

**THE CHICKEN AND THE EGG:
THE PURSUIT OF CHOICE FOR A HUMAN
HASTENED-DEATH AS A CATALYST FOR
IMPROVED END-OF-LIFE CARE; IMPROVED
END-OF-LIFE CARE AS A PRECONDITION
FOR LEGALIZATION OF ASSISTED DYING**

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I.
INTRODUCTION

This article considers the interface of assisted dying and pain management, addressing the following questions:

- Has the movement to legalize assisted dying had an impact on the field of pain management?
- Is improved pain management a necessary or desirable precondition to permitting assisted dying? Has legalized assisted dying in Oregon served as a catalyst to improve pain care in that state?
- Do efforts to nullify Oregon's Death with Dignity Act by U.S. Attorney General Ashcroft, and efforts to criminalize assisted dying in various states, jeopardize good pain care?

One can persuasively make the case that passage of an assisted-dying measure *spurs* improved pain management in the forum

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state, as has occurred in Oregon following passage of the Oregon Death with Dignity Act.¹ One can also plausibly hypothesize that in states where legalization is to be pursued, the chance of passing a measure is enhanced if opposition arguments suggesting that all that is really needed is better pain management can be defused by showing that in the forum state dying patients are likely to have access to good pain management because that state has policy, enacted by its legislature or passed by the state medical board, which encourages such care. Thus, strong pain policy can facilitate passage of an assisted-dying measure; passage of such a measure can prompt improved pain policy and practice in the forum state.

Any legal discussion of physician-assisted dying must, of course, begin with the *Washington v. Glucksberg*² and *Vacco v. Quill*³ rulings. These cases, which have been extensively examined elsewhere,⁴ sought to establish that competent dying patients have the constitutional right to choose a humane, physician-assisted death. The cases, and the legal issues they addressed (and ignored) are briefly reviewed in Part II.

Part III explores state legislative avenues available to provide the option of a legal, humane physician-assisted death, and specifically considers whether legislative efforts are best pursued when strong, positive pain policy is in place. In addition, Part III discusses the efforts by opponents of assisted dying to thwart efforts in the states to permit the practice, and specifically considers how opponents utilize the argument that assisted dying should not be permitted because what dying patients really seek is good pain management and palliative care.

Moving from the statehouse to the courthouse, Part IV discusses the potential for state court recognition of the right to choose a humane hastened death under state constitutional provi-

1. See *infra* notes 50–51.

2. 521 U.S. 702 (1997).

3. 521 U.S. 793 (1997).

4. A Westlaw Key Cite search conducted in March 2004 revealed that these cases have been discussed in more than 1,400 articles. Among many good articles discussing the cases are: Laurence H. Tribe, *Lawrence v. Texas: The "Fundamental Right" That Dare Not Speak Its Name*, 117 HARV. L. REV. 1893 (2004); Kathryn L. Tucker, *The Death with Dignity Movement: Protecting Rights and Expanding Options after Glucksberg and Quill*, 82 MINN. L. REV. 923 (1998); John A. Robertson, *Respect for Life in Bioethical Dilemmas—The Case of Physician Assisted Suicide*, 45 CLEV. ST. L. REV. 329, (1997); Seth F. Kreimer, *Second Time as Tragedy: The Assisted Suicide Cases and the Heritage of Roe v. Wade*, 24 HASTINGS CONST. L.Q. 863 (1997); David Orentlicher, *The Supreme Court and Terminal Sedation, Rejecting Assisted Suicide and Embracing Euthanasia*, 24 HASTINGS CONST. L.Q. 947 (1997).

sions. The way the forum state's pain policy might impact a state court's consideration of such a claim is explored.

Legal advocacy to prompt improved pain and palliative care has grown in the wake of efforts to legalize assisted dying, and is discussed in Part V.

Efforts to Legalize Physician-Assisted Dying

Increasingly, people dying from terminal illnesses want more control over the timing and manner of their deaths. Among these, a fraction wants to have the option of a humane, physician-assisted death if pain and suffering become intolerable.⁵ A substantial majority of American citizens believe that competent, terminally ill patients should have the option of receiving medication that patients could self-administer to bring about a humane and peaceful death if pain and suffering become intolerable.⁶ A majority of physicians believe such patients should have this option.⁷ However, most states have statutes prohibiting assisting suicide.⁸ Although it is unclear that such laws were intended to reach the act of a physician in prescribing medication that a dying patient could take to bring on a humane death, it is clear that the laws deter many physicians from doing so. Notwithstanding, a widespread underground practice of physician-assisted dying exists.⁹ The debate regarding physician-assisted dying is ongoing, although it must be recognized that the

5. See MARILYN WEBB, *THE GOOD DEATH, THE NEW AMERICAN SEARCH TO RESHAPE THE END OF LIFE* 1–80 (1997).

6. See, e.g., Kate Stewart, *Physician Aid in Dying*, *THE POLLING REP.*, Jul. 28, 1997, at 1, 6–7; Humprey Taylor, *2-to-1 Majorities Continue to Support Rights to Both Euthanasia and Doctor-Assisted Suicide*, HARRIS INTERACTIVE, Jan. 9, 2002, available at http://www.harrisinteractive.com/harris_poll/index.asp?PID=278 (the Harris Poll in 2001 shows support at 65%).

7. See Jerald Bachman et al., *Attitudes of Michigan Physicians and the Public Toward Legalizing Physician-Assisted Suicide and Voluntary Euthanasia*, 334 *NEW ENG. J. MED.* 303, 307 (1996); Jonathan S. Cohen et al., *Attitudes Toward Assisted Suicide and Euthanasia Among Physicians in Washington State*, 331 *NEW ENG. J. MED.* 89, 90–91 (1994); Melinda A. Lee et al., *Legalizing Assisted Suicide—Views of Physicians in Oregon*, 334 *NEW ENG. J. MED.* 310, 311–12 (1996).

8. See Kathryn L. Tucker & David J. Burman, *Physician Aid in Dying: A Humane Option, a Constitutionally Protected Choice*, 18 *SEATTLE U. L. REV.* 495, 496 n.1 (1995).

9. See, e.g., Diane E. Meier et al., *Characteristics of Patients Requesting and Receiving Physician-Assisted Death*, 163 *ARCH. INTERNAL MED.* 1537 (2003); Anthony Back et al., *Physician-Assisted Suicide and Euthanasia in Washington State: Patient Requests and Physician Responses*, 275 *J. AM. MED. ASS'N* 919 (1996) (revealing that twenty-four percent of Washington patients explicitly requesting medications that they could use to hasten death received a prescription for the medication from their physicians); Steve Heilig et al., *Physician-Hastened Death: Advisory Guidelines for the San Francisco Bay Area From the Bay Area Network of Ethics Committees*, 166 *W. J. MED.*

question is not really whether the practice should occur, but whether the practice should proceed underground and unregulated or openly and regulated to protect patients and accommodate legitimate state interests.

II. THE FEDERAL CONSTITUTIONAL CLAIM TO PHYSICIAN-ASSISTED DYING

A. *Background*

During the early 1990s, patients, physicians, and the public interest group Compassion in Dying challenged the assisted-suicide laws in New York and Washington to the extent that they prohibited physicians from providing medications competent dying patients could use to hasten their own deaths if they so chose. Liberty and equality guaranteed by the Fourteenth Amendment of the U.S. Constitution formed the basis of the claims.

