No. 04-623

In The
Supreme Court of the United States

ALBERTO R. GONZALES, Attorney General, et al.,

Petitioners,

v.

STATE OF OREGON, et al.,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

BRIEF OF *AMICUS CURIAE* AMERICANS UNITED FOR LIFE IN SUPPORT OF PETITIONERS

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INTEREST OF AMICUS[1]

Americans United for Life (AUL)[2] is a national, non-profit public interest legal and educational organization founded in 1971. As the oldest pro-life legal organization in the country, AUL is dedicated exclusively to nationwide efforts to reinstate respect for human life in American law and culture.

Over the last 32 years, AUL has filed many amicus briefs with this Court in cases implicating the sanctity of human life and the proper role of the medical profession at the beginning and end of life. Specifically, AUL has filed amicus briefs on behalf of interested parties in this Court's landmark end-of-life decisions: *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990); *Washington v. Glucksberg*, 521 U.S. 702 (1997); and *Vacco v. Quill*, 521 U.S. 793 (1997).

Over the last quarter century, AUL has also provided expert legislative consultation to state legislatures on end-of-life issues involving physician-assisted suicide and withdrawal of nutrition and hydration.

AUL advocates, among other things, that physician-assisted suicide is neither good medical practice nor good public policy. AUL believes that no terminally-ill patient should, or has to, die in pain. AUL also believes that those advocates who push physician-assisted suicide as the only method of pain management for terminally-ill patients are

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[1] This brief is filed with the written consent of the parties. Letters of consent have been filed with the Clerk of this Court.

[2] Alliance Defense Fund, a non-profit public interest organization, located in Scottsdale, Arizona, partially funded the preparation of this brief. No counsel for a party authored this brief in whole or in part.

out of step with the latest advances in palliative care. Since physician-assisted death is never necessary to ensure that terminally-ill patients die peacefully, AUL submits this brief in support of petitioners urging the reversal of the lower court's decision.

SUMMARY OF ARGUMENT

On November 9, 2001, Attorney General John Ashcroft published an interpretive rule under the Controlled Substances Act determining that assisting suicide is not a "legitimate medical purpose." He also recognized that pain management is a legitimate medical purpose. The Attorney General was correct in making this differentiation between physician-assisted suicide (PAS) and pain management.

Importantly, the only medical reason given by advocates of PAS is that assisted suicide is needed to alleviate pain for those patients whose pain is "uncontrollable" or "intolerable." As is evidenced by medical studies and associations, however, PAS is unnecessary for the treatment of pain in terminally-ill patients. Rather, the pain most patients experience can be completely alleviated through medications. The remaining patients can be sedated to a sleep-like state. Thus, pain is not "uncontrollable," but "uncontrolled." Unwarranted fears, untrained health care professionals, and uninformed patients are major barriers to proper pain management in terminally-ill patients.

In addition, there is no evidence that patients in Oregon have sought PAS because their pain is "untreatable" or "uncontrollable." Instead, patients are motivated

primarily by the desire not to lose autonomy or self-worth – neither of which is medical in nature.

For these reasons, the Attorney General was correct in determining that the prescription of controlled substances for PAS is not a legitimate medical purpose. As such, the Attorney General's interpretive rule should be upheld and the lower court's decision should be reversed.

ARGUMENT

The Controlled Substances Act (CSA) establishes a comprehensive, uniform federal scheme to regulate controlled substances in all 50 states. *See* 21 U.S.C. § 801 *et seq*. In *U.S. v. Moore*, this Court implied that the proper standard to utilize in best enforcing the intent of the CSA is a national standard. *See generally U.S. v. Moore*, 423 U.S. 122 (1975).

In accordance with the CSA and the Court's decision in *Moore*, Attorney General John Ashcroft published an interpretive rule on November 9, 2001, which determined, for purposes of the CSA, that assisting suicide is not a "legitimate medical purpose" and that "prescribing, dispensing, or administering federally controlled substances to assist suicide violates the CSA." Office of the Attorney General, Dispensing of Controlled Substances to Assist Suicide, 66 Fed. Reg. 56,607, § 1 (Nov. 9, 2001). On the other hand, the Attorney General acknowledged that pain management has long been recognized as a legitimate medical purpose. *Id*. at § 2. The Attorney General was correct in differentiating between the use of controlled substances for physician-assisted suicide (PAS) and the use of such substances for pain management purposes.

