

## **Gonzales v. Oregon case # 04-623**

### **Excerpts from Briefs of Respondents and Amici Supporting Respondents**

**Prepared by Compassion & Choices**

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#### **Brief for the Patient-Respondents** (Heller Erhman LLP; Kathryn Tucker, JD):

- “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,” p. 6.
- “There is no reason to think the democratic process will not strike the proper balance between the interests of terminally ill, mentally competent individuals who would seek to end their suffering and the State’s interests in protecting those who might seek to end life mistakenly or under pressure. \* \* \* [T]he \* \* \* challenging task of crafting appropriate procedures for safeguarding \* \* \* liberty interests is entrusted to the “laboratory” of the States \* \* \* in the first instance,” p. 6.
- “The Department of Justice is not an expert in the field of medicine,” p. 13.
- “Ashcroft’s interpretation of Section 1306.04 effectively federalizes the practice of medicine, and thus pushes the CSA too close to a constitutional line over which Congress was careful not to step,” p. 23.
- “The data from the Oregon experiment also suggest that physician-assisted dying and other, non-terminal end-of life options, such as palliative care, are not mutually antagonistic. Rather, they form a continuous spectrum of end-of life care alternatives available to terminally ill Oregonians,” p. 39.
- “Significantly, the Seventh Annual Report noted that “[t]he availability of [physician-assisted dying] as an option in Oregon also may have spurred Oregon doctors to address other end-of life care options more effectively.” It has promoted increased awareness of palliative care both amongst Oregon’s physicians and general public; over three quarters of physicians reported that the legislation had prompted them to improve their knowledge of pain medication and their ability to diagnose psychiatric disorders such as depression,” p. 40.
- “...one of the “happy incidents” of federalism is that “a single courageous state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country”; denial of the “right to experiment” may create “serious consequences for the nation,” p. 45.
- “The States have begun to grapple with” the “difficult, indeed agonizing, questions that are presented by the constantly increasing power of science to keep the human body alive for longer than any reasonable person would want to inhabit it,” p. 46.
- “Oregon’s experience with physician-assisted dying illustrates the concrete benefits of state-based experimentation with the profound issues of death and autonomy and confirms the wisdom of promoting the states’ role as engines of social change. One of the most important benefits arising from Oregon’s experience is the generation of scientifically validated, objective empirical data regarding physician assisted dying—information that was lacking in the debate prior to the Dignity Act’s enactment,” p. 47.

#### **Brief of Amici Curiae of Surviving Family Members in Support of Respondents**

(MacDonald Hoague & Bayless, Seattle, WA):

- Dr. Marcia Angell, M.D., a lecturer at Harvard, writes about her father’s gunshot death: “If physician-assisted-dying had been available to my father, as it is to the people of Oregon, I have no doubt that he would have chosen a less violent and lonely death. My mother could have been brought around to accepting his decision, death could have been peaceful, and his family could have been with him. If he knew he had the option to get help in ending his life at any time in the future, he probably would have chosen to live longer. That night would not have been his last chance,” p. 9.
- Scott Rice writes: “If my wife had not been able to access her right to die with dignity under the law because her physicians feared they would be prosecuted, her rights would have been taken away from her without recourse and she would have died a terrible death – one that she did not

want to experience and that no one should have to experience. She did not want that for herself or for us who would have had to stand by watching her drown in her own fluid," p. 11.

- Norma Davis died from a self-administered dose of barbiturates on July 16, 2001. She left this profound and prophetic poem: "Come Death walk toward me in your flower-printed silk and fine mossy velvet or in your impeccably tailored black suit come in all your perfection extending your hand and saying your name draw me toward you as my close friends do hold me elegantly still in dance position then waltz me away glancing over your shoulder once and with the smallest gesture let them know how much I like to dance," pp. 24-25.

