The Oregon Death with Dignity Act: Relief of Suffering at the End of Medicine’s Ability to Heal

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ABSTRACT

Not fully analyzed in the debate about Oregon’s physician-assisted suicide law is a discussion of the values underlying the Attorney General’s determination that physician-assisted suicide is not a “legitimate medical purpose.” According to the U.S. Attorney General’s strongest argument, the phrase “legitimate medical purpose” should be understood with reference to a view of medicine as a beneficent art aimed only at healing. Physician-assisted suicide cannot serve the goal of healing and therefore it cannot be a legitimate medical purpose. This argument defines the primary goal of medicine as patient benefit through healing and health promotion; however, it takes too narrow a view of the goals of medicine. The Attorney General’s view does not reflect the role of patient autonomy in defining legitimate medical purposes and does not consider that relief of suffering is the best benefit that medicine can achieve when health/healing is no longer attainable. Relief of suffering takes primacy over the goal of healing for terminally ill patients; with that goal in mind, physician-assisted suicide, under conditions defined by the Oregon Act, should be viewed as a legitimate medical practice because it respects the patient’s autonomous choice about how to treat his/her suffering.

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Physician-assisted suicide encompasses a variety of practices ranging from prescribing lethal medication to a patient to injecting lethal drugs for a patient. Oregon is the first—and so far only—state to enact a law permitting physician-assisted suicide in certain circumstances. The Oregon Death with Dignity Act [“Oregon Act”] allows a physician to give a written prescription for a lethal dose of medication to a terminally ill, competent patient once certain procedural safeguards have been met.

In November 2001, United States Attorney General John Ashcroft pronounced that physician-assisted suicide, as defined by the Oregon Act, is not a “legitimate medical purpose” under the Controlled Substances Act and its
implementing regulations, which regulate drugs such as those prescribed by Oregon physicians in accordance with the Oregon Act. The Attorney General’s objection to the Oregon Act is that since physician-assisted suicide is not a “legitimate medical purpose,” the prescription of lethal doses of controlled substances is against the public interest and subject to prosecution by the Drug Enforcement Administration.

The Oregon Act is animated by a fundamentally different understanding of the goals of medicine than the view of medicine upon which the Attorney General relies. Whereas the Attorney General believes medicine’s purpose is to heal and preserve life, Oregon’s law reflects a more nuanced conception of the goals of medicine than the traditional Hippocratic ethic because it incorporates respect for patient autonomy, especially where the patient is best situated to know his own limits.

Part I lays the foundation for my argument by briefly describing the case challenging the legal framework the Attorney General used to determine that prescribing controlled substances for physician-assisted suicide violates the Controlled Substances Act.

Part II discusses the legitimate medical purpose argument made by the Attorney General’s office in the Office of Legal Counsel (OLC) Memo. This memorandum plays a central role in delineating the Attorney General’s understanding of legitimate medical purpose and argues that physician-assisted suicide is not a “legitimate medical purpose” because it does not benefit the patient by serving the goal of healing.

Part III traces the evolution of the definition of “legitimate medical purpose” from an understanding based in Hippocratic norms to one focused on patient autonomy. Although the Attorney General believes that “legitimate medical purpose” can be understood by looking at historically accepted practices, the evolution of medical technology drives a corresponding evolution in the acceptable range of medical practices and choices. The Attorney General’s reliance on the goals of medicine reflected in the Hippocratic Oath is misplaced because the Hippocratic understanding is based on a narrow notion of beneficent paternalism. I will argue that such a view does not reflect the value of patient autonomy.

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4. See Controlled Substances Act, 21 U.S.C. §§ 801–971 (2000). There are five schedules of controlled substances ranging from those drugs with a high potential for abuse and no currently accepted medical use (Schedule I) to those drugs that have a low potential for abuse relative to all other classes and an accepted medical use (Schedule V). See 21 U.S.C. § 812. Barbiturates, opioids, and benzodiazepines are most commonly used in physician-assisted suicide and are classified as Schedule II or III drugs. See id.

5. When I refer to the Hippocratic ethic or Hippocratic goals of medicine, I mean an understanding of medicine that is based in Hippocrates’ most famous maxim “do no harm.” For discussion of the contested origins of the “do no harm” principle, see infra note 99. Part of this Hippocratic understanding of medicine is that the doctor knows what is best for the patient and is therefore justified in exerting a degree of paternalism over his patient.
that is also central to medicine. Relief of suffering is as important a goal as healing; indeed, it takes primacy for terminally ill patients who, by definition, cannot be healed. Because relief of suffering is the guiding goal, it is important to distinguish suffering from pain to avoid the counter-argument that pain can be adequately dealt with and therefore physician-assisted suicide is an unnecessary measure. Suffering is defined as a threat to “self” that is experienced in individualized and particularistic ways, of which pain is but one form.

Finally, Part IV concludes that the Oregon Act embodies a legitimate medical purpose when relief of suffering is the goal of medicine.

I. HISTORY OF THE OREGON DEATH WITH DIGNITY ACT

In 1994, the state of Oregon, through a voter-initiated referendum, enacted the country’s first law allowing physician-assisted suicide. The Oregon Act allows physicians to prescribe lethal doses of controlled substances, subject to a number of safeguards and regulatory measures, when requested by terminally ill patients. Prior to the law’s effective date, then-Senator John Ashcroft pressured then-Attorney General Janet Reno to declare the use of controlled substances in physician-assisted suicide a violation of the Controlled Substances Act (CSA). Attorney General Reno declined to do so and determined that the CSA did not authorize enforcement action against physicians involved in physician-assisted suicide using controlled substances. Congress unsuccessfully attempted to amend the CSA to authorize the Attorney General to revoke the registration of any physician who dispensed controlled substances to aid in suicide. Despite attempts at the state and federal level to prevent the Oregon Act from taking effect, the


7. See Oregon v. Ashcroft, 368 F.3d 1118, 1123 (9th Cir. 2004). The Controlled Substances Act was enacted to provide a comprehensive federal regulatory system for certain drugs—its principle purpose is to address the problems of drug abuse and illegal trafficking. See H.R. Rep. No. 91-1444 (1970), reprinted in 1970 U.S.C.C.A.N. 4566, 4567 (stating that the purpose of the Controlled Substances Act is to deal with the “growing menace of drug abuse” and to provide a more effective law enforcement regime).

8. See Oregon v. Ashcroft, 368 F.3d at 1123. Attorney General Reno issued a finding that the CSA was “not intended to displace states as the primary regulators of the medical profession, or to override a state’s determination of what constitutes a legitimate medical practice.” Id. (internal quotation marks omitted).

9. See id. at 1123 n.4.

10. Immediately after Oregon’s Measure 16 physician-assisted suicide ballot won a majority, a class action was instituted on behalf of terminally ill Oregon patients challenging the validity of the measure on the grounds that it violated the Equal Protection and Due Process Clauses of the Fourteenth Amendment, the First Amendment rights of freedom to exercise religion and to associate, and the Americans with Disabilities Act. The judge granted an immediate injunction pending the litigation of the constitutional issues. See Lee v. Oregon, 869 F. Supp. 1491, 1493 (D. Or. 1994). Judge Hogan eventually declared Measure 16 unconstitutional. See Lee v. Oregon, 891 F. Supp. 1429, 1438 (D. Or. 1995). After the Supreme Court’s decision in Washington v. Glucksberg, the state legislature introduced a ballot measure to repeal Oregon’s physician-assisted suicide law (Measure 51). With almost a week
Act became law after citizens of Oregon overwhelmingly voted for it a second time.11

For nearly four years, the Oregon Act regulated the practice of physician-assisted suicide for competent, terminally ill residents, with the aim of allowing these patients some control and dignity at the ends of their lives12 when, as the U.S. District Court for the District of Oregon characterized it, newly appointed Attorney General Ashcroft “with no advance warning . . . fired the first shot in the battle . . . over [who] has the ultimate authority to decide . . . .”13 In 2001, Attorney General Ashcroft issued his now controversial “Ashcroft Directive” without consulting Oregon officials.14 The Directive incorporates a memorandum drafted by two of his staff at the Office of Legal Counsel and declares that: 1) “assisting suicide is not a ‘legitimate medical purpose’ within the meaning” of the Drug Enforcement Administration’s regulations defining what is a proper prescription; and 2) “prescribing, dispensing, or administering federally controlled substances to assist suicide violates the CSA” because such conduct is “inconsistent with the public interest.”15

Attorney General Ashcroft used the Controlled Substances Act to oppose the Oregon law permitting physician-assisted suicide because the drugs used most often in that procedure are regulated under the Act.16 Under the CSA, physicians may prescribe and dispense controlled substances so long as they are registered by the Attorney General and receive a registration certificate from the Drug Enforcement Administration (DEA).17 Initially, physician registration occurred automatically so long as the physician was registered, in good-standing,
and duly licensed by her state. Congress amended the CSA so that registration could be denied if the Attorney General found it to be clearly against the public interest.\footnote{18} Although the CSA does not itself state that such prescriptions only may be written for legitimate medical purposes, that requirement has been made explicit in DEA implementing regulations.\footnote{19} The specific rule that provided the basis for Attorney General Ashcroft’s directive requires that controlled substance prescriptions written by physicians be issued “for a legitimate medical purpose . . . in the usual course of his professional practice.”\footnote{20} Having declared that physician-assisted suicide serves no “legitimate medical purpose,” the Attorney General could thus find that the registration of a physician who acts in accordance with the Oregon Act is “inconsistent with the public interest” and therefore revocable.\footnote{21} Had enforcement not been immediately enjoined, the Attorney General’s directive would have had the effect of specifically targeting Oregon’s physicians despite their compliance with Oregon state law.\footnote{22}