As reported by the Oregon Department of Human Services, the most common reasons patients give for desiring physician-assisted suicide are loss of autonomy, a decreasing ability to participate in activities that make life enjoyable, and loss of dignity. Oregon Dep't of Human Serv., *Seventh Annual Report on Oregon's Death with Dignity Act* 15 (2005); Oregon Dep't of Human Serv., *Sixth Annual Report on Oregon's Death with Dignity Act* 14 (2004).[3] Not one documented case of PAS in Oregon was requested because of untreatable pain.[4] Yet, the examples generally given by proponents of PAS point to the "hard cases" – those cases where PAS is deemed necessary because terminally-ill patients are suffering "uncontrollable" pain. However,

[3] *See also* NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT 25 (1994); HERBERT HENDIN, SEDUCED BY DEATH: DOCTORS, PATIENTS, AND ASSISTED SUICIDE 34 (1998) (HENDIN I); Timothy E. Quill et al., *The Debate over Physician-Assisted Suicide: Empirical Data and Convergent Views*, ANNALS OF INTERNAL MED. 1998; 128(7): 552-558, *available at* http://www.annals.org/cgi/content/full/128/7/552.

[4] While *Amicus* recognizes that, according to Oregon, a small minority of PAS patients has requested suicide on the basis of "inadequate pain control or concern about it," it is important to note that requesting PAS out of a *concern* about *possible* pain is simply not the same as requesting it because a patient is actually *experiencing* pain. *See Seventh Annual Report*, *supra*, at 24; *see also Sixth Annual Report*, *supra*, at 24 (acknowledging that patients discussing concerns about inadequate pain control were not necessarily experiencing pain). Furthermore, there is a significant difference between the "uncontrollable pain" PAS advocates contend requires assisted death and the reality of "inadequate pain control," which, as indicated by the AMA and other sources, results mainly from physicians' lack of pain management awareness and other barriers. *See* Part I.B., *infra*. By creating such an indistinct category as "inadequate pain control or concern about it," the State of Oregon confuses moderate pain, "uncontrollable" pain, and concern about possible pain by placing them all into the same vague grouping. This confusion cannot support the claim that PAS is medically necessary to alleviate pain.

according to studies by the American Medical Association (AMA),[5] the American Pain Society (APS), and the New York State Task Force,[6] such pain is not "uncontrollable," but "uncontrolled."[7] Thus, physician-assisted suicide is simply not necessary to relieve pain and suffering, and any suggestion to the contrary runs counter to medical authorities and studies, as well as to Oregon's annual reports. As such, the Attorney General was correct and reasonable in his determination that the prescription of controlled substances for PAS is not a legitimate medical purpose.

I. PHYSICIAN-ASSISTED SUICIDE IS UNNECESSARY FOR THE TREATMENT OF PAIN IN TERMINALLY-ILL PATIENTS

A. "Uncontrollable pain" can be completely alleviated through palliative care.

Of the reasons given by patients and advocates for the need for PAS, most involve autonomy and self-worth – the

[5] Throughout this brief, *Amicus* cites to various AMA sources, the majority of which are part of the AMA's current continuing medical education program designed specifically to educate physicians on proper pain management, including the end-of-life care of the terminally-ill. *See, e.g.*, AMA, *Module 12: Management of Cancer Pain: Other Analgesic Approaches and End of Life Care* (2003), *available at* http://www.ama-cmeonline.com/.

[6] This Task Force, whose members hold many different views on PAS and euthanasia, was convened by Governor Mario M. Cuomo with the mandate to recommend public policy on issues raised by medical advances. TASK FORCE, *supra*, at vii, xii. This Court cited the Task Force throughout its decision in *Washington v. Glucksberg* and recognized it as "an ongoing, blue-ribbon commission composed of doctors, ethicists, lawyers, religious leaders, and interested laymen." *See Washington v. Glucksberg*, 521 U.S. 702, 719 (1997).