**Brief of *Amici Curiae* of a Coalition of Medical Associations and Societies; Pain, Palliative, and Elder Care Associations; and Distinguished Individual Pain, Palliative, and Elder Care Professionals in Support of Respondents** (Arnold & Porter LLP):

- This court has likewise affirmed the states to be the primary regulators of medicine in the context of the treatment of the incapacitated and terminally ill. p.15.
- Oregonians reaffirmed their decision by a 60% to 40% vote. The question is not whether one argues with the substance of Oregon's decision; the question is whether Oregon has acted in the fashion the Court mandated. It unquestionably did. p. 20
- "...the data confirms, for the seventh year, that the policy in Oregon is working. There is no evidence of abuse or coercion or misuse of the policy." p. 24.
- "...in the present case, the AG has imposed a penalty on physicians – whose only interest is their patients' well-being – to prevent patients from ending their suffering in a less painful, less prolonged manner." p.28

**Brief of *Amicus Curiae* Coalition of Mental Health Professionals in Support of Respondents** (Weil, Gotshal & Manges LLP, New York, NY):

- "End of life decisions by terminally ill patients are not akin to what is commonly termed 'suicide', which is considered to be a self destructive act often related to feelings of depression. These decisions to hasten death are more accurately paralleled to a patient's thoughtful decision to decline life sustaining measures: a product of judgment and reason, based on the desire to maintain one's dignity in a period where death is pending. A working group of the American Psychological Association stated that: "It is important to remember that the reasoning on which a terminally ill person (whose judgments are not impaired by mental disorders) bases a decision to end his or her life is fundamentally different from the reasoning a clinically depressed person uses to justify suicide," p. 17.
- "A mental health professional can not only conduct an evaluation for capacity or impaired judgment to satisfy the letter of the law, but can also assist in identifying and ameliorating issues that are compromising the quality of life of the dying person and her or his loved ones. Professionals can, for example, help patients address issues such as pain, depression, dignity, tranquility, financial concerns, and the effectiveness or futility of available medical treatments; communicate with other health care providers, family members, social service providers, or others concerning the patient's needs, concerns, and preferences, to help ensure that the patient receives necessary support and that the treatment provided comports with the patient's wishes; and promote and monitor appropriate involvement by significant others in a patient's end-of-life decisions," p. 26.

***Amici Curiae* Brief of 52 Religious and Religious Freedom Organization and Leaders in Support of Respondents** (Jones Day, Washington, DC):

- "The decision to choose physician-assisted dying is inevitably and deeply connected to an individual's personal beliefs and concerns not only about bodily integrity, dignity, and autonomy, but also about the greater religious and spiritual implications of death and how one lives one's last moments," pp. 4.
- "Numerous faiths, religious organizations, and religious leaders strongly support physician-assisted dying as an entirely legitimate and moral choice by which the terminally ill can hasten their impending deaths with dignity and integrity," pp. 4-5.

- “Terminally ill patients’ interests in religious and spiritual freedom thus dictate that they be allowed to make this choice according to their own beliefs, unfettered by the religious beliefs of others,” p. 7.

**Brief of Autonomy, Inc. and Cascade AIDS Project as *Amici Curiae* Supporting Respondents** (Amy R. Sabrin, Washington, DC):

- “Quality of life is a subjective valuation that belongs to the individual, not to anyone else. Under the ODWDA, only the individual facing imminent death can decide whether his or her quality of life justifies enduring whatever emotional or physical pain and suffering he or she is experiencing,” p. 15.
- “For decades, individuals with disabilities have had to defend their right to make choices and maintain control over all aspects of their lives. [We] believe this right to autonomy and self-determination applies to the most uniquely personal, moral and religious choice of all – the choice of whether to hasten impending death from a terminal condition,” p. 26.

