequences of the custodian's failure to honor the levy flow from the Internal Revenue Code, it is state law that determines what constitutes "property" belonging to a delinquent taxpayer. See United States v. National Bank of Commerce, 472 U.S. 713, 722 (1985) ("[I]n the application of a federal revenue act, state law controls in determining the nature of the legal interest which the taxpayer had in the property . . . the federal statute creates no property rights but merely attaches consequences, federally defined, to rights created under state law.") (citations and internal quotations omitted). Thus, a custodian may successfully defend against a federal tax levy by showing that state law did not give the taxpayer a property interest in the levied property.

26 [52] See Philadelphia Citizens in Action v. Schweiker, 669 F.2d 877, 881 (3d Cir. 1982).

27 [53] See supra notes 48 & 49 and accompanying text.

CONCLUSION

On behalf of the people with disabilities whose interests we represent, Amici respectfully request that this Court permanently enjoin the Attorney General from enforcing his directive. The citizens of Oregon should be allowed to continue to implement the Oregon Act without concern that their physicians will be prosecuted, for the benefit of all people with terminal illnesses in the state.

Dated: New York, New York
March 7, 2002

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13 **<u>APPENDIX I</u>**
14 **<u>HARRIS POLL</u>**
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***THE HARRIS POLL®* #2, Embargo Until January 9, 2002**

2-to-1 Majorities Continue to Support Rights to Both Euthanasia and Doctor-Assisted Suicide

Clear majority also believes (when asked) that Attorney General Ashcroft is wrong to oppose Oregon proposition allowing physician-assisted suicide

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by Humphrey Taylor

By approximately two-to-one, most adults continue to favor the right to euthanasia and physician-assisted suicide. When read a brief description of the Oregon proposition, allowing physician-assisted suicide for patients who are thought to have less than six months to live, a 61% to 34% majority said that they would favor such a law in their state. Unsurprisingly most people say (by 58% to 35%), when told about it, that Attorney General Ashcroft was wrong to move to overrule the Oregon proposition.

These are some of the findings of the latest issue of *The Harris Poll* conducted by Harris Interactive via telephone with a nationwide sample of 1,011 adults between December 14–19, 2001. The key findings are:

- By 65% to 29%, a substantial majority thinks **"the law should allow doctors to comply with the wishes of a dying patient in severe distress who asks to have his or her life ended."** Harris Interactive has asked this question since 1982, when a 53% to 34% majority supported it. Support peaked, at 73% to 24%, in 1993 and has declined somewhat since then to the current 65% to 29% majority.

- A 63% to 32% majority disagrees with the 1997 Supreme Court ruling that individuals do not have a constitutional right to doctor-assisted suicide. These numbers are virtually identical to replies given in 1997 (65% to 32%).

- A 61% to 34% majority (when read a detailed description of it) favors the Oregon proposition that would allow doctor-assisted suicide for patients with six months to live, if all three of the following conditions were met:

  a) The patient requests it three times.
  b) There is a second physician's opinion.
  c) There is a 15-day waiting period for the patient to change his or her mind.

  It is worth noting that the 58% to 35% majority which believes that the Attorney General is wrong to oppose this proposition is slightly smaller than the 61% to 34% majority which favors the Oregon proposition. This may reflect some sympathy for the Attorney General who has been enjoying positive ratings recently, along with other senior members of the Cabinet who have been visible in fighting the "war on terrorism."

These findings *do not mean* that most people have heard about, or have opinions about, the Oregon proposition or the Attorney General's actions.

In Conclusion

No matter which questions are asked, there is a strong, approximately two-to-one majority in favor of an individual's right to euthanasia and physician-assisted suicide where terminally ill patients clearly want this to happen. Whether the opposition of many conservatives, Republicans, and the Catholic Church, among others, can reverse this position is unclear. In the short and medium term however it is seems likely that the majority support for this position found in this poll will continue.

Humphrey Taylor is the chairman of The Harris Poll®, Harris Interactive.

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TABLE 1
ATTITUDES TO EUTHANASIA -- TREND

"Do you think that the law should allow doctors to comply with the wishes of a dying patient in severe distress who asks to have his or her life ended, or not?

Base: All adults

	1982	**1987**	**1993**	**1997**	2001 Dec.
	%	%	%	%	%
Yes, should allow	53	62	73	68	65
No, should not allow	34	32	24	27	29
Not sure	8	4	3	4	6

TABLE 2
AGREE/DISAGREE WITH SUPREME COURT RULING

"In 1997, the U.S. Supreme Court ruled that individuals do not have a constitutional right to doctor-assisted suicide. Do you agree or disagree with this decision?"