The liberty claim argued that the United States Supreme Court has consistently recognized that the Fourteenth Amendment's protection of liberty extends to important personal decisions that individuals make about their lives and how they will live them.¹⁰ This sort of protection, it was claimed, ought to extend to the profoundly personal choice about how one will cross the threshold to death when dying from a terminal illness.

The equal protection claimants argued that classifications that unequally distribute access to fundamental choices are presumptively invalid under the Equal Protection Clause; to permit patients to invite medical behavior that brings about death in some circumstances (e.g., the withdrawal of life sustaining medical care such as a ventilator or feeding tube) but not others (e.g., provision of medications that would bring about a humane hastened death) was claimed to violate principles of equal protection.

One of the arguments made in opposition suggested that what terminally ill patients really needed was good pain management

370 (1997); Richard Knox, *1 in 5 Doctors Say They Assisted a Patient's Death*, *Survey Finds*, BOSTON GLOBE, Feb. 28, 1992, at 5.

10. See, e.g., *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990) (refusal of unwanted medical treatment); *Loving v. Virginia*, 388 U.S. 1 (1967) (marriage); *Griswold v. Connecticut*, 381 U.S. 479 (1965) (contraception); *Prince v. Massachusetts*, 321 U.S. 158 (1944) (family relationships); *Skinner v. Oklahoma*, 316 U.S. 535 (1942) (procreation); *Pierce v. Soc'y of Sisters*, 268 U.S. 510 (1925) (child rearing and education).

and palliative care, not hastened death.¹¹ Two federal courts of appeals, including the Ninth Circuit sitting en banc, agreed that statutes preventing patients from exercising this option were unconstitutional.¹² The United States Supreme Court reversed these decisions, but as discussed below, left the door open to both a successful federal constitutional claim and legislative reform.

B. Where Do We Stand Following Glucksberg and Quill?

The Court rendered unanimous decisions upholding the laws challenged in *Glucksberg* and *Quill*. The decisions were quite clearly influenced by the lack of information on how a legalized program for physician-assisted dying would work, since at the time the cases were presented no state had legalized this option.¹³ Five justices, a majority of the Court, wrote or joined concurring opinions that limited the scope of the majority's ruling and carefully reserved issues for future cases. These five concurring justices left the question of federal constitutional protection of the choice at issue very much open to future developments.¹⁴

In considering the *Quill* and *Glucksberg* cases and their impact, attention is due to the following four significant points:

1. The Court only answered the broad question of a right to suicide, and left open the much narrower question of whether a dying suffering patient has a protected right to choose physician assistance in dying;
2. The Court recognized a right to adequate pain and palliative care;
3. The Court invited legislative reform on the subject of assisted dying; and
4. The decisions have served as catalysts for improved pain treatment and improved end of life care.

11. This argument is seen, for example, in New York State Task Force on Life and the Law, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context* (1994), available at <http://www.health.state.ny.us/nysdoh/provider/death.htm> (opposing legalization of assisted suicide, focusing on lack of adequate pain and symptom management at the end of life), cited by the states and their amici, and quoted extensively by the Court in *Glucksberg*, 521 U.S. 702, 719 (1997).

12. See *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir. 1996) (en banc), *rev'd sub nom. Washington v. Glucksberg*, 521 U.S. 702 (1997); *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996), *rev'd*, 521 U.S. 793 (1997).

13. *Glucksberg*, 521 U.S. at 723.

14. The Court's decision in June 2003 to strike down Texas's sodomy law suggests that the due process claim advanced in support of a dying person's right to control the timing and manner of death may be more viable than previously thought. See *Lawrence v. Texas*, 539 U.S. 558 (2003); see also *Tribe, supra* note 4.

The majority opinion, written by Chief Justice Rehnquist, did not actually resolve the narrow question posed by those challenging the states' laws. Instead, the Court answered a more general and easily resolved question, one on which the parties were not in dispute: "whether the 'liberty' specially protected by the Due Process Clause includes a right to commit suicide which itself includes a right to assistance in doing so."¹⁵ The Court recognized that the more difficult question, whether a dying suffering patient has a protected right to choose physician assistance in dying, was not foreclosed by its ruling on the more general question.¹⁶

Justice O'Connor, who cast the crucial fifth vote, revealed in her concurrence that she joined the majority only on the understanding that the question decided by the Court was the "easy" one, stating:

The Court frames the issue in [this case] as whether the Due Process Clause of the Constitution protects a "right to commit suicide which itself includes a right to assistance in doing so." . . . I join the Court's opinions because I agree that there is no generalized right to "commit suicide."¹⁷

She went on to state that on the "difficult" question, however, she has reserved judgment:

[R]espondents urge us to address the narrower question whether a mentally competent person who is experiencing great suffering has a constitutionally cognizable interest in controlling the circumstances of his or her imminent death. I see no need to reach that question in the context of the facial challenges to the New York and Washington laws at issue here.¹⁸

Thus, Justice O'Connor along with Justice Breyer, who separately concurred in judgment, explained that a viable constitutional claim remained for a future case specifically involving patients who could not obtain relief with palliative care.¹⁹ These justices also set forth

15. *Glucksberg*, 521 U.S. at 723; *see also id.* at 735 n.24 ("Our opinion does not absolutely foreclose such a claim.").

16. *See id.*

17. *Id.* at 736 (O'Connor, J., concurring).

18. *Id.*

19. *See id.* at 737, 791 (Justice Ginsberg joined Justice O'Connor's concurrence). The available data indicate that while most patients will be able to get relief with palliative care, some patients have intractable pain that cannot be relieved short of sedation to an unconscious state. *See, e.g.,* Ada Jacox et al., *New Clinical-Practice Guidelines for the Management of Pain in Patients with Cancer*, 330 *NEW ENG. J. MED.* 651, 651 (1994) (finding that pain in up to ninety percent of cancer patients can be controlled). *See generally* WEBB, *supra* note 5, at 81-125. The subset of patients whose pain cannot be controlled with medication appear to have a

the view that provision of pain-relieving medication to a patient, which hastened death, would not violate state laws prohibiting assisted suicide. Rather, as 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, from qualified physicians, to alleviate that suffering, even to the point of causing unconsciousness and hastening death."²⁰ She further wrote, "There is no dispute that dying patients . . . can obtain palliative care, even when doing so would hasten their deaths."²¹

Justice Breyer, for his part, concurred in the judgments upholding the states' challenged laws, but disagreed with the majority's "formulation of [the] claimed 'liberty' interest."²² He expressed the view that on the narrower, more difficult question, there was "greater support" in "our legal tradition" for a "right to die with dignity"²³ and he explicitly reserved judgment on that question:

I do not believe, however, that this Court need or now should decide whether or not such a right is "fundamental." That is because, in my view, the avoidance of severe physical pain (connected with death) would have to constitute an essential part of any successful claim and because, as JUSTICE O'CONNOR points out, the laws before us do not force a dying person to undergo that kind of pain.²⁴

Unfortunately, and contrary to the assumption of these justices, legal barriers to obtaining medication sufficient to adequately relieve pain do exist. Indeed, it is widely recognized that physicians fail to prescribe adequate medication for relief of pain,²⁵ and legal constraints contribute to that situation.²⁶

claim that the five concurring Justices in *Quill* and *Glucksberg* would find within the scope of liberty protected by the Fourteenth Amendment.