[7] *See* Parts I & II, *infra*.

preservation of neither of which is *medical* in nature.[8] While advocates typically cite to the "hard cases" where terminally-ill patients suffer "uncontrollable" pain during their last days, such cases are "extremely rare" and almost non-existent. TASK FORCE, *supra*, at 40, 93; HENDIN I, *supra*, at 49.

Contrary to claims by other *amici*, most experts in pain management believe that 95 to 98 percent of pain can be relieved in terminally-ill patients.[9] Only two percent of patients in hospice care experience pain that is difficult for a skilled team to manage. Project on Death Brief, *supra*, at Part II.A.1 n.10; Burt, *supra*, at 166 n.37 (citing the AMA). Even proponents of PAS admit that palliative care can relieve most terminal suffering and that the debate focuses on a relatively small number of patients. Quill et al., *supra*, at 208-11.

According to the New York State Task Force, the APS, and the AMA, pain can be effectively treated in most patients simply through the use of analgesic medications

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[8] *See* Part II, *infra*, for discussion of the definition of "medical."

[9] Timothy E. Quill & Christine K. Cassel, *Professional Organizations' Position Statements on Physician-Assisted Suicide: A Case for Studied Neutrality*, ANNALS OF INTERNAL MED. 2003; 138(3): 208, *available at* http://www.annals.org/cgi/reprint/138/3/208.pdf. *See also* Project on Death in America/Open Society Institute, Brief as *Amicus Curiae* for Reversal of the Judgments Below at Part II.A.1, *Vacco v. Quill*, 521 U.S. 793 (1997) (stating that pain can be alleviated in 98 percent of cases); Robert A. Burt, *Constitutionalizing Physician-Assisted Suicide: Will Lightning Strike Thrice?*, 35 DUQ. L. REV. 159, 166 (1996) (stating that knowledgeable physicians and researchers claim that pain can be alleviated in 98 percent of cases); Kathleen M. Foley, *Transforming the Culture of Dying*, PROJECT ON DEATH IN AMERICA: JANUARY 2001 – DECEMBER 2003 REPORT OF ACTIVITIES 11 (Open Society Institute, 2004) ("Death is inevitable, but severe suffering is not.") (Foley I).

and pain relief techniques. TASK FORCE, *supra*, at 35, 193; AMA, *Report 4 of the Council on Scientific Affairs: Aspects of Pain Management in Adults* ¶ 3 (1995), *at* http://www.ama-assn.org/ama/pub/category/13672.html. *See also* J. Andrew Billings, *Recent Advances: Palliative Care*, BRITISH MED. J. 2000; 321: 555-56. The pain of the remaining patients – who amount to less than three percent – can *always* be relieved through sedation.[10] To put it simply, "[p]ain can always be alleviated," and it is fallacious to claim that killing patients is at times the only method of pain relief. Ira R. Byock, *Why Do We Make Dying So Miserable?*, WASHINGTON POST, January 22, 1997, at ¶ 6, *available at* http://www.afsp.org/about/byock.htm; SMITH, *supra*, at 223.[11]

The basic component of pain management is analgesic medication.[12] TASK FORCE, *supra*, at 37. Two types of medications are widely used: nonsteroidal anti-inflammatory drugs (NSAIDS), such as aspirin and ibuprofen, and opioids, such as codeine and morphine. *Id*. at 37-38.[13] In

[10] American Geriatrics Society, Brief as *Amicus Curiae* Urging Reversal of the Judgments Below at Part I.B, *Vacco v. Quill*, 521 U.S. 793 (1997); WESLEY J. SMITH, FORCED EXIT: THE SLIPPERY SLOPE FROM ASSISTED SUICIDE TO LEGALIZED MURDER 207 (1997).