Oregon immediately instituted a lawsuit to enjoin the Attorney General from giving his directive legal effect.\footnote{23} On January 17, 2006, the Supreme Court issued an opinion foreclosing the Attorney General’s attack on the Oregon Act by affirming the Ninth Circuit Court of Appeals’s conclusion that the Ashcroft Directive exceeded the Attorney General’s powers under the CSA.\footnote{24} The court of appeals’s opinion took “no position on the merits or morality of physician assisted suicide” and expressed “no opinion on whether the practice is inconsistent with the public interest or constitutes illegitimate medical care.”\footnote{25} Simi-

\footnote{18. See 21 U.S.C. § 823(b) (2000). In determining what is “against the public interest” the Attorney General is required to consider five factors. See id. This section states that the Attorney General shall consider the five listed factors in determining the public interest with respect to controlled substance distributor registration. The factors include: (1) “maintenance of effective control against diversion of particular controlled substances into other than legitimate medical, scientific, and industrial channels”; (2) “compliance with applicable State and local law”; (3) “prior conviction record of applicant under Federal or State laws relating to the manufacture, distribution, or dispensing of such substances”; (4) “past experience in the distribution of controlled substances”; and (5) “such other factors as may be relevant to and consistent with the public health and safety.” Id. The Ashcroft Directive is seemingly based solely on the fifth factor. See OLC Memorandum, supra note 3, at 271 (taking note of the fact that the fifth factor includes “such other factors as may be relevant to and consistent with the public health and safety.”).}


\footnote{20. Id.}

\footnote{21. See Ashcroft Directive, supra note 3.

\footnote{22. See Oregon v. Ashcroft, 192 F. Supp. 2d 1077, 1093 (D. Or. 2002) (ordering a permanent injunction against the enforcement of the Ashcroft Directive); Ashcroft Directive, supra note 3, at 56, 608. Attorney General Ashcroft’s directive instructed the DEA to take enforcement action “regardless of whether state law authorizes or permits such conduct.” Id. The Attorney General’s directive could certainly have been used as grounds for enforcement actions against physicians who were illegally involved in physician-assisted suicide. But because physician-assisted suicide is only legal in Oregon, which has imposed stringent reporting requirements on those doctors who assist patients, physicians in that state would have been particularly easy targets for DEA enforcement action.


\footnote{24. Gonzales v. Oregon, 126 S. Ct. 904 (2006) (aff’d Oregon v. Ashcroft, 368 F.3d 1118, 1127 (9th Cir. 2004)).

\footnote{25. Oregon v. Ashcroft, 368 F.3d at 1123.}}
larly, Justice Kennedy’s majority opinion avoided taking a stance on the merits of physician-assisted suicide or whether it constitutes a “legitimate medical purpose.”

Rather, the majority based its opinion almost entirely on statutory interpretation of Congress’s grant of power with regard to regulating prescriptions.

While no court involved in this case explicitly addressed the definition of a “legitimate medical purpose,” the phrase played an important role in the arguments made. Both the Attorney General’s argument and Justice Scalia’s strongly-worded dissent based their opinion that physician-assisted suicide is not a “legitimate medical purpose” largely on a determination of what practices are acceptable according to Hippocratic goals of medicine. The majority, however, characterized this view of “medicine’s boundaries” as but “one reasonable understanding of medical practice.”

Justice Scalia responded that the “only explanation for such a distortion” of the “overwhelming weight of authority” cited by the Attorney General is “that the Court confuses the normative inquiry of what the boundaries of medicine should be . . . with the objective inquiry of what the accepted definition of ‘medicine’ is.”

Justice Scalia and the Attorney General, however, fail to acknowledge that their conception of the goals of medicine reflects a narrow notion of medicine’s ultimate end and limits the role of the physician to healer, and healer alone.

II. LEGITIMATE MEDICAL PURPOSE: “ONE REASONABLE UNDERSTANDING”

Although neither the Ninth Circuit nor the Supreme Court explored whether physician-assisted suicide is a legitimate medical purpose, a further explication of this issue is warranted because it enriches the majority view and because it responds to the objections of both the Attorney General and Justice Scalia. With so much of the Attorney General’s argument focused on the phrase “legitimate medical purpose,” it might seem surprising that the courts have paid it so little attention. Arguments about what constitutes a legitimate medical purpose or practice in end-of-life decisionmaking are central to the ongoing debate, especially if Congress moves to overrule the Oregon Act or authorize the Attorney General to undertake the regulatory action proposed by the Ashcroft Directive.

The Controlled Substances Act does not define the phrase “legitimate medical

26. See Gonzales, 126 S. Ct. at 916.
28. See Gonzales, 126 S. Ct. at 924.
29. Id. at 932 (Scalia, J., dissenting). But see Brief of Margaret P. Battin, et al. as Amici Curiae Supporting Plaintiff-Appellees at 8–10, Oregon v. Ashcroft, 368 F.3d 1118 (9th Cir. 2004) (No. 02-35587) (hereinafter Oregon Bioethicist Brief) (stating that only a minority of contemporary ethicists view medicine as having fixed objectives).
30. See OLC Memorandum, supra note 3, at 273–82. This section of the OLC argument is by far the lengthiest; other sections are each only a few paragraphs long.
purpose.” The DEA implementing regulations merely state that for a prescription to be valid it must have been written pursuant to a “legitimate medical purpose” without defining that phrase. The DEA’s rule does not contemplate a complete philosophy of medicine as a prerequisite to making determinations about whether prescriptions for controlled substances are lawful. Rather, the agency is tasked with looking more narrowly at whether prescriptions are written pursuant to a lawful and accepted practice. The DEA has used the phrase “legitimate medical purpose” to refer primarily to individual medical practices and activities. The Office of Legal Counsel has taken a very different approach—the argument that physician-assisted suicide is not a “legitimate medical purpose” is informed by a particular view of the overall goals of medicine and the physician’s role in furthering those goals. The OLC’s view of the goal of medicine is but one interpretation which leads inexorably to the Attorney General’s conclusion that physician-assisted suicide is not a legitimate medical purpose.

The OLC Memorandum gives three reasons why assisting suicide through the prescription of controlled substances is not a “legitimate medical purpose.” First, the OLC states that this reading of the regulatory language is supported by case law. Second, the traditions and policies of both the federal and state governments support such a reading. Lastly, such an interpretation concurs with the “dominant views” of the medical professions in the United States.

A. EVIDENCE FROM CASE LAW

The OLC Memorandum argues that case law supports a determination that physician-assisted suicide is not a “legitimate medical purpose” under the CSA.

31. I do not purport to undertake an analysis of the phrase “legitimate medical purpose” based on principles of statutory interpretation or even its meaning within the confines of the CSA. Rather my analysis critiques the reasoning of the Office of Legal Counsel. The OLC Memo relied on exogenous sources in determining that physician-assisted suicide was not a legitimate medical purpose. I consider each of those sources in turn and consider additional sources in an effort to show that the U.S. government’s interpretation reflects a singularly narrow view, perhaps even artificially so, of the goals of medicine.


33. I contend that “legitimate medical purpose” refers not to the purpose of medicine as an art or profession but rather to the medical purpose of certain practices or procedures. (I will use the terms “legitimate medical purpose” and “legitimate medical practice” relatively interchangeably.) One can hardly argue that the Drug Enforcement Administration is the body with expertise and institutional competence to determine the purposes of the medical profession but it may be competent to determine that some practices/procedures are so far outside the bounds of medicine that they are rightly considered to be drug trafficking. See infra text accompanying notes 38–44.

34. For instance, a morphine prescription for cancer pain control is recognized as a legitimate use of a controlled substance. See, e.g., H.R. REP. No. 105-46, § 3, at 15 (1997), as reprinted in 1997 U.S.C.C.A.N. 30, 41–42. However, prescriptions for methadone that are not given in conjunction with a step-down drug rehabilitation program are not legitimate because methadone has not been approved for use outside of such a setting. See, e.g., U.S. v. Moore, 423 U.S. 122, 144 (1975).

35. See OLC Memorandum, supra note 3, at 273.

36. See id.

37. See id.
The OLC relies upon *United States v. Moore* for the proposition that a physician’s actions must “conform to standards ‘generally recognized and accepted’” throughout the country. The OLC uses this language to conclude that because physician-assisted suicide is not “generally recognized and accepted” everywhere in the United States, it follows that prescribing controlled substances to assist in suicide is not a legitimate medical purpose. However, *Moore* dealt not with a physician engaged in prescribing practices approved in any state but rather with prescribing practices that are clearly outlawed in all states and by the federal government. Dr. Moore had written more than 11,100 prescriptions for 800,000 methadone tablets during a five-and-a-half month period. At one point, Moore was writing about 100 prescriptions per day and billing his “patients” on a sliding-scale according to how much of the drug was prescribed.