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

21. *Id.* at 737–38.

22. *Id.* at 790 (Breyer, J., concurring).

23. *Id.*

24. *Id.* at 791 (emphasis omitted).

25. See, e.g., Jacox, *supra* note 19, at 651 (noting that the pain associated with cancer is frequently under-treated). See generally Ben Rich, *A Prescription for the Pain: The Emerging Standard of Care for Pain Management*, 26 WM. MITCHELL L. REV. 1, 11 (2000).

26. Robyn S. Shapiro, *Health Care Providers' Liability Exposure for Inappropriate Pain Management*, 24 J. LAW, MED. & ETHICS 360, 363 (1996) (identifying fear of legal penalties, especially disciplinary action, as one of the most important reasons health professionals under-treat pain); see also David Joranson, *State Medical Board Guidelines for Treatment of Intractable Pain*, 5 AM. PAIN SOC'Y BULL. 2 (1995); AP-

Justice Stevens, also concurring in the judgments, wrote “separately to make it clear that there is also room for further debate about the limits that the Constitution places on the power of the States to punish the practice [of physician-assisted suicide].”²⁷ Because the Court addressed only the “easy” question, Justice Stevens emphasized that its holding “does not foreclose the possibility that some applications of the statute might well be invalid.”²⁸ Similarly, Justice Souter’s concurrence reflected his reservation of decision on the narrower, more difficult question: “I do not decide for all time that respondents’ claim should not be recognized”²⁹

Thus, Justices O’Connor, Breyer, Ginsberg, Stevens, and Souter appear to have answered a question the parties had not actually posed and, in doing so, have recognized that there is a constitutional right to adequate pain medication. The Court explicitly endorsed the aggressive practice of pain and symptom management known as terminal or palliative sedation.³⁰

Ultimately, the opinions, both majority and concurring, invited legislative reform. As Chief Justice Rehnquist’s opinion for the Court recognized, “Throughout the Nation, Americans are engaged in an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society.”³¹

Similarly, Justice Souter’s concurring opinion made explicit his preference for legislative action in this area. “The Court should . . . stay its hand to allow reasonable legislative consideration,”³² and, “the legislative process is to be preferred.”³³ And, Justice O’Connor’s key concurrence demonstrated her belief that the proper sphere for action was in the state legislatures rather than the court system: “States are presently undertaking extensive and serious evaluation of physician-assisted suicide and other related issues. In such circumstances, ‘the . . . challenging task of crafting appro-

PROACHING DEATH: IMPROVING CARE AT THE END OF LIFE 191, 197 (Marilyn J. Field & Christine K. Cassel eds., 1997) [hereinafter “APPROACHING DEATH”].

27. *Glucksberg*, 521 U.S. at 738 (Stevens, J., concurring).

28. *Id.* at 739. Stevens further stated: “[A] decision upholding a general statutory prohibition of assisted suicide does not mean that every possible application of the statute would be valid.” *Id.* at 741.

29. *Id.* at 789 (Souter, J., concurring).

30. See, e.g., Robert A. Burt, *The Supreme Court Speaks: Not Assisted Suicide but a Constitutional Right to Palliative Care*, 337 NEW ENG. J. MED. 1234, 1234–35 (1997).

31. *Glucksberg*, 521 U.S. at 735.

32. *Id.* at 789 (Souter, J., concurring).

33. *Id.* at 788.

ropriate procedures for safeguarding . . . liberty interests is entrusted to the 'laboratory' of the States.'"³⁴

The *Quill* and *Glucksberg* cases, it is universally acknowledged, served as a tremendous catalyst to improve pain and symptom management for all dying patients. As the Institute of Medicine stated: "Deficiencies in care of the dying were recognized well before [the] recent assisted suicide . . . court challenges. Nonetheless, much of the recent attention to deficiencies in end-of-life care arose only when the issue of assisted suicide came before the Supreme Court."³⁵ Similarly, authors writing in the Journal of the American Medical Association observed: "After years as a philosophy on the fringe of medicine, end-of-life care is now becoming a mainstream discipline. Perhaps its rise was spurred by the debate surrounding physician-assisted suicide . . . but whatever the reasons, the medical community is taking action."³⁶ Even vociferous opponents of choice at the end of life have recognized the important role the *Quill* and *Glucksberg* cases have played: "The debate over assisted suicide has helped to stimulate the medical community, and palliative care specialists in particular, into accepting the challenge to provide better care at the end of life."³⁷ Attempts have been made to estimate the investment in the effort to improve end-of-life care in the years since the *Quill* and *Glucksberg* cases pressed the issue to the national forefront. One estimate places the figure at \$300 million.³⁸

III.

LEGISLATIVE REFORM TO EXPAND PATIENT CHOICE AND ITS IMPACT ON END OF LIFE CARE

A. *Background*

To date only Oregon has passed a law permitting physician-assisted suicide.³⁹ Entitled the Oregon Death with Dignity Act

34. *Id.* at 737 (O'Connor, J., concurring) (citation omitted).

35. APPROACHING DEATH, *supra* note 26, at 206.

36. Mike Mitka, *Suggestions for Help When the End is Near*, 284 J. AM. MED. ASS'N 2441 (2000); *see also* IMPROVING PALLIATIVE CARE FOR CANCER 36 (Kathleen M. Foley & Helen Gelband eds., 2001) (recognizing that the *Quill* and *Glucksberg* decisions "assert[ed] a right to palliative care" and that this is among "a constellation of factors that has put palliative care on the agenda as a medical issue").

37. *See* Kathleen Foley & Herbert Hendin, *Conclusion: Changing the Culture, in THE CASE AGAINST ASSISTED SUICIDE* 311, 331 (Kathleen Foley & Herbert Hendin eds., 2002).

38. David M. McGrew, *AAHPM Headlines and Perspectives*, 6 J. PALLIATIVE MED. 529, 529 (2003).

39. *See* Or. Rev. Stat. §§ 127.800-127.995 (2001).

(“ODWDA”), this law was passed in 1994 through the initiative process.⁴⁰ Opponents sought to defeat the ODWDA politically by forcing a repeal measure on the ballot in November of 1997. That effort failed when sixty percent of Oregon voters rejected the repeal.⁴¹ Having exhausted their judicial and (state) political avenues, opponents of the ODWDA next sought relief from the Federal Government. They urged the Drug Enforcement Agency (“DEA”) to take action against Oregon physicians who acted in compliance with the law on the basis that such activity violates the Controlled Substances Act (“CSA”).⁴²

The DEA initially opined that its agents could revoke the registrations of physicians who assisted in hastening deaths under the ODWDA. United States Attorney General Janet Reno, however, promptly overruled this position, concluding that the CSA did not reach such conduct.⁴³ Having once again failed in their attempts, the opponents then sought, in two successive sessions of Congress, to amend the CSA to expand its scope to reach the ODWDA.⁴⁴ Both efforts failed in the face of strong opposition from the medical community, founded on the concern that the proposed measures would exacerbate physicians’ fears regarding the use of controlled substances in pain management.⁴⁵

40. Implementation was obstructed for several years by a lawsuit brought by opponents. In a lawsuit that turned upside down the equal protection argument advanced in the *Glucksberg* and *Quill* cases, the challengers argued that a law permitting terminally ill patients to choose physician assistance in dying denied the terminally ill equal protection of the laws. The Ninth Circuit dismissed the case on the grounds that the plaintiffs lacked standing. *Lee v. Oregon*, 891 F. Supp. 1429 (D. Or. 1995), *vacated* 107 F.3d 1382 (9th Cir. 1997).