**Brief for *Amici Curiae* in Support of Respondents – Bioethicists** (Dechert LLP):

- The good physician provides the patient with comprehensive care, addressing the patient’s psychological and emotional concerns as well as physical ailments. p. 7.
- “Thus, the modern physician’s role is not confined exclusively to curing or preventing disease or repairing injury. Physicians assist their patients in many different ways, including genetic counseling, dietary care, assistance in reproduction, and various forms of palliative care, including hospice care. Common to all of these forms of modern care are a concern for the alleviation of pain and suffering, emotional as well as physical, and a commitment to the patient’s well-being. Various forms of medical assistance aimed at such relief are now taught in medical schools throughout the United States and have gained wide acceptance in the everyday practice of medicine. Modern views about the range of ways in which physicians should appropriately care for patients have evolved over a period of decades. Palliative and hospice care, for example, were at first controversial, because in providing such care a physician forgoes further efforts at a cure. (Indeed, under the Attorney General’s strained and narrow view, such care would not constitute legitimate practice, since it does not involve the prevention or cure of disease),” p. 7
- “For these Oregon residents, the Death With Dignity Act affords a final measure of self-determination that their illnesses might otherwise have denied them. It enables them to end their lives in a manner they consider humane and dignified,” pp. 18-19.
- “Those who lack the legal option to seek assistance in dying may seek assistance illegally, without the safeguards the Oregon statute affords that state’s residents. Other such patients will resort to violent self-help. The Oregon statute regulates assistance in dying and subjects it to scrutiny through extensive record-keeping requirements,” p. 20.
- “The federal act does not contemplate, much less authorize, administrative rulings by the Attorney General to curtail medical practices that do not conform to his views about how physicians should care for their patients. If the Court were to uphold the Attorney General’s rule, however, this could occur. The CSA was not intended to subordinate medical practice to ideology,” p. 26.
- “The people of Oregon have made a reasonable policy choice that has worked as they intended. The Oregon statute authorizes medical care that is well within the legitimate practice of medicine as understood by many physicians, scholars of bioethics, and patients today. It does not conflict in any way with federal efforts to thwart drug trafficking, and is a legitimate exercise of state legislative power. The Court should not permit the Attorney General to block access by terminally ill Oregon patients to medications they request, that their physicians find appropriate, and that the people of Oregon have authorized them to obtain,” p. 28

**Brief of American College of Legal Medicine as *Amicus Curiae* in Support of Respondents** (Kamensky Rubinstein Hochman and Delott, LLP):

- “...the Attorney General’s attempt to define “legitimate medical purpose” constitutes a unilateral, uninformed, and politically-motivated action.” pp. 2-3.

- “Many legitimate medical interventions are not therapeutic. For example, the FDA has approved the prescription use of botulism injection “to temporarily improve the appearance of moderate to severe frown lines between the eyebrows.” This is a legitimate medical purpose, although its objective is cosmetic rather than to cure, alleviate, prevent or treat disease. Indeed, the Attorney General’s position would place the entire field of cosmetic surgery outside the legitimate practice of medicine, thereby making surgeons who employed controlled substances in the course of their cosmetic practice felons and at risk of losing their DEA registrations,” pp. 6-7.
- “Allowing the Attorney General to define “legitimate medical purpose” and, in so doing, bar physician-assisted suicide, would be an unconstitutional invasion of the State of Oregon’s police power,” p. 16.
- “...avoiding intolerable pain and the indignity of living one’s final days incapacitated and in agony is certainly ‘at the heart of [the] liberty...to define one’s own concept of existence, of meaning, of the universe, and of the mystery of human life. As a result, the Attorney General’s restricting the states’ ability to allow a dignified and pain-free death unconstitutionally violates the liberty interests of an entire class of Oregonians,” p. 19.