[11] Moreover, the overwhelming majority of terminally-ill patients do not desire suicide and fight for life until the end. HENDIN I, *supra*, at 34. Even where PAS is requested, in most cases the patient will withdraw the request after proper palliative care has been provided. TASK FORCE, *supra*, at 108 n.113, 120-21.

[12] Obviously, removing the source of the pain is ideal, and the use of chemotherapy and radiation in palliative care is also widely accepted. AMA, *Module 11: Management of Cancer Pain: Pharmacotherapy* 10 (2003), *available at* http://www.ama-cmeonline.com/.

[13] *See also* AMA, *Module 2: Pain Management: Overview of Management Options* 12 (2003), *available at* http://www.ama-cmeonline.com/; Shannon Brownlee & Joannie M. Schrof, *The Quality of Mercy:*

(Continued on following page)

1986, the World Health Organization proposed an "analgesic ladder" approach which has become the guide for the management of all pain. *Id*. at 38.[14] The first step in conquering pain is the use of NSAIDs; the next step is using a weak opioid drug combined with a non-opioid. *Id*.; AMA Module 11, *supra*, at 11. For example, codeine could be combined with acetaminophen. TASK FORCE, *supra*, at 38. Patients with continuing pain could receive a stronger opioid, such as morphine. *Id*.; AMA Module 11, *supra*, at 11.[15] The best relief is provided when analgesic medications are given at regular intervals rather than waiting for pain to intensify.[16] HENDIN I, *supra*, at 235.

Effective Pain Treatments Already Exist. Why Aren't Doctors Using Them?, U.S. NEWS & WORLD REPORT, Mar. 17, 1997, at ¶ 12, *available at* http://www.masmith.inspired.net.au/pain/mercy.htm.

[14] *See also* UNAIDS, AIDS: PALLIATIVE CARE 5 (Oct. 2000); AMA Module 2, *supra*, at 11; AMA Module 11, *supra*, at 11. While most research has concerned cancer and AIDS patients, the AMA instructs that the treatment principles apply to *all types* of persistent pain associated with terminal illnesses. AMA, *Module 10: Pain Management: Overview and Assessment of Cancer Pain* 3 (2003), *available at* http://www.ama-cmeonline.com/.

[15] The combination of an intraspinal administration of opioids and local anesthetic can provide effective pain control when pain is otherwise intractable. TASK FORCE, *supra*, at 40. Anti-depressant medication has also been effective in relieving otherwise intractable pain. HENDIN I, *supra*, at 235; AMA Module 11, *supra*, at 27.

[16] Techniques such as a self-administered opioid drip control pain and help patients maintain their autonomy. TASK FORCE, *supra*, at 135. According to an article published by the U.S. Health Resources & Services Administration, unlike PAS, analgesic medications are also available in liquid and patch forms for those patients who cannot swallow. Carla Alexander, *Palliative and End-of-Life Care*, A GUIDE TO THE CLINICAL CARE OF WOMEN WITH HIV 354 (J. Anderson ed., Heath Resources and Service Admin., HIV/AIDS Bureau, 2001).

The New York State Task Force found that the pain experienced by 90 percent of cancer patients can be alleviated through such pharmacological treatments alone. TASK FORCE, *supra*, at 40. The remaining patients may also gain significant relief from pain through palliative efforts. *Id*. Non-pharmacological therapies can be applied in addition to analgesic and ancillary medications.[17] *Id*. at 39; AMA Report 4, *supra*, at ¶ 12.

For the very small number of patients for whom pharmacological and non-pharmacological remedies do not offer enough relief, sedation to a sleep-like state is available to keep patients from experiencing severe pain and suffering. TASK FORCE, *supra*, at 40; SMITH, *supra*, at 207. Such sedation is now a *widely accepted* medical, ethical, and legal option when patients cannot be helped in any other way, and sedation will *always* eliminate a patient's symptoms near death. American Geriatrics Society Brief, *supra*, at Part III.D.; HENDIN I, *supra*, at 234, 242; AMA Module 12, *supra*, at 14.