41. See David Garrow, *The Oregon Trail*, N.Y. TIMES, Nov. 6, 1997, at A31; Kim Murphy, *Voters in Oregon Soundly Endorse Assisted Suicide*, L.A. TIMES, Nov. 5, 1997, at 1.

42. See generally Timothy Egan, *Threat from Washington Has Chilling Effect on Oregon Law Allowing Assisted Suicide*, N.Y. TIMES, Nov. 19, 1997, at A18.

43. In an opinion letter issued June 5, 1998, Reno stated that “[t]he Department has conducted a thorough and careful review of the issue . . . [and] has concluded that adverse action against a physician who has assisted in a suicide in full compliance with the Oregon Act would not be authorized by the CSA.” Statement of Attorney General Reno on Oregon’s Death with Dignity Act, U.S. Dep’t of Justice, June 5, 1998. Reno concluded that “[t]here is no evidence that Congress, in the CSA, intended to displace the states as the primary regulators of the medical profession, or to override a state’s determination as to what constitutes legitimate medical practice in the absence of a federal law prohibiting that practice.” *Id.*

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

45. See Marcia Angell, *Caring for the Dying: Congressional Mischief*, 341 NEW ENG. J. MED. 1923 (1999) (“If the bill becomes law, it will almost certainly discourage

A change in federal administration and philosophy led to a change in legal interpretation. The Bush administration's attorney general, John Ashcroft, issued a Directive on November 6, 2001 (the "Ashcroft Directive"), advising that the Department of Justice had concluded that prescribing controlled substances under the ODWDA violated the CSA because "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]."⁴⁶ In particular, "[s]uch conduct by a physician registered to dispense controlled substances may 'render his registration . . . inconsistent with the public interest' and therefore subject to possible suspension or revocation under 21 U.S.C. § 824(a)(4)."⁴⁷

The Ashcroft Directive was immediately challenged in federal court by the State of Oregon, an Oregon physician and pharmacist, and a group of terminally ill Oregonians. The plaintiffs assert that the Ashcroft Directive violates the CSA, the Administrative Procedure Act, and the U.S. Constitution.⁴⁸ After issuing a temporary restraining order and then a preliminary injunction, the court in April 2002 issued its final decision, reaching only the question of whether the directive was within the scope of the CSA. The court concluded that it was not. Rather, the Directive exceeded the authority granted under the CSA, and a permanent injunction was entered:

The determination of what constitutes a legitimate medical practice or purpose traditionally has been left to the individual states. State statutes, state medical boards, and state regulations control the practice of medicine. The CSA was never intended, and the USDOJ and DEA were never authorized, to establish a national medical practice or act as a national medical board. To allow an attorney general—an appointed executive whose tenure depends entirely on whatever administration occupies the White House—to determine the legitimacy of a

doctors from prescribing or administering adequate doses of drugs to relieve the symptoms of dying patients."); David Orentlicher & Arthur Caplan, *The Pain Relief Promotion Act of 1999, A Serious Threat to Palliative Care*, 283 J. AM. MED. ASS'N 255 (2000) ("[P]rogress [in the area of improved pain care] may be dealt a severe setback should Congress decide to enact the [PRPA]. . . . [T]he most likely effect of PRPA would be to discourage physicians nationwide from adequately treating the suffering of their dying patients.")

46. Att'y Gen. Order No. 2534-2001, 66 Fed. Reg. 56, 607 (Nov. 9, 2001).

47. *Id.*

48. The impact the Ashcroft Directive would have on good pain management nationwide is discussed *infra* at text accompanying notes 76–79.

particular medical practice without a specific congressional grant of such authority would be unprecedented and extraordinary.⁴⁹

B. Lessons Learned From Implementation of the ODWDA

The ODWDA has now been implemented for six years. Each year teams of epidemiologists from the state and federal governments review data related to implementation and issue reports summarizing the data.⁵⁰ The clear, unambiguous message of these reports is that the risks opponents argued would ensue if this option were available have not been realized.⁵¹ Indeed, many important and measurable improvements in end-of-life care in general have followed on ODWDA's heels in Oregon.⁵² This includes, specifically, evidence that physicians have increasingly sought additional education in pain management and have increased the volume of strong pain medications provided to patients in Oregon.⁵³

Given that risks have not been realized from the availability of a choice of a humane hastened death, and important improvements in end-of-life care *have* been realized in the wake of implementation of the ODWDA, it is particularly disturbing to see efforts to overturn the act, such as the Ashcroft Directive. Attorney Gen-

49. *Oregon v. Ashcroft*, 192 F. Supp. 2d 1077, 1092 (D. Or. 2002), *appeal filed*, Case No. 02-35587, *argued* May 7, 2003.

50. See Office of Disease Prevention and Epidemiology, Dept. of Human Services, *Sixth Annual Report on Oregon's Death with Dignity Act* (Richard Leman ed., 2004) available at <http://www.dhs.state.or.us/publichealth/chs/pas/pas.cfm>; K. Hedberg et al., *Five Years of Legal Physician-Assisted Suicide in Oregon*, 348 NEW ENG. J. MED. 961-64 (2003); K. Hedberg et al., *Legalized Physician-Assisted Suicide in Oregon, 2001*, 346 NEW ENG. J. MED. 450-52 (2002); A.D. Sullivan, *Legalized Physician-Assisted Suicide in Oregon, 1998-2000*, 344 NEW ENG. J. MED. 605-07 (2001); A.D. Sullivan et al., *Legalized Physician-Assisted Suicide in Oregon—The Second Year*, NEW ENG. J. MED. 342, 598-604 (2000); G. Chin et al., *Legalized Physician-Assisted Suicide in Oregon—The First Year's Experience*, 340 NEW ENG. J. MED. 577 (1999).

51. See *supra* note 50; see also L. Ganzini et al., *Oregon Physicians' Attitudes About and Experiences With End-of-Life Care Since the Passage of the Oregon Death With Dignity Act*, 285 J. AM. MED. ASS'N 2363-69 (2001); M.A. Lee & S.W. Tolle, *Oregon's Assisted Suicide Vote: The Silver Lining*, 124 ANNALS OF INTERNAL MED. 267, 267-69 (1996). Opponents of the ODWDA have attempted to criticize the data generated. See, e.g., Foley & Hendin, *supra* note 37. If critics have legitimate criticisms that different or more data ought to be collected and analyzed, this could be accomplished. To date, critics have not sought such a remedy, engendering speculation that their opposition is not based on concerns about implementation but is a generalized opposition based on personal religious or moral views.