The issue in *Moore* was about which section of the CSA could be used to prosecute the physician rather than whether he had prescribed Schedule II drugs for a “legitimate medical purpose.” Moore argued that he was prescribing for a legitimate purpose and in the course of professional conduct, claiming that he was testing a new drug abuse detoxification regime. But the court found he was acting as a “large-scale ‘pusher’—not as a physician.” Congress did not authorize physicians to prescribe controlled drugs in a way that is patently illegal—the CSA was designed to address drug abuse and diversion of prescriptions for trafficking. At best, this case only illustrates the obvious with respect to the meaning of “legitimate medical purpose”—pedaling large quantities of addictive drugs is not a legitimate medical purpose. Indeed this activity should probably not even be considered a medical purpose at all. Even if read more favorably to the Attorney General’s position, *Moore* is distinguishable from the physician-assisted suicide case because that practice is legalized by the state of Oregon while physician-facilitated drug dealing is not legal anywhere. Thus, *Moore* is not particularly illuminating with respect to what constitutes a “legitimate medical purpose.”

The OLC Memo also relies heavily on *Washington v. Glucksberg* as proof that physician-assisted suicide is not a legitimate medical purpose because it does not meet the “generally recognized and accepted” standard that the Moore Court enunciated. The Memo draws support from language in the *Glucksberg*
opinion cataloging historical opposition to suicide and assisted suicide in the United States, which is relevant to the Court’s substantive due process analysis.46 Indeed, the issue in Glucksberg is not about whether physician-assisted suicide constitutes a legitimate medical purpose; rather, the issue is whether there is a right to commit suicide—including a right to assistance in that endeavor—protected by the Due Process Clause.47

Glucksberg was a Fourteenth Amendment challenge to a Washington state law that prohibited physician-assisted suicide in circumstances similar to those in which assisted suicide was allowed by the Oregon Act.48 After the state of Washington explicitly banned physician-assisted suicide, a group of physicians and terminally ill patients challenged that law claiming that mentally competent, terminally ill persons have a constitutionally protected liberty interest in physician-assisted suicide.49 The Office of Legal Counsel relied exclusively on Chief Justice Rehnquist’s comprehensive review of historical opposition to physician-assisted suicide—which Chief Justice Rehnquist undertook in the context of substantive due process analysis50—while ignoring the opinion’s federalism tenor.51 The Glucksberg majority characterized their holding as allowing the “earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide” to continue “as it should in a democratic society.”52 Although Glucksberg upheld a statute outlawing physician-assisted suicide, it did not preclude states from passing different laws, and it left open the question of whether assisted suicide is a legitimate medical practice. There is a distinction

46. See id. at 274–75.
48. See id. at 705–06.
49. Id. at 708.
50. See id. at 710–19. It is notable that the Chief Justice’s recitation of historical opposition to suicide was undertaken for substantive due process purposes, rather than because of any question of what practices have a legitimate medical purpose. Substantive due process rights are those grounded in the concept of liberty protected by the Fourteenth Amendment, discernable through a consideration of which types of choices have historically been considered a part of “ordered liberty.” See, e.g., Planned Parenthood v. Casey, 505 U.S. 833, 851 (1992).
51. See OLC Memorandum, supra note 3, at 274–75. My characterization of the opinion’s federalism tenor is not meant to imply that the opinion was decided on federalism grounds—but language in the majority and concurring opinions indicates the Court was cautious not to remove the issue from consideration by individual states. See Glucksberg, 521 U.S. at 735 (Rehnquist, C.J.); id. at 736–38 (O’Connor, J., concurring); id. at 738–39 (Stevens, J., concurring in the judgments); id. at 787–89 (Souter, J., concurring in the judgment). However, there is scholarly debate about exactly how far this “federalism tenor” extends. Compare Norman Redlich & David R. Lurie, Federalism: A Surrogate for What Really Matters, 23 OHIO N.U. L. REV. 1273, 1285 n.68 (1997) (“[N]either side in the recent physician assisted suicide case, Washington v. Glucksberg . . . in which the Court refused to recognize a proposed new constitutional right-to-die, and left the issue to the states—viewed the result as a triumph of federalism. Rather, all parties to the debate, including the Justices authoring opinions in the case, addressed the soul searching issue presented as one of governmental regulatory authority versus individual rights, not of state versus federal regulatory powers.”) with Steven B. Datlof, Beyond Washington v. Glucksberg: Oregon’s Death with Dignity Act Analyzed from Medical and Constitutional Perspectives, 14 J.L. & HEALTH 23, 37–40 (2000) (“[T]he Court has indicated that it wants to promote, rather than stifle debate on end-of-life decision making. It has also stated that the legislature, not the courts, should be setting policy in this realm. The Court has acknowledged that refraining from expanding the concept of substantive due process by defining new fundamental rights serves these interests.”).
52. See Glucksberg, 521 U.S. at 735.
between declaring that someone has a right or liberty interest in physician-assisted suicide and deciding that physician-assisted suicide may constitute a legitimate medical practice. Granting physician-assisted suicide status as a protected liberty interest would effectively remove the question of legalizing or outlawing the practice from the broader public, democratic process. On the other hand, allowing that physician-assisted suicide may be a legitimate medical practice provides an opportunity for states to explore the issue and decide for themselves whether and under what circumstances it should be allowed. By refusing to recognize a protected liberty interest in physician-assisted suicide, the Court left it to the “laboratory of the states” to “strike the 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.”

The OLC Memo tries to support its claim that physician-assisted suicide is illegitimate with case law that does not actually address the meaning of “legitimate medical purpose.” Moore clearly illustrates that pedaling controlled substances is not a legitimate medical purpose while Glucksberg upholds a law banning physician-assisted suicide because the practice does not enjoy constitutional protection as a liberty interest. Whether physician-assisted suicide may be a legitimate medical practice is not addressed by either case.

B. EVIDENCE FROM FEDERAL AND STATE POLICIES

The OLC Memo claims that both state and federal policy support the argument that physician-assisted suicide is not a legitimate medical purpose.

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53. Such a determination likely would not quell debate or discussion itself and in fact might intensify it. But classifying something as a protected liberty interest restricts states from determining through democratic processes how to deal with controversial issues. If physician-assisted suicide was a protected liberty interest, the Washington statute at issue in Glucksberg would have been unconstitutional and states would be required to allow the practice as an exercise of individual due process rights.

54. In this respect, the physician-assisted suicide debate mirrors the abortion debate. There has been a great deal of criticism of Roe v. Wade on the grounds that the Supreme Court effectively removed abortion from democratic debate by finding a protected constitutional interest and then prescribing when and how it might occur. See, e.g., Editorial, The Right to Strife, NEW REPUBLIC, June 6, 1981, at 5 (“[P]oliticians at the state level were beginning to grapple with abortion reform in the late 1960s, but the Supreme Court, with its landmark 1973 decision, Roe v. Wade, short-circuited the political process.”). In Planned Parenthood v. Casey, Justice Scalia issued a stinging indictment of Roe as elevating abortion to the national level “where it is infinitely more difficult to resolve” and said of the Casey majority that “to portray Roe as the statesmanlike ‘settlement’ of a divisive issue, a jurisprudential Peace of Westphalia that is worth preserving, is nothing less than Orwellian.” 505 U.S. 833, 995 (1992). Glucksberg can be viewed as an attempt by the Supreme Court to fix what may be viewed as Roe’s misstep by leaving the debate about physician-assisted suicide to the states. See John F. Basiak, Jr., Dangerous Predictions: Referencing “Emerging” History and Tradition in Substantive Due Process Jurisprudence in an Era of Blue State Federalism, 15 WIDENER L.J. 135, 153–60 (2005); Richard H. Fallon, Jr., The Supreme Court, 1996 Term—Foreword: Implementing the Constitution, 111 HARV. L. REV. 54, 139–41 (1998) (noting that “Glucksberg reflected none of the judicial hubris often ascribed to Roe” and stating that “[a]lthough no Justice said so, the continuing controversy surrounding Roe v. Wade almost surely played a large role in the Court’s thinking”).

55. See Glucksberg, 521 U.S. at 737 (O’Connor, J., concurring) (quoting Cruzan v. Dir. of Mo. Dep’t of Health, 497 U.S. 261, 292 (1990)) (internal quotation marks omitted).
And, though many states have laws that ban assisted suicide of any kind and others specifically ban physician-assisted suicide, the mere existence of such laws does not dictate any conclusions about whether physician-assisted suicide was disapproved of because it was viewed as an illegitimate medical purpose or for other reasons entirely.