**Brief of the American Civil Liberties Union and the ACLU of Oregon as *Amici Curiae* in Support of Respondents** (Mayer, Brown, Rowe & Maw LLP):

- “A terminally ill patient’s constitutional claim to invoke the DWDA is based on more than his or her interest in a pain-free death. Indeed, the majority of Oregonians who have used the DWDA have given as their reasons for doing so loss of autonomy and loss of dignity,” p. 18.
- “A dying individual’s basic “freedom” includes an “interest in dignity, and in determining the character of the memories that will survive long after her death.” This kind of “[p]ersonal control over the manner of death” is an essential component of one’s right to die with dignity,” p. 20.
- “...a competent, terminally ill adult has a constitutionally cognizable liberty interest in avoiding the kind of suffering experienced by the plaintiffs in this case. *That liberty interest encompasses an interest in avoiding not only severe physical pain, but also the despair and distress that comes from physical deterioration and the inability to control basic bodily or mental functions in the terminal state of an illness,*” p. 20.
- “Extreme, uncomfortable, and/or invasive palliative measures such as “sedation to a sleep-like state,” “surgically denervat[ing] painful areas,” “anesthetic interventions to block nerve transmission,” and “spinal infusion pumps” might render a terminally ill patient pain-free, but at the cost of eviscerating the last bit of liberty, privacy, and dignity that patient has in his final days,” p. 22.
- “How [a person] dies will affect how that life is remembered...The constitutional interests of a patient in his or her final days are greater – and far more nuanced – than being free of pain. As such, the availability of pain-relief measures does not render the Ashcroft Directive any less of a threat to the constitutional rights of the individuals eligible for Oregon’s DWDA,” p. 23.

**Brief of *Amici Curiae* Healthlaw Professors in Support of Respondents** (Arthur B. LaFrance, Portland, OR):

- “In essence then, Oregon law leaves to the competent, well informed, terminally ill patient a choice, but surrounds the patient with safeguards and safety nets. The experience of the past seven years demonstrates the success of this structure,” p. 6.
- “It is important to emphasize that Oregon does not make the physician the agent of death. Most are not even present at the time of death. The choice and act remain with the patient, consistent with accepted professional principles,” p. 26.
- “The facts are these: In Oregon, competent patients, for competent reasons, when faced with a terminal illness, may wish to choose the time, place and manner of death. Oregon has assured its citizens they may do so, safely and with dignity. And, in choosing to assist death, physicians are practicing good medicine. This is the well-grounded position of the electorate and citizenry of Oregon, who have twice authorized the Oregon Death with Dignity Act by state-wide referenda,” p. 29.

**Brief for Professors of Law as *Amici Curiae* Supporting Respondents** (Wilmer Cutler Pickering Hale and Dorr LLP):

- “Respect for the States’ sovereignty, and their primary authority over the regulation of medicine within their borders, requires that federal statutes be interpreted so as *not* to frustrate state law, absent a clear indication that Congress so intended,” p. 10.
- “[T]he good physician is not just a mechanic of the human body whose services have no bearing on a person’s moral choices, but one who does more than treat symptoms, one who ministers to the patient. . . . This idea of the physician as serving the whole person is a source of the high value traditionally placed on the medical relationship.’ Nothing in either the CSA or the regulation suggests otherwise, or intimates that Oregon may not permit doctors, in the course of their professional practice, to assist a terminally ill person to control the circumstances of his death,” p. 16.
- “In Justice Brandeis. famous words: To stay experimentation in things social and economic is a grave responsibility. Denial of the right to experiment may be fraught with serious consequences to the nation. It is one of the happy incidents of the federal system that a single courageous state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country,” p. 24.
- “The Directive would eliminate the only opportunity to learn, through experience with various approaches to regulation and monitoring of physician- assisted suicide, whether opponents. concerns about its use are valid, and which approach best accommodates the deeply important interests implicated. Oregon’s choice to permit regulated physician-assisted suicide in limited circumstances, on the other hand, provides the chance to obtain experience and empirical data that can help answer those questions.” pp. 24-25.