52. See *supra* notes 50-51.

53. See *id.*

eral Ashcroft encourages a perverse result in seeking to nullify the Oregon law; in his effort to prevent this end-of-life option from being available, he jeopardizes good pain care for all patients. This will result because increasing scrutiny of physician conduct in prescribing pain medication to dying patients will unavoidably and certainly serve to chill physician willingness to treat pain aggressively.⁵⁴

Opponents of assisted dying frequently argue that requests for assisted dying are really nothing more than a call for good pain management. If pain was properly managed, they suggest, the patient's desire to hasten death would evaporate.⁵⁵ Further, they argue that motivation to improve pain management will be undermined if assisted dying is an available option.⁵⁶ Yet, in Oregon it has been shown that legalization of assisted dying has galvanized efforts to improve pain management.⁵⁷ Terminally ill Oregonians do not choose assisted dying because they have untreated pain. Rather, they have access to good pain management and only those who persist in a desire to hasten impending death go on to utilize the ODWDA.

Was the improvement in pain practice and policy prompted by the legalization of assisted dying in Oregon? One can argue convincingly that it was, since following implementation of the ODWDA various indicia show that efforts to improve pain care were undertaken and, various concrete indicators, such as morphine consumption, reflect that more pain medication was dispensed.⁵⁸ In addition, important policy measures to promote and support good pain care have been enacted in the wake of the ODWDA.⁵⁹

54. *See supra* notes 25–26 (programs of scrutiny deter adequate prescribing of strong pain medications); *infra* note 76 (cases involving prosecution of physician for prescribing pain medications).

55. *See, e.g.*, Foley & Hendin, *supra* note 37, at 331 (If end-of-life care can be improved, “assisted suicide will cease to seem an option that is truly needed.”); *see also* Brief of Amici Curiae American Medical Association et al. at 6–8, *Vacco v. Quill*, 518 U.S. 1055 (1996) (No. 95-1858).

56. *See generally* Brief of Amici Curiae National Hospice Organization, *Vacco v. Quill*, 518 U.S. 1055 (1996) (No. 95-1858, 96-110).

57. *See supra* notes 50–51.

58. *See id.*

59. For example, in the 2003 Oregon legislative session, a measure was passed and signed into law which requires the health professional regulatory boards to “encourage the development of state-of-the-art multidisciplinary pain management services and the availability of these services to the public.” S. 434 (SB 434-A), 72nd Leg. (Or. 2003) (The state’s Board of Medical Examiners, Board of Dentistry, Board of Nursing, Physical Therapist Licensing Board, Board of Chiropractic Examiners, and Board of Pharmacy are covered by the legislation.).

What lessons might be drawn from this? One can persuasively make the case that in states where legalization is pursued, the chance of passing a measure is enhanced if the opposition's arguments pertaining to pain management can be defused by showing that in the forum state dying patients are likely to have access to good pain management because that state has policy, enacted by its legislature or passed by the state medical board, which encourages such care.⁶⁰ Having said this, it is apparent that passage of an assisted-dying measure *itself spurs* improved pain management in the forum state, as has occurred in Oregon following passage of the ODWDA.⁶¹ Thus, strong pain policy can facilitate passage of an assisted-dying measure; passage of such a measure can prompt improved pain policy and practice in the forum state.

Although public opinion strongly favors permitting competent dying patients the right to control the timing and manner of death

60. Thus, in states like California, which has undertaken a series of steps to promote good pain management, opposition to an assisted-dying measure could find little basis to mount a pain management-based attack. *See* CAL. BUS. & PROF. CODE § 2241.5 (Intractable Pain Treatment Act 1990); CAL. HEALTH & SAFETY CODE § 124960 (Pain Patient's Bill of Rights 1997); CAL. BUS. & PROF. CODE § 2089 (mandatory medical school curriculum in pain management and palliative care); CAL. BUS. & PROF. CODE § 2190.5 (mandatory continuing medical education in pain management and palliative care); "Prescribing Controlled Substances For Intractable Pain" (Policy Statement of the MBC, adopted May 6, 1994.); "Guideline for Prescribing Controlled Substances for Intractable Pain" (Guideline Adopted by the MBC July 29, 1994). In states where strong pain policy is not in place, its absence can form a basis for opposing passage of an assisted dying measure. This can be seen for example in the current effort to pass an assisted dying measure in Vermont. The Vermont Nurses Association issued a position statement opposing passage of the measure, largely focusing on the need to improve pain care *before* passing an assisted dying measure. *See* Stephen Kiernan, *State Nurses Association Opposes Assisted Suicide*, THE BURLINGTON FREE PRESS, Jan. 2, 2004, at 1B ("Much of the [policy statement of the Vermont Nurses' Association] describes the kind of care dying patients deserve, from pain relief to the right to refuse treatment . . . 'We need to address these areas before we devote a lot of time and money' to assisted suicide, [the executive director of the nurses' association] said. Good end-of-life care 'needs to be in place for everyone first.'"); *see also*, Stephen Kiernan, *Groups Oppose Suicide Bill*, THE BURLINGTON FREE PRESS, Jan. 30, 2004 at 1B ("Untreated or under treated pain is often a determining factor in a terminally ill patient's decision to end their [sic] own life," the [Vermont Chapter of the American Cancer Society statement] says. "With advances in pain management, people with terminal illnesses need not suffer hopelessly.")

61. *See* Ganzini, *supra* note 51; *see also* Lee & Tolle, *supra* note 51. Some of the most vociferous opponents of choice at the end of life are unwilling to acknowledge even the clear positive impact that legalization of assisted dying has had on pain practice and policy in Oregon. *See, e.g.*, Foley & Hendin, *supra* note 37, at 331. The refusal of these few commentators to credit the Oregon experience undermines the validity of their work as a whole.

by having access to medications that could be used to bring about a humane and dignified death, and the United States Supreme Court has encouraged resolution of the issue in state legislative procedures, the opposition of the right-to-life lobby, the Catholic Church and certain factions of organized medicine may continue to make legislative reform difficult. Thus, a return to the courts for relief may be necessary. As discussed above, the Supreme Court may find a federal constitutional right in a future case. Indeed, recent decisions of the Supreme Court suggest that the Court is more open to the due process claim than it was at the time the *Quill* and *Glucksberg* cases were before the Court.⁶² In addition, patient rights advocates have the option of seeking relief from state high courts under provisions of state constitutions, as discussed in Part IV.

IV. STATE CONSTITUTIONAL LITIGATION

Many states have constitutions that are more textually explicit regarding protection of individual liberties than is the U.S. Constitution, or have similar text that has been construed by the states' high courts as more protective of individual liberties.⁶³ Thus, for example, state courts have found that restrictions on the use of Medicaid funds for abortions offend state constitutions,⁶⁴ notwithstanding that the United States Supreme Court has held that there is no federal constitutional right to such funding.⁶⁵

State courts have often spoken in resounding terms of the greater protection of individual liberties afforded by state constitutions.⁶⁶ It is now well-recognized that state courts can and will ac-

62. See, e.g., *Lawrence v. Texas*, 539 U.S. 558 (2003). For a thorough discussion of *Lawrence* and its implications, see Tribe, *supra* note 4.