To illustrate federal policy support for the claim against physician-assisted suicide, the OLC points to the Assisted Suicide Funding Restriction Act of 1997. The Assisted Suicide Funding Restriction Act banned federal funding of assisted suicide because assisted suicide/euthanasia was illegal in every state at the time. Congress recognized that the Oregon Act might become law but decided that the federal government would not provide financial assistance in support of such practices even if they were legalized at the state level. The OLC also cites correspondence noting that the Health Care Financing Administration determined that physician-assisted suicide is barred from reimbursement under Medicare because it is not “‘reasonable and necessary’ to the diagnosis and treatment of disease or injury.” The OLC uses these documents to draw an inference that physician-assisted suicide is not a legitimate medical practice. However, rather than speaking directly to the issue of legitimate medical purpose, the Funding Restriction Act and related correspondence reflect a policy choice by Congress not to pay for things that are unreasonable or unnecessary in the treatment or diagnosis of disease or injury. The language delineating that policy choice also includes any number of other procedures and practices (for example, cosmetic surgery, experimental cancer treatments, etc.) that the OLC is not arguing are illegitimate medical practices just by virtue of falling outside the designation “‘reasonable and necessary’ to the diagnosis and treatment of disease or injury.” These simply are procedures which the Medicare administrative body determined should not be covered under statutory language requiring that payments be made only for services reasonably necessary to diagnose or treat disease or injury. Finally, the OLC cites the Surgeon General’s Call to Action to Prevent Suicide and concludes that “dispensing controlled substances to assist the suicides . . . of the most vulnerable . . . is manifestly incon-

56. See OLC Memorandum, supra note 3, at 275–76.
58. Id. § 14401(a)(3)–(4).
59. See OLC Memorandum, supra note 3, at 277 (citing correspondence from the chairmen of the House and Senate Committees on the Judiciary to the Administrator of the DEA in which the chairmen note the Health Care Financing Administration’s position).
60. Opponents of physician-assisted suicide may seize on this as a concession on my part. However, I concede nothing other than the very narrow point that physician-assisted suicide does not diagnose disease or treat disease or injury, in the sense of healing or curing. However, this does not preclude the argument that physician-assisted suicide may be a legitimate medical practice when used for relief of suffering.
61. U.S. PUBLIC HEALTH SERVICE, THE SURGEON GENERAL’S CALL TO ACTION TO PREVENT SUICIDE (1999). In 1996, the World Health Organization (WHO) recognized suicide as a public health problem. The United States formed an innovative public/private partnership to develop a national strategy on suicide prevention. This report was part of the work-product of that group. It recognizes that suicide
sistent with the Surgeon General’s policy” statement. There are certainly reasons for grave concern about suicide among depressed or mentally impaired persons. But this charge alone is not enough to support the claim that physician-assisted suicide is not a legitimate medical purpose without evaluating whether there are ways to regulate and monitor the practice such that those “most vulnerable” populations are protected.

The OLC Memorandum fails to demonstrate persuasively that state and federal policies oppose physician-assisted suicide as a legitimate medical practice. The earnest debate about physician-assisted suicide that many states are engaged in is illustrated by a number of ballot measures and legislative proposals. While Oregon is the only state to legalize physician-assisted suicide, there is far from a consensus that physician-assisted suicide should be illegal or that it is an illegitimate medical practice.

C. EVIDENCE FROM THE VIEWS OF THE MEDICAL PROFESSION

Finally, the OLC argues that because leading medical professional organizations condemn the practice of physician-assisted suicide, it cannot be a legitimate medical practice. The OLC Memorandum cites the views of the American Medical Association (AMA), the American Nursing Association (ANA), and forty-four other national medical organizations as presented in an amicus brief in Washington v. Glucksberg. Centrally, the amici organizations view physician-assisted suicide as “fundamentally incompatible with the physician’s role as healer”—a role that is enshrined in both the AMA’s Code of Ethics and the Hippocratic Oath.

One might consider this the most damning evidence against physician-assisted suicide because doctors, nurses, and other medical professionals are presumably best situated to pass judgment on what constitutes legitimate medical practice. But while members of the AMA and ANA might sincerely believe that physician-assisted suicide is not a legitimate medical purpose, their opposition should not be the final word in the debate in part because it is not at all

accounts for more deaths than homicides and is particularly pernicious among people with mental and substance abuse disorders. See id. at 1–2.

62. See OLC Memorandum, supra note 3, at 277–78.

63. California, Washington, and Michigan have proposed ballot measures to legalize physician-assisted suicide, and Art Caplan, a bioethics professor, has opined that “we will see some movement toward . . . emulating Oregon.” See Anderson Cooper 360 Degrees (CNN television broadcast Jan. 17, 2006). Other states have attempted to pass bills; Maine and Vermont are expected to try again. Id. Maine’s “Question 1,” which would have legalized physician-assisted suicide under conditions similar to Oregon’s law, “failed by a whisker.” Fears about how the law would be implemented, rather than whether physician-assisted suicide was a legitimate medical purpose, caused the defeat. See Editorial, Details Deciding Factor in Maine Ballot Issues, Portland Press Herald, Nov. 9, 2000, at 16A.

64. See OLC Memorandum, supra note 3, at 279.


66. See id. at 2–5.
clear that these professional organizations speak for the profession as a whole.\textsuperscript{67} Although the “AMA leadership has emphasized that it believes physician-assisted suicide to be morally wrong and poor public policy,” an empirical study of the issue suggests that “this view is probably not shared by most practicing physicians.”\textsuperscript{68} Physician-assisted suicide conflicts with the current \textit{institutional} view of the AMA and other organizations; that view can be understood as based on a narrow conception of the goals of medicine, which is but one among competing conceptions.

The next Part argues that whether physician-assisted suicide is considered a legitimate medical purpose depends on what the goals of medicine are. The AMA’s position relies on the Hippocratic ethic informed by a notion of beneficent paternalism.\textsuperscript{69} However, I argue that a broader understanding of the goals of medicine that incorporates respect for patient autonomy is necessary.

III. SHIFTING PERSPECTIVES: BALANCING BENEFICENCE-BASED MEDICINE WITH AUTONOMY

It makes little sense to try to define or articulate the meaning of “legitimate medical purpose” without considering the goals of medicine. How could we determine what practices should be deemed legitimate if we do not first figure out what medicine hopes to accomplish? As discussed, “legitimate medical

\textsuperscript{67} See Simon N. Whitney et al., \textit{Views of United States Physicians and Members of the American Medical Association House of Delegates on Physician-Assisted Suicide}, 16 J. Gen. Internal Med. 290 (2001). “The AMA's strong position might suggest that it speaks for a united profession, but [until now] there has never been a nationwide study of the opinions of physicians of all specialties towards physician-assisted suicide.” \textit{Id.} at 290. Indeed, the results of the survey indicate that the “views of members of the AMA House of Delegates are strikingly different” from non-delegates’ views. \textit{Id.} at 296. Of the AMA delegates surveyed, 62% favored outlawing physician-assisted suicide, while 45% of non-delegate physicians supported legalization and only 34% believed it should be illegal (the remaining non-delegate physicians were uncertain). \textit{Id.} at 292–93. One explanation for the difference is that AMA House of Delegates members were more likely to be older, white, politically conservative men than doctors sampled from the general population. \textit{Id.} at 293. But even when other personal characteristics were held constant, the study found that “being a delegate was an independent and strongly significant predictor of opposition toward physician-assisted suicide.” \textit{Id.} The study’s authors further opined that “perhaps the rank-and-file [non-delegate] physician focuses primarily on his or her individual patients,” while the delegate physician focuses more on large policy issues. \textit{Id.} at 296.

\textsuperscript{68} See \textit{id.} at 296.

\textsuperscript{69} I call this view beneficent paternalism, rather than using either descriptor alone, because I think it best reflects the particular conception of the Hippocratic ethic that I argue is implicit in the Attorney General’s position. Inherent in paternalism is a notion that when the paternalistic actor overrides another’s choices, he is doing so because paternalism benefits the overridden person. In this way, “beneficent paternalism” might be considered redundant. But I use the phrase to reflect both the view that “doctor knows best” (paternalism) and medicine’s commitment to beneficence as understood by the Hippocratic ethic to promote healing. Thus, beneficent paternalism can be understood as paternalism that aims always at a goal of healing. So, a doctor acting according to a principle of beneficent paternalism would be justified in overriding his patient’s autonomous choice if that choice would conflict with the doctor’s goal of healing. For a comprehensive discussion of the principles of beneficence, paternalism, and autonomy, see Tom L. Beauchamp & James F. Childress, \textit{Principles of Biomedical Ethics} 57–112, 165–224 (5th ed. 2001).
“Purpose” is nowhere defined in the CSA, nor is it clearly defined by the OLC Memorandum. In trying to make the case that physician-assisted suicide is not a legitimate medical practice, the Attorney General invokes history and tradition, both to determine which practices are acceptable and to support his conception of the goals of medicine based on beneficent paternalism.\(^70\)

Traditionally accepted medical practices are insufficient bases to define legitimate medical purposes because of the changing nature of medical technology. A richer, more nuanced view of the goals of medicine guided by the principle of autonomy, tempered with beneficence, supports the view that physician-assisted suicide is, at least sometimes, a legitimate medical practice.

A. CHANGING NOTIONS OF HISTORICALLY/TRADITIONALLY ACCEPTED MEDICAL PRACTICES

One possible theory which seems to inform the Attorney General’s conception of “legitimate medical purpose” assumes that we can know what is currently legitimate by looking at historically or traditionally accepted medical practices.\(^71\) But history and tradition cannot be the only signposts to define legitimate medical purposes. Fast-paced technological advancements in medicine drive changes in what is medically possible and therefore acceptable. Similarly, these advancements have driven changes in normative views of what practices are acceptable. Thus, medical practices not considered legitimate even a few years ago are now widely accepted.\(^72\) Numerous examples could be drawn upon to illustrate this point, but I will focus on two: 1) the definition of death; and 2) decisions about withholding or withdrawing treatment.