Base: All adults

	1997	**2001 December**
	%	%
Agree	32	32
Disagree	65	63
Not sure	3	4

TABLE 3
FAVOR/OPPOSE LEGALIZING ASSISTED SUICIDE BASED ON NEW OREGON LAW*

"In 1994, people in Oregon voted on a proposition that would allow doctor-assisted suicides for PATIENTS WITH LESS THAN SIX MONTHS TO LIVE. Doctors would be allowed to help patients to commit suicide -- but only if -- ALL of the three following conditions were met:

a) The patient requests it three times.
b) There is a second opinion from another doctor.
c) There is a 15-day waiting period for the patient to change his or her mind.

Would you favor or oppose such a law in your state?"

Base: All adults

	2001 December
	%
Favor	61
Oppose	34
Not sure	5

TABLE 4
WAS ATTORNEY GENERAL RIGHT OR WRONG TO OVERRULE OREGON PROPOSITION

"This proposition, allowing physician-assisted suicide, was approved by a majority in Oregon. Attorney General Ashcroft recently moved to overrule the proposition, which he says is now illegal.
Do you think Attorney General Ashcroft was right or wrong to do this?

Base: All adults

	2001 December
	%
Right	35
Wrong	58
Not sure/refused	7

The Views of People With Disabilities

TABLE 1
ATTITUDES TO EUTHANASIA

"Do you think that the law should allow doctors to comply with the wishes of a dying patient in severe distress who asks to have his or her life ended, or not?"

Base: People with disabilities

	1997	2001
	%	%
Yes, should allow	77	68
No, should not allow	21	26
Not sure	3	6

TABLE 2*
FAMILIAR WITH RECENT DOCTOR-ASSISTED SUICIDE CASE

"How familiar are you with the recent case argued before the U.S. Supreme Court involving doctor-assisted suicide -- very familiar, somewhat familiar, not very familiar or not at all familiar?"

Base: People with disabilities

	1997
	%
Very familiar	16
Somewhat familiar	59
Not very familiar	16
Not at all familiar	9

* Question asked in 1997 only

TABLE 3
AGREE/DISAGREE WITH SUPREME COURT RULING

"In 1997, the U.S. Supreme Court ruled that individuals do not have a CONSTITUTIONAL RIGHT to doctor-assisted suicide. Do you agree or disagree with this decision?"

Base: People with disabilities

	1997	2001
	%	%
Agree	27	29
Disagree	70	66
Not sure	2	4

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TABLE 4
FAVOR/OPPOSE LEGALIZING ASSISTED SUICIDE BASED ON NEW OREGON LAW

"In 1994, people in Oregon voted on a proposition that would allow doctor-assisted suicides for PATIENTS WITH LESS THAN SIX MONTHS TO LIVE. Doctors would be allowed to help patients to commit suicide -- but only if -- ALL of the three following conditions were met:

a) The patient requests it three times.
b) There is a second opinion from another doctor.
c) There is a 15-day waiting period for the patient to change his or her mind.

Would you favor or oppose such a law in your state?"

Base: People with disabilities

	1997	2001
	%	%
Favor	73	68
Oppose	23	29
Not sure	4	3

TABLE 5**
WAS ATTORNEY GENERAL RIGHT OR WRONG TO OVERRULE OREGON PROPOSITION

"This proposition, allowing physician-assisted suicide, was approved by a majority in Oregon. Attorney General Ashcroft recently moved to overrule, which he says is now illegal. Do you think Attorney General Ashcroft was right or wrong to do this?"

Base: People with disabilities

	2001
	%
Right	31
Wrong	63
Not sure	6

** Question asked in 2001 only

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Methodology

This issue of *The Harris Poll*® was conducted by telephone within the United States between December 14–19, 2001 among a nationwide cross section of 1,011 adults. Figures for age, sex, race, education, number of adults and number of voice/telephone lines in the household were weighted where necessary to align them with their actual proportions in the population.

In theory, with a probability sample of this size, one can say with 95 percent certainty that the results have a statistical precision of plus or minus 3 percentage points of what they would be if the entire adult population had been polled with complete accuracy. Unfortunately, there are several other possible sources of error in all polls or surveys that are probably more serious than theoretical calculations of sampling error. They include refusals to be interviewed (non-response), question wording and question order, interviewer bias, weighting by demographic control data and screening (e.g., for likely voters). It is difficult or impossible to quantify the errors that may result from these factors.

These statements conform to the principles of disclosure of the National Council on Public Polls.

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APPENDIX II

PERSONAL STATEMENTS