63. See generally William J. Brennan, Jr., *State Constitutions and the Protection of Individual Rights*, 90 HARV. L. REV. 489, 491 (1977); JENNIFER FRIESEN, *STATE CONSTITUTIONAL LAW: LITIGATING INDIVIDUAL RIGHTS, CLAIMS AND DEFENSES* (1992); Robert F. Williams, *State Constitutional Law: Teaching and Scholarship*, 41 J. LEGAL EDUC. 243 (1991).

64. See Linda M. Vanzi, *Freedom at Home: State Constitutions and Medicaid Funding for Abortions*, 26 N.M. L. REV. 433 (1996).

65. See *Harris v. McRae*, 448 U.S. 297 (1980); see also *Maher v. Roe*, 432 U.S. 464 (1977).

66. A recent decision of the California Supreme Court exemplifies this: "[T]he scope and application of the state constitutional right of privacy is broader and more protective of privacy than the federal constitutional right of privacy as interpreted by the federal courts." *Am. Acad. of Pediatrics v. Lungren*, 940 P.2d 797, 808 (Cal. 1997).

tively turn to their state constitutions to reach results beyond those mandated by the U.S. Constitution.⁶⁷

State court challenges to assisted-suicide prohibitions based on state constitutional provisions protecting individual privacy, liberty, or dignity may offer a route to reform in such states. The fact that the United States Supreme Court did not definitively reject recognition of such a right under the U.S. Constitution in *Glucksberg* or *Quill* makes the prospect of a state high court victory more likely, as it is always more difficult to persuade a state high court to reach a conclusion squarely at odds with that of the Supreme Court construing a similar provision in the U.S. Constitution.

To date, only two state high courts have considered the matter. Neither found that its state constitution protected the choice of a competent terminally ill patient to choose a humane hastened death.⁶⁸ However, the first of these cases arose before *any* implementation of the ODWDA, and the second when only a year of data was available. It is likely that as Oregon's experience with the ODWDA yields additional data, concerns about abuse and risk, so central to the opposition, will be assuaged and defused. Even staunch opponents of assisted suicide have begun to publicly acknowledge that continued opposition to such laws cannot be justified in light of the Oregon experience.⁶⁹

When faced with federal or state constitutional challenges to a state assisted-suicide law, states and their amici routinely argue that the claim for constitutional protection of the choice for a humane hastened death ought not be recognized because the patients are actually in need of good pain management, and that the state has an interest in protecting dying patients from choosing to hasten death when what is really needed is good pain management.⁷⁰ This sort of argument can be defused if the state where judicial recognition of a claimed right to assisted dying is presented has a strong pain policy adopted by the state legislature or the state medical board. Thus, in a case claiming a state constitutional right to a hu-

67. See, e.g., *Gryczan v. State*, 942 P.2d 112 (Mont. 1997) (privacy clause).

68. *Sampson v. Alaska*, 31 P.3d 88 (Alaska 2001); *Krischer v. McIver*, 697 So. 2d 97 (Fla. 1997).

69. Daniel Lee, *Physician-Assisted Suicide: A Conservative Critique of Intervention*, HASTINGS CTR. REPORT, Jan. 2003, at 17–19.

70. See, e.g., New York State Task Force on Life and the Law, *supra* note 11 (opposing legalization of assisted suicide, focusing on lack of adequate pain and symptom management at the end of life); Foley & Hendin, *supra* note 37, at 331 (If end-of-life care can be improved, “assisted suicide will cease to seem an option that is truly needed.”); see also Brief of Amici Curiae American Medical Association, *supra* note 55, at 6–7.

mane hastened death, if the state (or its amici) were to argue that state interests justified a prohibition on the practice because the state must protect vulnerable patients who might be motivated to seek a hastened death because of poor pain care, the plaintiffs could rebut such an argument by showing that state pain policy was in place to promote and support good pain management.

V.

THE PROBLEM OF UNDER-TREATED PAIN AND EFFORTS TO REDRESS

A. *Law and Medicine Recognize that Patients Have a Right to Adequate Pain Care*

The American Medical Association has declared: "Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death."⁷¹ A great proliferation of authoritative literature has been published in medical journals in the past decade exhorting physicians to treat pain attentively and aggressively. The United States Supreme Court has recognized that dying suffering patients have a right to adequate pain management.⁷²

B. *Patients Do Not Receive Adequate Pain Care*

Notwithstanding the recognition in both law and medicine that seriously ill and dying patients in the United States have the right to adequate pain care, a great percentage of such patients are routinely under-treated for pain. In a landmark study, researchers found that fifty percent of all patients who died during hospitalization "experienced moderate or severe pain at least half of the time during their last three days of life."⁷³ At the same time, it is well-

71. COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, AM. MED. ASS'N, CODE OF MEDICAL ETHICS 40 (1996).

72. *Vacco v. Quill*, 521 U.S. 793 (1996); *Washington v. Glucksberg*, 521 U.S. 702 (1996).

73. Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments ("Support") Principal Investigators, *A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients*, 274 J. AM. MED. ASS'N 1591, 1594 (1995); see also Rich, *supra* note 25, at 12; AHCPR, *Acute Pain Management: Operative or Medical Procedures and Trauma, Clinical Practice Guideline*, at <http://www.ahcpr.gov/clinic/medtep/acute.htm>; *Means to a Better End: A Report on Dying in America Today*, LAST ACTS (Robert Wood Johnson Foundation Nov. 2002); *Breaking Down the Barriers to Effective Pain Management*, Recommendations to Improve the Assessment and Treatment of Pain in New York State, Report to the Commissioner of Health (Jan. 1998); APPROACHING DEATH, *supra* note 26, at 197; David Joranson, *State Medical*

established that perhaps only ten percent of dying patients have conditions in which alleviation of pain is truly difficult or impossible.⁷⁴

C. Causes of Under-Treatment of Pain

While inadequate pain management has many contributing factors, two among these stand out as most significant: physicians' fear of regulatory agency oversight, and inadequate education of physicians in pain management.

1. Programs of Oversight Chill Prescribing for Pain Management

Prescription monitoring programs, designed to prevent diversion of strong medications to the black market, have the collateral effect of chilling physician willingness to prescribe such medications.⁷⁵ Highly publicized cases in which physicians have been investigated and punished for prescribing strong pain medications, even though the physician's conduct met guidelines for pain management, create a climate of fear which deters appropriate prescribing.⁷⁶

Thus, it is particularly alarming to see new programs of scrutiny and sanction introduced, such as the effort by Attorney General John Ashcroft, discussed above. In his effort to overturn the will of the Oregon people who have voted to permit dying patients to obtain medications they can self-administer to achieve a humane hastened death, he puts at risk good pain management for all dying patients nationwide. The Ashcroft Directive provides that any physician who is determined to have intended to hasten a patient's death by provision of pain medications is subject to punishment under the CSA.

Clinicians point out that determining a physician's intent in prescribing pain medication at the bedside of a suffering dying patient is open to an investigator's after-the-fact second-guessing: was the intent to relieve pain and suffering or to hasten death?⁷⁷

Board Guidelines for Treatment of Intractable Pain, 5 AMERICAN PAIN SOCIETY BULLETIN (May/June 1995). See generally Shapiro, *supra* note 26, at 360.

74. See Jacox, *supra* note 19, at 651; Am. Pain Soc'y, *Treatment of Pain at the End of Life: A Position Statement from the American Pain Society*, available at <http://www.ampainsoc.org/advocacy/treatment/htm> (last visited Mar. 30, 2004).