1. The Evolving Definition of Death

The definition of death is a clear example of medical technology driving changes in how acceptable medical practices are defined. Until technology advanced sufficiently to allow fine-tuned assessment of brain function, death was defined as the cessation of cardiac function. The cardiac definition of death served as a reference point for physicians in determining what medical practices were acceptable—for instance, calling time of death. But because “technology permits us to treat the body organ by organ, cell by cell,” it becomes necessary

70. See OLC Memorandum, supra note 3, at 279–80 (citing AMA Brief); Brief of C. Everett Koop et al. as Amici Curiae Supporting Defendants-Appellants, Oregon v. Ashcroft, 368 F.3d 1118 (9th Cir. 2004) (No. 02-35587) [hereinafter Koop Brief].

71. See infra Part III.A.1–2. As we saw, opponents of legalizing physician-assisted suicide have relied heavily on history and tradition to show that suicide and assisted suicide have long been condemned. See, e.g., Washington v. Glucksberg, 521 U.S. 702, 710–16 (1997). The Bush Administration concluded on that basis that the practice must not be a legitimate medical purpose. See OLC Memorandum, supra note 3, at 279–82.

72. I base my argument here on practices that were initially opposed as not conforming to acceptable medical practice. Examples of practices that were once historically acceptable but now are not would also be illuminating, but they are beyond the scope of this Note.
to rethink what it means to declare a person dead. \(^{73}\) In 1968 Harvard introduced the concept of brain death, \(^{74}\) but only relatively recently has the “whole-brain death” criterion become widely accepted as the legal standard. \(^{75}\) Prior to adopting this new definition, it would not have been an acceptable medical practice to withdraw a respirator from a patient with cardiac activity even if it could be shown that his whole brain, including the brain stem, had ceased to function. \(^{76}\) Indeed, until the whole-brain definition of death was adopted, a doctor’s removal of the respirator, rather than the injury that destroyed the patient’s brain, would have been the legal cause of death. \(^{77}\) Defining death is deceptively complicated; even now, almost forty years after the Harvard definition was first put forth, there is disagreement and debate about the definition \(^{78}\) and the consequences of defining death in one way or another. \(^{79}\) Despite the complexity of defining death, this example serves to illustrate that history and tradition, while helpful in guiding determinations of what medical practices are legitimate, are not themselves sufficient.

2. Withholding/Withdrawing Treatment

The second example where history fails to provide concrete guidance for determining current legitimate medical practices is in the context of withholding or withdrawing treatments. As medicine has become more technologized, both the practices themselves and the normative values that inform judgments about which practices are acceptable have changed. Before antibiotics became widely available, patients often died of infection and there was no need to consider withholding treatment; similarly, before respirators and dialysis ma-

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74. Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death, A Definition of Irreversible Coma, 205 JAMA 85, 85–88 (1968). “Whole brain” death refers to the permanent cessation of all functions of the brain—both the “upper” brain, traditionally viewed as the seat of conscious existence, and the brain stem, which controls automatic bodily functions like respiration and blood pressure. See id. at 88; President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Defining Death: A Report on the Medical, Legal, and Ethical Issues in the Determination of Death 15–16 (1981) [hereinafter President’s Commission, Defining Death].
75. See Uniform Determination of Death Act § 1 (1980); President’s Commission, Defining Death, supra note 74, at 3–8, 18.
77. See Veatch, supra note 73, at 4.
chines were available, patients died because there were no medical mechanisms for artificially supporting necessary life functions. Thus there were no decisions to be made about withdrawing such treatments. Once such technologies became available, the medical community was faced with questions such as: Is it an acceptable medical practice to decide not to use this technology for this patient in the first place (that is, withholding treatment)? Is it an acceptable medical practice to stop the use of this technology for this patient (that is, withdrawing treatment)?

There is a long-established common law doctrine that a person has a right to the “possession and control of his own person,” or a right to bodily integrity, which has been extended to encompass a right of informed consent in medical decision-making. The Supreme Court has found, as a logical corollary to this doctrine of bodily integrity and informed consent, a concomitant right not to consent—that is, to refuse treatment. Although these pronouncements no longer seem startling, it was initially unclear that it was an acceptable medical practice to withhold treatment. For example, in *Thor v. Superior Court*, a physician requested a court order that would allow him surgically to insert a feeding tube in a quadriplegic patient who had refused to be spoon fed. In part, Dr. Thor requested the court order because he was concerned about his legal liability if his patient died as a result of not being fed—in other words, Dr. Thor believed that acceptable medical practice required him to insert a feeding tube. The court determined that although a “doctor might well believe that an operation or form of treatment is desirable or necessary,” the patient had a right to refuse the feeding tube surgery. Although Dr. Thor thought that withholding medical treatment was not a legitimate or acceptable medical practice because it would not benefit the patient, the court rejected beneficent

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82. See *Cruzan*, 497 U.S. at 270. The “right to refuse treatment” is somewhat confusing. The word “refuse” has alternately been used to mean both withhold and withdraw treatment. In *Cruzan* the court continues its analysis by discussing *In re Quinlan*, 355 A.2d 647 (N.J. 1976), as a right-to-refuse case, although the issue in *Quinlan* was a decision to turn off, or withdraw, a respirator from a comatose patient. Withholding and withdrawing treatment are two distinct choices that might be made. To avoid analytical confusion, I use withholding treatment to connote a choice by the patient not to have a treatment started—in other words, the patient’s refusal of certain measures (for example, the patient’s choice to refuse the administration of antibiotics in the first place). I use the term withdrawing treatment to connote a choice by the patient to cease a treatment that has already been commenced (for example, the patient’s choice to have a respirator turned off).
83. 855 P.2d 375 (Cal. 1993). The factual record in the case is rather slim because Dr. Thor’s initial request for a court order was made in an *ex parte* proceeding. *Id.* The *ex parte* nature of the proceeding is further evidence of the doctor’s absolute lack of concern for the patient’s wishes.
84. See *id.* at 380.
85. Thor would have been liable for medical malpractice if his actions deviated from the acceptable standards of practice of the medical community. See, e.g., 61 AM. JUR. 2d, *Physicians, Surgeons, and Other Healers* § 188. Thus, his concerns about liability indicate that he believed that the standard of care, or acceptable medical practice, was to insert a feeding tube.
paternalism in favor of recognizing patient autonomy as the guiding principle.

In re Quinlan is an even clearer example of disagreement about what constitutes a legitimate medical practice in the withdrawing treatment context. Karen Ann Quinlan’s father requested legal guardianship of his daughter, who was in a respirator-dependant irreversible coma, so that he could remove her respirator and allow her to die. Ms. Quinlan’s physician refused to remove the respirator because removal “would not conform to medical practices, standards, and traditions.” Here, the doctor clearly stated what he believed to be the legitimate medical practice in this context (that is, continuing respiratory support despite a request to withdraw the treatment). But the court repudiated this conclusion in a long discussion of the special problems that technology raises in defining acceptable medical practices. Instead of relying on the doctor’s opinion of acceptable medical choices, the court found that Ms. Quinlan had a constitutional right of privacy to terminate her treatment and allowed her parents to exercise that right on her behalf.

As technological advances make it medically possible to push death further off, legitimate medical practices at the end of life have evolved, too. In the withholding or withdrawing treatment context, what has driven this evolution in defining acceptable medical practice is a shift from beneficence-based medicine to a focus on patient autonomy. As Thor explains, despite what a physician may believe to be the required medical care (that is, what the physician thinks is in the patient’s best interest), it is really the patient who has the power to choose whether to undergo treatment or not. What is remarkable is the shift in opinion from one where withholding or withdrawing treatment was unacceptable, to the current position that it is not only acceptable, but is in fact often required medical practice.

Although history and tradition may serve as guideposts, they do not provide a de facto understanding of what medical practices are acceptable. Nor does the physician’s view of patient benefit alone define legitimate medical practices. Rather, patient autonomy must be accorded broad deference.

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88. Id. at 651.
89. Id. at 655, 657. Ms. Quinlan’s doctor “asserted that no physician would have failed to provide respirator support at the outset, and none would interrupt its life-saving course thereafter, except in the case of cerebral death.” Id. at 657.
90. See id. at 665–68.
91. Id. at 662–64. Ms. Quinlan was incompetent and unable to assert a right to terminate treatment. While there are important issues involved in the decisions about withholding and withdrawing treatment in competent versus incompetent patients, I will not discuss those issues in this Note.
93. See, e.g., President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forego Life-Sustaining Treatment: A Report on the Medical, Legal, and Ethical Issues in Treatment Decisions 3 (1983) [hereinafter President’s Commission, Life-Sustaining Treatment] (“The voluntary choice of a competent and informed patient should determine whether or not life-sustaining therapy will be undertaken . . . .”).
B. THE HIPPOCRATIC OATH, PHYSICIAN-ASSISTED SUICIDE, AND THE ENDS OF MEDICINE

This shift in principles from beneficence to autonomy is also apparent in discussions of the proper goals or ends of medicine. The Attorney General’s conclusions about “legitimate medical purpose” are based in part on various medical professional organizations’ views about the proper goals of medicine and the physician’s role. Their particular view of the goals of medicine is based on the Hippocratic ethic of patient benefit and the “physician’s role as healer.” The Oath understands the profession to be narrowly driven by beneficent paternalism.