**Brief of the States of California, Mississippi, Missouri, Montana, and the District of Columbia as *Amici Curiae* in Support of Respondent State of Oregon** (Bill Lockyer, Sacramento, CA):

- “State policy disagreement over some medical procedures has been a reality for much of our history. Birth control and abortion are obvious examples of medical procedures that some States came to accept as a matter of state policy while others did not,” p. 5.
- “State experimentation in social policy has been the source of many important innovations, such as the right of women to vote, the advent of unemployment insurance and minimum-wage laws, and environmental protection,” p. 9.
- “Federalism’s wisdom of deferring to the States’ inventiveness for solving pressing issues of public health and welfare has no less force because one State’s experiment challenges conventional norms. Reflection on the traditions from which States *break* is as important as reflection on the traditions to which they *adhere* in discerning an appropriate constitutional balance between respect for individual rights and the demands of organized society,” p. 10.

**Brief of the American Public Health Association as *Amicus Curiae* in Support of Respondents** (David T. Goldberg, New York, NY):

- “Researchers have consistently found that experience in Oregon does not bear out concerns that physician-assistance ‘would be disproportionately chosen by or forced on terminally ill patients who were poor, uneducated, uninsured, or fearful of the financial consequences of their illness.’ ” At p. 18. (emphasis in original. Quoting Chin et al and Hedberg reports published in the NEJM).
- “Applied literally, the cited definitions would exclude *entire fields* of professional practice – and many medical procedures that are regularly performed, with controlled substances. For example, fertility treatments and cosmetic surgery (and non therapeutic abortions) are often found *not* to entail “the cure, alleviation, and prevention of disease \* \* \* [or] the restoration and preservation of health,” p. 11.
- “Consistent with these expectations, Oregon’s decision to strike a different “balance” – to serve as a “laboratory” for the “novel social \* \* \* experiment,” or physician-assisted suicide...has catalyzed deliberation and action elsewhere, and its experience under the DWDA has informed the public discussion of the subject and promoted the reasoned development of public health policy,” p. 17.

**Brief for the Cato Institute as *Amicus Curiae* in Support of Respondents (O'Melveny & Myers LLP):**

- "...The very purpose of the states' role as laboratories of social experimentation is to foster unorthodox ideas – even ideas that may be anathema in other parts of the country – and thereby inform judgments of competing sovereignties, state and local. Unorthodoxy may bring information to light that reigning common wisdom has ignored. And it may expose error – and hence promote consensus – far more effectively than the imposition of an artificial consensus by national fiat." pp. 7-8.
- "...if any understanding of states' role is "obvious," given the Court's longstanding articulation of the structural underpinnings of federal power, it is that states are the preferred regulators of local medical standards – and, at a bare minimum, are presumptively favored as such in the absence of a clear legislative statement to the contrary." p. 24.
- "...there are colorable liberty interests at stake – namely, those of individuals to make end-of-life medical decisions without coercion by state bureaucrats in a distant capital." p. 29.

**Brief of the Members of the Oregon Congressional Delegation as *Amici Curiae* in Support of Respondents (Hughes Hubbard & Reed LLP):**

- "As members of Congress, *amici* are directly concerned with the need to carefully circumscribe within constitutional and statutory limits the authority of the Executive Branch to preempt the considered policy judgments made by the states and their citizens," p. 1.
- "In light of the purpose and substance of the 1984 amendments, the grant of authority to the Attorney General cannot be read as an open-ended invitation to block as "illegitimate" state sanctioned medical practices of which he disapproves," p. 13.
- "The absence of authorization in the CSA for federal officials to regulate physician-assisted suicide is not a coincidence. Policy decisions respecting physician-assisted suicide sit at the crossroads of moral judgment and medical regulation. Tradition and constitutional doctrine recognize that decisions in these areas are properly entrusted to the states," p. 23.
- "As the current debate in California and debates in other states throughout the country make clear, the wisdom of authorizing physicians to assist terminally-ill patients in hastening their deaths is a matter on which reasonable minds can and do differ. The Attorney General should not be permitted to deprive the people of Oregon and the nation of the opportunity to benefit from the ultimate outcome of the "earnest and profound debate" in which they are engaged," p. 27.