75. See Rich, *supra* note 25, at 48-49; see, also Shapiro, *supra* note 26, at 363.

76. See, e.g., Hoover v. Agency for Health Care Admin., 676 So. 2d 1380 (Fla. Dist. Ct. App. 1996); State v. Naramore, 965 P. 2d 211 (Kan. Ct. App. 1998); Hollabaugh v. Arkansas State Med. Bd., 861 S.W.2d 317 (Ark. Ct. App. 1993).

77. See, e.g., Jerome Groopman, *Separating Death from Agony*, N.Y. TIMES, Nov. 9, 2001, at A27 ("Nothing could be further from the truth than Mr. Ashcroft's

If the Ashcroft Directive were permitted to take effect, the desire to avoid this sort of investigation would cause physicians to be *even less* willing to treat the pain of dying patients. Widespread recognition in the medical, hospice, and bioethics communities that the Ashcroft Directive will operate in this manner to impair pain care nationwide prompted broad amicus participation opposing the directive.⁷⁸ This amicus participation included groups neutral on the assisted-dying question and also those officially opposed to legalization of the practice.⁷⁹

Similarly, state legislation ostensibly designed to prevent physician-assisted suicide will also serve to increase physician concerns that their prescribing for pain of their dying patients will bring scrutiny and sanction, and will further chill physicians' already reluctant willingness to treat pain. Such a bill was introduced in the 2003 legislative session in the North Carolina legislature.⁸⁰ The opposition to the North Carolina measure from the medical, legal, and health policy communities was based on the recognition and concern that the measure would undermine good pain care.⁸¹ This opposition succeeded in preventing passage of the proposal.

statement that a federal drug agency could readily discern the 'important medical, ethical and legal distinctions between intentionally causing a patient's death and providing sufficient dosages of pain medication necessary to eliminate or alleviate pain.' In fact, it is medically impossible to dissociate intentionally ameliorating a dying patient's agony from intentionally shortening the time left to live.").

78. See, e.g., Brief for Amicus Curiae American Public Health Association, Oregon v. Ashcroft, 192 F.Supp. 2d 1077, 1092 (D. Or. 2002), *appeal filed*, Case No. 02-35587, argued May 7, 2003; Brief of Amici Curiae American Academy of Pain Management, California Medical Association, San Francisco Medical Society, Society of General Internal Medicine, Washington State Medical Association, National Academy of Elder Law Attorneys, Southern California Cancer Pain Initiative, Washington State End of Life Consensus Coalition, et al., *Ashcroft* (No. 02-35587); Brief of Amici Curiae Medical Society and Concerned New York Physicians, *Ashcroft* (No. 02-35587); Amicus Curiae Brief of the American College of Legal Medicine, *Ashcroft* (No. 02-35587).

79. See *supra* note 78.

80. S.B. 145, 2003 Gen. Assem. (N.C. 2003).

81. Memo from Kate Mewhinny, Clinical Professor of Law, Wake Forest University School of Law, to Individuals and Organizations Concerned About N.C. Senate Bill 145 (Jul. 7, 2003) (on file with *The NYU Annual Survey of American Law*) (listing some of the opposition letters sent to sponsoring Senator Hartsell by North Carolina physicians, hospice professionals, professors of medicine, and health and elder law attorneys).

2. Inadequate Physician Education in Pain Management Results in Inadequate Pain Care

Many physicians lack knowledge of modern pain management practices and principles. Physicians are not sufficiently educated regarding pain treatment.⁸² This is due to the failure of medical schools to adequately teach pain and symptom management, as well as the failure of licensing boards to require, as a condition of maintaining a license to practice medicine, that physicians take a minimum number of hours of continuing medical education in pain and symptom management. A number of states have begun to address this by passing measures to require such training.⁸³ Hopefully, these will serve as models for other states to follow.⁸⁴

As noted above, in Oregon, the one state to have legalized assisted dying, one immediately recognized effect of the assisted dying law was increased physician enrollment in pain and palliative care educational courses.⁸⁵ The Oregon experience provides a strong basis to argue that when assisted dying is an available option, clinicians strive to ensure that it is not selected due to inadequate pain care, and redouble efforts to become educated about modern pain management practices and principles. Thus, while it might be easier, as suggested above, to pass an assisted-dying measure in a state with strong, positive pain policy already in place, even in a state where this is not accomplished prior to passage it appears that

82. See, e.g., Hellen Gelband, *Professional Education in Palliative and End-of-Life Care for Physicians, Nurses, and Social Workers*, in *IMPROVING PALLIATIVE CARE FOR CANCER* 277–89 (Kathleen M. Foley & Hellen Gelband eds., 2001); Sharon Abele Meekin et al., *Development of a Palliative Education Assessment Tool for Medical Student Education*, 75 *ACADEMIC MED.* 986, 987 (2000) (“Over the past 25 years, studies conducted to assess the type and amount of palliative care education occurring in the U.S. medical schools have revealed that little attention is paid to this topic.”).

83. CAL. BUS. & PROF. CODE §§ 2089, 2190.5 (West 2003) (mandating medical training and continuing education in pain management and end-of-life care); W. VA. PROFESSIONS AND OCCUPATIONS CODE § 30-1-7a (2001) (mandating continuing education in end-of-life pain treatment).

84. Leading clinicians and medical educators in New York recently developed a comprehensive tool to assess the adequacy of palliative care education in medical schools. This tool is known as the Palliative Education Assessment Tool (PEAT). Curriculum in pain management and palliative care for undergraduate medical education was also developed. E.B. Wood, *Enhancing Palliative Care Education in Medical School Curricula: Implementation of the Palliative Education Assessment Tool*, 77 *ACADEMIC MED.* 285, 285–91 (Apr. 2002); Meekin et al, *supra* note 82, at 986–92. These were important steps in the right direction. States should consider mandating utilization of PEAT, to assess the adequacy of the curriculum in the medical schools in each state, and then implement plans to ensure adequate education in these essential areas.

85. See *supra* notes 50–51.

passage will serve as a catalyst to improved pain practice in that state.

D. Accountability for Failure to Treat Pain Adequately: The Time Has Come

With the attention focused by the *Quill* and *Glucksberg* cases on the inadequacies of end-of-life care, a growing awareness has emerged that failure to treat pain adequately should bring accountability.⁸⁶ Accountability for inadequate pain management can arise in various contexts. The most appropriate is via the state medical licensing boards that are vested with authority to supervise the conduct of the licensees in their jurisdictions and to protect the public from physicians whose conduct is injurious to patients.⁸⁷ A second correction can come through tort exposure.