The Hippocratic Oath has long been considered the central guiding doctrine of the medical profession. The relevant portions of the Oath relating to a physician’s duties to his patient state:

I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice.

I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect. Similarly I will not give a woman an abortive remedy. In purity and holiness I will guard my life and my art.

I will not use the knife, not even on sufferers from stone, but will withdraw in favor of such men as are engaged in this work.

According to the Oath, benefit to the patient is medicine’s highest goal; this benefit requirement has been interpreted to mean that the physician’s foremost role is that of healer, and his goal that of healing. The Hippocratic aphorism, “first, do no harm” has often been cited as an associated goal or further manifestation of the requirement to benefit the patient, although this phrase is nowhere contained in the Oath. The Oath’s benefit requirement and the “do no harm” principle are foundational to the medical profession.

94. See OLC Memorandum, supra note 3, at 279–80.
95. See supra text accompanying note 69.
98. See id. at 177, 201, 228–34.
99. There is a great deal of scholarly disagreement about whether the admonition to “do no harm” is contained anywhere within the Hippocratic Corpus. Compare Sherwin B. Nuland, Doctors: The Biography of Medicine 15–16 (2d ed. 1995) (noting that the Latin phrase “Primum non nocere” is found in the book Epidemics, a part of the Hippocratic Corpus) and Gary Seay, Do Physicians Have an Inviolable Duty Not to Kill?, 26 J. Med. & Phil. 75, 84–85 (2001) (recognizing “do no harm” as essential to the Hippocratic tradition) with Robert M. Veatch, Doctor Does Not Know Best: Why in the New Century Physicians Must Stop Trying to Benefit Patients, 25 J. Med. & Phil. 701, 707 (2000) (calling the phrase “do no harm” a “corrupt variation on the Hippocratic slogan” which “is nothing
“harm” dictum denote a paternalistic, beneficence-based understanding of medicine in which “doctor knows best” and acts, based on that knowledge, to benefit the patient—often with no regard for the patient’s own wishes.\(^\text{100}\) Based on the Hippocratic ethic, physician-assisted suicide cannot be a legitimate medical practice because it does not heal and therefore is not beneficial to the patient; as such, the physician can impose this view on the patient on the grounds that the doctor’s understanding of legitimate medical practices benefits the patient.

In addition to the support garnered from the beneficence-based goal of the Oath, proponents of the position that physician-assisted suicide is not a legitimate medical purpose cite the Oath’s unequivocal bar against the practice: a physician will not give a lethal drug or counsel a patient to take one.\(^\text{101}\) This particular portion of the Oath has been codified in the AMA’s Code of Ethics which states that physician-assisted suicide is antithetical to the physician’s role as healer.\(^\text{102}\) Both the Hippocratic Oath and the AMA’s Code of Ethics have been relied upon as absolute proof of the medical profession’s rejection of physician-assisted suicide in all instances as illegitimate and unacceptable.\(^\text{103}\) Though the Hippocratic Oath concededly does proscribe physician-assisted suicide, there is serious doubt as to whether its particular view of medicine still has relevance. As one prominent philosopher has described it: “Medical ethics . . . enters the next [century] with the Hippocratic slogan in shambles.... The Hippocratic ethic will be relegated to the ash heap of history . . . .”\(^\text{104}\)

C. SAVING THE OATH FROM THE “ASH HEAP OF HISTORY”

Is there any hope for the Hippocratic ethic of medicine, or is it really headed for the “ash heap of history”? There are two distinct problems that threaten the guiding force of the Hippocratic Oath. First, the Oath’s proscription against physician-assisted suicide is not nearly as bright a line as has been represented, and it may directly conflict with the benefit requirement. Second, and more importantly, the Oath represents a narrow, outdated view of the goals of medicine and the physician’s duties.

1. Embers of the Oath: Abandonment and Self-Contradiction

The Oath can be considered anachronistic, even to the point of tacit abandonment, in a world of rapidly advancing medical technologies.\(^\text{105}\) While patient

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Hippocrates ever said” and instead dating the statement to the mid-nineteenth century). Despite disagreement about the origins of the phrase “do no harm,” for my purposes I consider it part of the guiding Hippocratic philosophy.

101. See KASS, supra note 96, at 229.
103. See supra notes 64–66 and accompanying text. But see supra notes 67–68 and accompanying text.
104. Veatch, supra note 99, at 702.
benefit in the form of healing is still a primary goal of medicine and will continue to be a goal, the prohibitions on physician conduct contained in the Oath have been questioned and even abandoned outright.\textsuperscript{106} Focusing only on the prohibition against physician-assisted suicide, it is clear that this ban is not strictly adhered to anymore, nor can it be, given the state of medical technology. The Oath is still cited as stating a complete and irrevocable ban on physician-assisted suicide; however, the reality of modern medicine is that the bright line has not held.\textsuperscript{107}

For example, a doctor who provides terminal sedation\textsuperscript{108} to a patient acts in accordance with common and accepted medical practice\textsuperscript{109} but violates the Hippocratic oath because she is providing a drug to a patient for pain control knowing that the consequence of its use will be death. However, one could argue that the drug is not “deadly” because even though it causes death, it is given for the purpose of pain relief and not as an agent of death. Further, the drug is not given with the intent that it will cause death; rather, this is the unfortunate but acceptable “double effect” (respiration is suppressed to the point of unconsciousness and death) of the necessary dosage for pain control. Therefore, terminal sedation does not violate the Oath, but physician-assisted suicide does. In \textit{Glucksberg}, Justice O’Connor stated: “[A] patient who is suffering from a terminal illness and who is experiencing great pain has no legal barriers to obtaining medication . . . to alleviate that suffering, even to the point

\begin{itemize}
\item \textsuperscript{106} See Keränen, \textit{supra} note 96, at 57–58. More than twenty-two versions of the Hippocratic Oath exist, and the moral obligations outlined in the various versions often conflict with one another. See \textit{id.} at 62. The prohibition of abortion was only contained in eight percent of the oaths sworn to in 1993. \textit{Id.} at 63. Ninety-seven percent of oaths sworn did not contain a prohibition on sexual relations between physician and patient, which was another central tenet of the original Hippocratic Oath. \textit{Id.}
\item \textsuperscript{107} The fact that the line has not held does not necessarily mean that the current state of affairs is morally acceptable. See OLC Memorandum, \textit{supra} note 3, at 281. The Office of Legal Counsel takes issue with the argument from proponents that physician-assisted suicide is actually a widespread occurrence and, by implication, is therefore a legitimate medical practice. There is dispute about whether physician-assisted suicide is in fact widespread. See Brief of Am. Geriatrics Soc’y. as Amicus Curiae Supporting Defendant-Appellant at 10, Quill v. Vacco, 521 U.S. 793 (1997) (No. 95-1858).
\item \textsuperscript{108} Terminal sedation refers to the administration of narcotics, sedatives, barbiturates, or major tranquilizing drugs to sedate a patient who is experiencing unremitting pain and/or suffering as a result of his or her illness. Sedation is continued until the patient dies, which may be due to the underlying disease process or because food and hydration have been withdrawn (either at the patient’s request or independently by the physician). See David Orentlicher, \textit{The Supreme Court and Terminal Sedation, in Physician Assisted Suicide} 303 (Margaret P. Battin, Rosamond Rhodes & Anita Silvers eds., 1998). Terminal sedation is often accomplished with a combination of opioids and sedatives, which are controlled substances scheduled under the CSA. See 21 C.F.R. § 1308 (2000); Michael E. Salacz & David E. Weissman, \textit{Controlled Sedation for Refractory Suffering}, 8 J. PALLIATIVE MED. 136, 137–38 (2005) (defining terminal sedation and describing how it is performed).
\item \textsuperscript{109} See Washington v. Glucksberg, 521 U.S. 702, 750–51 (1997) (Stevens, J., concurring) (noting that the AMA “unequivocally endorses the practice of terminal sedation”); Orentlicher, \textit{supra} note 108, at 303. However, there is some disagreement about whether this practice is really acceptable. David Orentlicher posits that although terminal sedation appears to be a well-accepted practice, it is actually a form of euthanasia. \textit{Id.} at 303–06. According to Orentlicher’s argument, terminal sedation is equivalent to euthanasia because the patient dies as a result of the physician’s intentional acts (the sedation, and sometimes, the concomitant withdrawal of nutrition and hydration). See \textit{id.}
\end{itemize}
of causing unconsciousness and hastening death.”110 Terminal sedation remains acceptable under the Ashcroft Directive, while physician-assisted suicide, even where legalized, does not.111 The distinction that allows this result is based on the intent of the doctor. Both physician-assisted suicide and terminal sedation consist of giving patients access to huge doses of controlled substances that can (and will, if used) cause death. In cases of terminal sedation, the doctor does not intend his patient to die, but rather he intends to relieve pain and death is merely an unfortunate side effect. Doctors who write lethal prescriptions, however, intend that their patients will die. Intent is a false distinction because the doctor in both cases knows that death will result and may or may not intend that result. Thus, physician intent cannot rationally be viewed as a distinguishing characteristic of either medical practice.