1. Medical Board Correction

State medical boards have been slow to recognize their responsibility to correct physicians who under-treat pain. Even in California, where the Medical Board of California (“MBC”) has been remarkably progressive in adopting policies recognizing the importance of good pain management,⁸⁸ the problem persists. When presented with a formal complaint, supported by an independent expert opinion, which indicated that the pain care provided to an elderly, terminally ill cancer patient was inadequate, the MBC, notwithstanding its determination that the physician had failed to provide adequate pain care, declined to pursue any action against the physician.⁸⁹ Fortunately, the MBC appears to have evolved in its handling of such complaints, and in a more recent similar case the board filed charges against the physician and corrective action was

86. See Kathryn L. Tucker, *End of Life Care a Human Rights Issue*, 30 HUM. RTS. 11 (2003); Kathryn L. Tucker, *Pain Management: Advising and Advocating for Good Care, Seeking Redress and Accountability for Inadequate Care*, 15 NAELA Q. 17–21 (2002); Kathryn L. Tucker, *Failure to Treat Pain Adequately: Hospital and Provider Risk of Regulatory, Disciplinary and Tort Accountability*, 19 HOSP. L. NEWS 1 (2002); Kathryn L. Tucker, *A New Risk Emerges: Provider Accountability for Inadequate Treatment of Pain*, 9 ANNALS OF LONG-TERM CARE 52, 54 (2001); Kathryn L. Tucker, *Improving Pain Care: A Safe Harbor Is Not Enough*, 11 HEALTH LAW. 15 (1999).

87. Kathryn L. Tucker, *Medical Board Corrective Action With Physicians Who Fail to Provide Adequate Pain Care*, 87 J. MED. LICENSURE & DISCIPLINE 130 (2001).

88. See *Guidelines for Prescribing Controlled Substances for Pain*, 87 MBC ACTION REP. 1, 4 (2003) (improving effective pain management of patients), available at <http://www.medbd.ca.gov/10-03actionreport.pdf>.

89. See Sheryly Gay Stolberg, *Amid New Calls for Pain Relief, New Calls for Caution*, N.Y. TIMES, Oct. 13, 1998, at F7; see also Tucker, *supra* note 87, at 130–31.

taken.⁹⁰ Medical boards must become receptive to correcting physician conduct that involves failure to provide pain management adequate to meet the patient's needs.⁹¹ Recognition of the need for such correction is now coming even from within the profession.⁹²

Medical boards should promulgate policies that require disciplinary action when there is failure to adequately prescribe, order, administer or dispense controlled substances, including opioid analgesics, for the relief or modulation of pain in accordance with prevailing clinical practice guidelines.

2. Tort System Correction

Correction may come from the tort system. Until recently, physicians have not been held liable for failing to adequately treat the pain of their dying patients by the tort system. However, real exposure exists for physicians and health care facilities, in cases where pain management is inadequate. Tort liability would be made easier if the safe harbor laws were amended to include an explicit private cause of action for failure to treat pain, but even absent an explicit private cause of action, liability may be founded upon more conventional theories of medical negligence or creative application of other statutes such as those governing elder abuse.

In 2001, a case was tried before a state court jury in California where the sole claim was failure of the physician to adequately treat the pain of an elderly man dying of a painful form of lung cancer. The physician was ignorant of the great body of authoritative literature governing pain management, had not bothered to stay current

90. *In re the Accusation Against: Eugene B. Whitney, MD*, Case No. 12 2002 133376 (Dec. 15, 2003) (Dr. Whitney received a public reprimand and was ordered to undergo an assessment of knowledge and skills, complete a minimum of forty hours of continuing medical education in pain management/palliative care, and complete a physician-patient communication course).

91. The duty of a physician when treating a patient experiencing pain associated with terminal illness is to inform the patient of the possible treatment options for management of pain and the anticipated side effects of any such treatments, and to permit the patient to make an informed choice about treatment. For example, increasing dosage of strong pain medications such as morphine may have the foreseeable but unintended consequence of suppressing respiration and possibly advancing the time of death. This "double effect" is accepted in medical ethics and practice and has been endorsed by the United States Supreme Court. See *supra* text accompanying notes 20–21. The choice whether to accept the double effect risk of medication must be the patient's choice, not imposed by a paternalistic physician.

92. See David E. Weissman, *Care Near the End of Life: What is Unprofessional Behavior?*, 6 J. PALLIATIVE MED. 1, 2 (2003).

with the many developments in the field since he had graduated from medical school almost thirty years before, and had used outmoded and discredited pain management strategy; and the patient suffered unnecessarily during his final week of life as a result. The jury hearing the case determined that the physician's conduct was reckless⁹³ and awarded the family \$1.5 million for the patient's pain and suffering under the state elder abuse statute.⁹⁴ Such verdicts reverberate in the medical community⁹⁵ and apply a strong prompt to correct such behavior.⁹⁶

VI. CONCLUSION

Public opinion strongly favors permitting competent dying patients the right to choose a humane hastened death by obtaining a lethal dose of medications from their physician that the patients can self-administer for this purpose. The United States Supreme Court has encouraged the states to serve as a laboratory for the nation on this complex issue, and the data emerging from Oregon is providing a wealth of valuable information on how a legalized practice of assisted dying works. Among the most important findings emerging from this data is the clear evidence that the availability of the option serves as a catalyst for improved end of life care and specifically improved pain care.

Improving pain care may reduce the number of dying patients who seek a hastened death. When strong pain policy is in place, the feasibility of passing legislation to permit assisted suicide may be increased, as a central argument against permitting the practice is removed from the debate. Permitting the option of a humane hastened death galvanizes improvements in pain and symptom management.

93. Under the elder abuse cause of action maintained in the case, the plaintiffs were required to prove reckless, as opposed to simply negligent, conduct. Notwithstanding this heavy burden, the plaintiffs prevailed.

94. *Bergman v. Eden Med. Ctr.*, No. H205732-1 (Cal. Super. Ct., Alameda County Jun. 13, 2001).

95. See, e.g., Tanya Albert *Doctor Guilty of Elder Abuse for Under-Treating Pain*, AM. MED. NEWS, July 23, 2001 at 1; *Doctor Tagged with \$1.5 M verdict in Landmark Elder Abuse Case*, NURSING HOME LEGAL INSIDER, July 2001; Mark Crane, *Now You May Be Liable for Under-Treating Pain*, MED. ECON., Sept. 2001; Che Parker, *Court Ruling Pushes Better Pain Control*, AM. HOSP. NEWS, June 25, 2001.

96. See generally Timothy McIntire, *Is the Pain Getting Any Better? How Elder Abuse Litigation Led To A Regulatory Revolution In The Duty To Provide Palliative Care*, 11 ELDER L. J. 329 (2003).

Some religious organizations and right-to-life activists continue to obstruct and seek to nullify legislative reform, although even staunch opponents of the practice of assisted dying increasingly recognize that continued opposition cannot be justified in light of the Oregon experience.⁹⁷ As Ronald Dworkin has so eloquently observed: “Making someone die in a way that others approve, but he believes a horrifying contradiction of his life, is a devastating, odious form of tyranny.”⁹⁸

Excellence in end-of-life care requires that the pernicious problem of inadequate pain management be addressed. Increased correction by state medical boards is one part of the solution. There is also a role for correction through the tort system, and amendments to safe harbor legislation to explicitly provide for such actions would facilitate this form of correction. In addition, mandatory minimum palliative care education for both physicians in training in the medical school curricula and for physicians in practice through continuing medical education requirements could raise the floor of clinician knowledge in this arena.⁹⁹

97. See Lee, *supra* note 69.

98. RONALD DWORKIN, *LIFE'S DOMINION* 217 (1993).

99. California has shown leadership in this direction, requiring that medical students receive training in pain management and palliative care and that practicing physicians obtain continuing medical education in these areas. See *supra* note 83.