Another factor contributing to the Oath’s potential obsolescence is that, although it purports that patient benefit is its primary goal, that goal can directly conflict with the proscription against physician-assisted suicide in some instances. “If the Hippocratic Oath requires the physician to act so as to benefit the patient, why should the physician not act to put a patient out of her misery if there is no other way to relieve severe, intractable suffering?”112 The puzzle posed by modern medicine’s ability to preserve life, even beyond where we might want it preserved, is this: if healing the patient is no longer possible, then the only benefit that a physician may be able to confer on the patient is to help the patient die more peacefully and with less suffering. There are two possible responses to this dilemma. First, physician-assisted suicide may be the morally correct, or even morally required, answer to uncontrolled suffering when there is no further chance to benefit the patient through healing.113 If this is so, then it is incorrect to read the Hippocratic Oath as completely banning physician-assisted suicide. On the other hand, it may be that it is simply never right for a physician to participate in active killing, regardless of the patient’s expressed wishes. If so, the Oath’s bar against physician-assisted suicide remains, regardless of the fact that this reading may result in great harm to the patient. This second alternative still does not avoid pitting two Hippocratic maxims against each other; rather, under this alternative, the physician would follow the directive to maximize health even where futile, and in doing so would harm the patient by prolonging suffering.

While the Hippocratic Oath certainly offers guidance to the medical profession, it does not offer as clear-cut a picture of medical ethics as the AMA and other opponents of physician-assisted suicide would have us believe. The Oath

111. See Ashcroft Directive, supra note 3, at 56,608.
112. Veatch, supra note 99, at 713.
113. Edmund Pellegrino eloquently describes this terrain despite his disagreement with physician-assisted suicide and with the argument that it could ever be moral, let alone morally required. See Edmund D. Pellegrino, Distortion of the Healing Relationship, in Ethical Issues in Death and Dying 161–62 (Tom L. Beauchamp & Robert M. Veatch eds., 1996).
does, however, serve as a ritualistic rhetorical device that promotes solidarity among physicians.114 Adherents of the Oath argue that it still has moral force through its illumination of the central ethical principles of medicine. And yet, as I have argued, there is a gap between the “mythic ideal of the Oath and its content as actually pledged”115 and as it is practiced. The Oath’s anachronisms endanger its continued usefulness and force; if the Oath “is to reach its full suasive potential, it must somehow embody only those very general moral guidelines that are accepted almost universally.”116 Examination of this general guiding framework shows that the Oath’s statement of the goals of medicine is far from universally accepted as a complete understanding of what principles ought to guide doctors.

2. The Hippocratic Goals of Medicine: Resurrection through an Enriched Reading

The Hippocratic ethic can be saved from the “ash heap of history” by rejecting beneficent paternalism and instead embracing an understanding of patient benefit that encompasses respect for autonomy as part of that benefit. Advancing technology and the “medicalization” of life have raised concerns that the proper goals of medicine are no longer clear. Leon Kass has written eloquently about medicine’s goals in the face of changing scientific and technical knowledge:

It is ironic, but not accidental, that medicine’s great technical power should arrive in tandem with great confusion about the standards and goals for guiding its use. When its powers were fewer, its purpose was clearer. Indeed, since antiquity, medicine has been regarded as the very model of an art, of a rational activity whose powers were all bent toward a clear and identifiable end.117

The “clear and identifiable” end to which Kass refers is patient benefit, which is understood to be health promotion.118 Before the advent of modern medical technology, the best that medicine could do was to stave off death for as long as possible. But now, medicine is capable of myriad wonders from things that clearly promote the goal of health (for example, advanced chemotherapeutic drugs and organ transplants) to procedures that have no clear connection with traditional notions of health (for example, cosmetic surgery and in vitro fertilization). Medicine is no longer confined, at least by technology, merely to the goal

115. See id. at 63.
116. See id. at 66.
117. Kass, supra note 96, at 158.
118. See id. at 159, 200–01.
The interpretation that health/healing is the primary, indeed only, goal of medicine leads to the logical conclusion that physician-assisted suicide cannot be a legitimate medical practice. A strong version of this position, held by Kass and espoused by *amici* in support of Attorney General Ashcroft’s position\(^{120}\) is that goals other than health, "even where . . . their goodness as goals” is accepted, are “false goals for medicine” and pursuit of them is a “perversion[] of the art.”\(^{121}\) This view understands healing as the *only* proper interpretation of the Hippocratic mandate to benefit the patient.\(^{122}\)

While health as the goal of medicine seems to be a less contentious norm espoused by the Hippocratic Oath, the position that health promotion is the only goal is simultaneously too narrow and untenable because it cannot always be achieved. Kass defined health as “the well-working of the organism as the whole.”\(^{123}\) What happens when the “well-working” of the body is no longer possible? What goal then? Kass concedes that for patients for whom “well-working” as an organismic whole is no longer possible, the relief of suffering “stands, next to health, as a crucial part of the medical goal, and medicine has always sought to comfort where it cannot heal.”\(^{124}\) Although health promotion and healing are certainly important goals of medicine, when achievement of

\(119.\) Id. at 159 (“[H]ealth is not the only possible and reasonable goal of medicine, since there are other prizes for which medical technique can be put in harness.”).

\(120.\) See Koop Brief, *supra* note 70, at 2–3. “The good to which the medical profession is chiefly devoted is health, a naturally given although precarious standard or norm, characterized by ‘wholeness’ and ‘well-working’ toward which the living body moves on its own.” Leon R. Kass, “I Will Give No Deadly Drug”: Why Doctors Must Not Kill, in THE CASE AGAINST ASSISTED SUICIDE 21 (Kathleen Foley & Herbert Hendin eds., 2002). This view has been characterized as an unduly narrow view held by a small minority. See Oregon Bioethicist Brief, *supra* note 29, at 8–11.

\(121.\) KASS, *supra* note 96, at 159. “Health and only health is the doctor’s proper business.” Id. at 177.

\(122.\) Kass rejects any number of additional goals including: happiness or pleasure (for example, satisfying a patient’s “wishes”), social adjustment or obedience (for example, “the taming of juvenile delinquents”), alternation of human nature, and the prolongation of life or prevention of death. See *id.* at 159–62. This last “false” goal may be surprising, given that Kass is a clear opponent of physician-assisted suicide. Prolonging life and preventing death is a false goal, Kass argues, because *to be alive* is *not to be healthy*; thus, death prevention focuses on immortality rather than health. See *id.* at 162–63. His argument is a “suggestion that doctors keep their eye on their main business, restoring and correcting what can be corrected and restored, always acknowledging that death will and must come, that health is a mortal good, and that as embodied beings we are fragile beings that must snap sooner or later, medicine or no medicine.” *Id.* at 163.

\(123.\) *Id.* at 174. I will not endeavor to explore his definition or dispute it; rather, I use it as a jumping off point for arguing that there must be other acceptable goals of medicine where health is no longer attainable.

\(124.\) See *id.* at 204. Kass never explains his new position that relief of suffering is crucial to the medical goal of health. (Remember, Kass took the hard-line position that health is the only proper goal of medicine. All other goals are false or external to medicine.) Others would argue that “the drive to sustain life can conflict with another fundamental (and arguably more venerable) objective of medicine—the relief of suffering.” PRESIDENT’S COMMISSION, LIFE-SUSTAINING TREATMENT, *supra* note 93, at 15 (footnote omitted). The President’s Commission implies that relief of suffering may be a goal of even higher priority than health.
patient benefit in the form of healing is no longer possible, relief of suffering ought to be considered the primary method of benefiting the patient.

D. SUFFERING: AN END-OF-MEDICINE AT THE END OF MEDICINE’S ABILITY TO HEAL

The untempered beneficent paternalism of the Hippocratic tradition represents a doctor-centric view of medicine that is an increasing cause for concern.\(^{125}\) This concern results because medicine seems “now to close in on death itself, leading some to treat it as an immoral power to be driven from the community like the Salem witch.”\(^{126}\) This “overwhelming bias [of medicine] to treat” engenders very real fear among patients about loss of control at the end of life.\(^{127}\) Loss of control (or fear of it) can contribute greatly to end-of-life suffering.\(^{128}\) Understanding the goals of medicine to reflect patient autonomy supports the argument that physician-assisted suicide is in fact a legitimate medical purpose where employed by a patient who requests it for relief of suffering.

The notion of suffering is often invoked along with the concept of pain, as in “pain and suffering,”\(^{129}\) but they are separate concepts. Pain is defined as “[a] primary condition of sensation or consciousness, the opposite of pleasure; the sensation which one feels when hurt . . . .”\(^{130}\) Suffering, however, includes the broader notion of possible “awareness of something that threatens (or is perceived to threaten) the whole person.”\(^{131}\) Although these are discrete concepts, both sides of the debate are guilty of sometimes equating pain and suffering.\(^{132}\) For example, opponents of physician-assisted suicide sometimes argue that suffering cannot justify physician-assisted suicide in most (or all) instances because pain can be (or will be able to be) adequately managed.\(^{133}\) This argument makes the mistake of equating the two concepts rather than viewing


\(^{126}\) Veatch, supra note 73, at 4.

\(^{127}\) Salem, supra note 125, at 125, at 30.


\(^{131}\) See id. at 127. Proponents of physician-assisted suicide often carelessly refer to the relief of pain and suffering as justification. Opponents of physician-assisted suicide then reply that pain can be adequately controlled with good palliative care, and thus, relief of pain and suffering is not a justification for physician-assisted suicide. See id. I am surprised that proponents of physician-assisted suicide have not clarified their arguments about suffering to avoid this criticism. Perhaps relief of pain truly is a concern because there seems to be much dispute about whether palliation and pain medication are used to the full extent possible and necessary.

\(^{132}\) Note the conflation of pain and suffering. See, e.g., Brief of Amici Curiae Christian Legal Society and Christian Medical Ass’n in Support of Defendants-Appellants and Reversal of the Decision Below at 9, Oregon v. Ashcroft, 368 F.3d 1118 (2004) (No. 02-35587) (“[T]he only alleged legitimate
pain as a subset of suffering.

While “pain” and “suffering” are distinct, pain can be considered a form of suffering rather than the equivalent of suffering. Note also that pain is defined in terms of physical sensations and it may be associated with “specific, subjective experiences” such as injury. To some extent, pain is objective and measurable—it often accompanies a verifiable physical injury and may include physiological symptoms such as increased heart rate and blood pressure. Pain, when treated well, may not cause suffering because the patient is still able to function, carry on a fairly normal existence, and pursue internal goals. But pain may constitute a form of suffering; insofar as it does, the argument that proper palliation can adequately relieve pain is valid against the argument that physician-assisted suicide may be justifiable to relieve suffering.

If suffering is understood to be something different and separate from physical pain, then relief of suffering, as a goal of medicine, may still offer a justification for physician-assisted suicide even if we concede that relief of physical pain does not. Eric Cassell, in response to the dearth of discussion about what is meant by the term “suffering” within the physician-assisted suicide debate, posits that suffering is not physical, emotional, or existential; rather, those are dimensions on which suffering can be experienced. Cassell’s understanding of suffering is important insofar as he unites suffering from notions of psychological or existential distress and conceives of it as a threat to the whole person—“not merely to . . . lives but . . . integrity as persons.” A definition of suffering must go beyond psychological anguish to avoid falling prey to the depression charge. A full understanding of suffering must be integrative rather than reductive so that it more accurately reflects suffering as it is actually experienced.

Suffering is integrative of both mind and body and involves whole persons. Suffering is subjective (this is where the confusion enters that suffering is an injury to consciousness or mental existence) insofar as it is experienced only by the person suffering and cannot really ever be known by others. Understanding suffering only as a “state of psychological burden or oppression” is problematic because opponents of physician-assisted suicide argue

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134. See Resnik, supra note 130, at 127; Stan van Hooft, Suffering and the Goals of Medicine, 1 Med. Health Care & Phil. 125, 125 (1998) (“Pain refers to extreme physical distress.”).
135. See Resnick, supra note 130, at 139. And yet, part of pain is psychosocial and subjective. Id.
136. See van Hooft, supra note 133, at 129.
138. Cassell, supra note 128, at 35.
139. See id. at 32; van Hooft, supra note 133, at 126.
140. See Cassell, supra note 128, at 33–34.
that such suffering can be ameliorated. Depression is cited as the single factor that is the best predictor of which patients will request aid in dying; there is almost universal agreement that physician-assisted suicide should not be available to depressed persons. As a form of psychological “pain,” suffering could be equated with depression, thereby invalidating it as a potential reason for providing aid in dying. Equating suffering only with a mental process is a form of dualism—suffering is seen as psychological and separate from the physical. Modern science and medicine have been particularly guilty of perpetuating this mind-body dualism by only understanding suffering as the psychological experience of the brain rather than an integrative harm suffered by the whole person.

Suffering can best be understood as an assault on the person; patients suffer when the integrity of their person is threatened by biological processes, intense sensations of bodily pain, or an inability to carry on normal activities or to find continued meaning in life within the terms of the suffering. How to best approach suffering requires a personal and subjective assessment of its impact on the continued existence of the person suffering. “Deciding that the benefits [of life-saving treatment] are proportionate requires the inherently nonmedical determination of how valuable it is to continue living. It should be obvious that these are judgments that no outsider should be able to make.” Because suffering is inherently subjective, a medical ethic that respects patient autonomy above the profession’s traditional beneficent paternalism is clearly preferable. The patient knows her limits, and respect for autonomy would dictate that when she says “enough is enough” the physician should be guided by his desire to relieve suffering and respect for his patient’s autonomous choice. Within this framework of medicine, which takes as its goal the relief of suffering and respect for patient autonomy, physician-assisted suicide is a legitimate medical purpose when used by those who are competent to request it for relief of suffering.

IV. THE OREGON ACT: A LEGITIMATE MEDICAL PURPOSE GROUNDED IN PATIENT AUTONOMY

The Oregon Act protects the autonomous choices of those patients for whom there is little that medicine can do besides attempt to ameliorate suffering. It allows a terminally ill, competent adult to make a written request for medication.
for the purpose of ending his or her life.\textsuperscript{149} The Act includes a number of safeguards to ensure that the person making the request is protected. The Act requires two physicians to verify: (1) that the person has a terminal illness; (2) that the person is competent; and (3) that the request for the prescription is voluntary and informed.\textsuperscript{150} The statute requires the attending or consulting physician to refer the patient for psychiatric evaluation if either doctor is concerned about psychological impairment.\textsuperscript{151} Further requirements include both written and oral requests, a waiting period, and documentation and reporting requirements.\textsuperscript{152} All of these provisions are meant to ensure that persons who make use of the Act are in fact making autonomous choices.

Importantly, the reasons that Oregonians give for requesting physician-assisted suicide reflect this desire for autonomy. Physicians reporting to the Oregon Department of Human Services cite their patients’ concerns about loss of autonomy and decreased ability to participate in enjoyable and meaningful activities as reasons for requesting lethal prescriptions.\textsuperscript{153} Other reasons commonly cited include loss of dignity and loss of bodily functions.\textsuperscript{154} Less frequently cited reasons include patients’ fears about being burdensome to family, inadequate pain control, and the financial ramifications of treatment.\textsuperscript{155} Because suffering is perceived as a threat to one’s continued existence and integrity as a person,\textsuperscript{156} some patients suffer because they are unable to find meaning in their greatly shortened lives and fear loss of control. The option of physician-assisted suicide is itself a source of relief of suffering.\textsuperscript{157}

Under the Act, the lethal prescription is available only to patients who have been diagnosed with a terminal illness. By its definition, a terminal illness is incurable. Thus, the goals of healing and health are no longer attainable for the patients involved, and relief of suffering is the primary benefit which medicine can confer. Insofar as the biological body is suffering from a disease process and that disease process is incurable and unstoppable, physicians will fail at relieving this form of suffering. However, suffering that threatens the patient as a person can best be relieved by listening to and respecting the patient’s autonomous choices.\textsuperscript{158} Because the patient’s own suffering is only experienced by the patient, the doctor does not know best how to act for the patient’s

\begin{itemize}
\item \textsuperscript{149} See Or. Rev. Stat. § 127.805(1) (2005).
\item \textsuperscript{150} See id. §§ 127.815–.820.
\item \textsuperscript{151} See id. § 127.825.
\item \textsuperscript{152} See id. §§ 127.840–.855.
\item \textsuperscript{153} See Oregon 2004 Report, supra note 16, at 16.
\item \textsuperscript{154} See id. at 16 tbl.4.
\item \textsuperscript{155} See id.
\item \textsuperscript{156} See Cassell, supra note 128, at 35.
\item \textsuperscript{157} See Oregon Bioethicist Brief, supra note 29, at 3.
\item \textsuperscript{158} See Washington v. Glucksberg, 521 U.S. 702, 746–47 (1997) (Stevens, J., concurring in the judgments) (stating that allowing a terminally-ill individual to make a choice gives “proper recognition to the individual’s interest in choosing a final chapter that accords with her life story, rather than one that demeans her values and poisons memories of her”).
\end{itemize}
At the end of life, when a person suffers from a terminal disease, the medical goal of relief of suffering may counsel that aid in the dying process is legitimate and acceptable when autonomously requested. Accepting physician-assisted suicide as a legitimate medical purpose under Oregon’s prescribed rules respects autonomy in the patient’s choices about how much suffering she can take.

**CONCLUSION**

The view propounded by the Attorney General and the Office of Legal Counsel Memo that the only true goals of medicine are health and healing is impoverished and fails to adequately serve those for whom healing is not possible. Relief of suffering is a legitimate goal for the medical profession and one that ought to be paramount at the end of life. For terminally ill patients, respect for autonomous choices about how best to deal with their own experience of suffering validates physician-assisted suicide as a legitimate medical purpose. The Oregon Death with Dignity Act is an appropriate measure for terminally ill and competent patients who request lethal prescriptions because the aim of the act is to provide a modicum of control through the dying process.

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159. See id. at 779 (Souter, J., concurring in the judgment). In explaining comparisons between the abortion and assisted suicide contexts, Justice Souter stated that “[t]he good physician is not just a mechanic of the human body whose services have no bearing on the person’s moral choices, but one who does more than treat symptoms, one who ministers to the patient.” Id. Indeed, he further explains the argument that when death is imminent, “the decision to end life is closest to decisions that are generally accepted as proper instances of exercising autonomy over one’s own body . . . instances in which the help of physicians is accepted as falling within the traditional norm.” Id.