[17] These treatments include cognitive and behavioral approaches such as relaxation exercises and distraction; applications of heat or cold; exercise; anesthetic interventions to block nerve transmission on a temporary or ongoing basis; and neurosurgery to cut nerves. TASK FORCE, *supra*, at 39; AMA Module 2, *supra*, at 9; AMA Module 12, *supra*, at 10-11, 13; AMA Report 4, *supra*, at ¶ 12. Procedures designed to surgically denervate painful areas are available for every level of the nervous system. AMA Module 12, *supra*, at 12. Acupuncture, acupressure, physical therapy, and transcutaneous electrical nerve stimulation (TENS) are also widely used. Alexander, *supra*, at 366; AMA Report 4, *supra*, at ¶ 12; Timothy Moynihan, *Cancer Pain Treatment: An Interview with a Mayo Clinic Specialist* ¶ 7, October 20, 2003, *at* http://www.mayoclinic.com/invoke.cfm?id=CA00021. *See also* AMA Module 2, *supra*, at 9; AMA Module 12, *supra*, at 11, 13.

It is evident that options other than PAS already exist. PAS is simply not necessary to relieve pain and suffering. As such, it is not a "legitimate medical purpose," and the Attorney General's interpretation of the CSA is correct and reasonable. This Court should reverse the Ninth Circuit's decision, and the Attorney General's interpretation should be upheld and enforced.

B. Reasons for the existence of uncontrolled pain relate to unwarranted fears, untrained heath care professionals, and uninformed patients.

Pain exists because it is uncontrolled – not because it is uncontrollable. Dr. Ira Byock, the president of the American Academy of Hospice and Palliative Medicine, states that the only reason that "hard cases" exist at all is because "undertreatment and maltreatment at the end of life is endemic." SMITH, *supra*, at 206. These hard cases result because certain barriers block effective palliative care. *Id*. at 146. Indeed, medical experts agree that a "serious gap" exists between the abilities of modern medicine and the type of palliative care generally received by terminally-ill patients. *Id*. at 147; TASK FORCE, *supra*, at 35; Richard M. Doerflinger, *Conclusion: Shaky Foundations and Slippery Slopes*, 35 DUQ. L. REV. 523, 531 (1996).

There are three primary barriers to the effective treatment of pain: 1) unwarranted fears grounded in palliation myths propagated by advocates of physician-assisted suicide and euthanasia; 2) the lack of training of hospital and health care professionals in pain control methods and palliative care; and 3) the patients' own beliefs and lack of information about pain and pain management. *See* TASK FORCE, *supra*, at xi, 35; AMA, *Module*

3: Pain Management: Barriers to Pain Management and Pain in Special Populations 9 (2003), *available at* http://www.ama-cmeonline.com/.

First, physicians and patients tend to believe the following myths: use of palliative care methods such as analgesics lead to respiratory depression and other side effects; palliative care and analgesics hasten death; and the use of analgesics such as morphine lead to addiction and an unhealthy tolerance of medications which will prohibit pain relief when "really needed." There are also misconceptions about the nature of sedation.

These myths have led physicians to undertreat patients and have led patients to forgo mentioning their pain. However, each myth is baseless. Fears concerning respiratory depression are "unjustifiable" and "unfounded." TASK FORCE, *supra*, at 44; Yale Kamisar, *The "Right to Die": On Drawing (and Erasing) Lines*, 35 DUQ. L. REV. 481, 497 (1996). The AMA reports that patients with severe pain – *i.e.*, the "hard cases" – become *resistant* to the respiratory depressant effects of morphine and morphine-like medications. AMA Report 4, *supra*, at ¶ 30. In addition, patients rapidly develop a tolerance that lessens the impact of respiratory depression and other opioid side effects.[18] TASK FORCE, *supra*, at 162; *see also* NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, WHEN

[18] This tolerance minimizes other side effects, such as mental cloudiness. TASK FORCE, *supra*, at 162. Sedation and cognitive impairment disappear in most patients. AMA Module 2, *supra*, at 26; AMA Module 11, *supra*, at 26. Other side effects such as nausea generally dissipate with continued use, and patients will return to normal or improved functioning. Alexander, *supra*, at 355; AMA Module 2, *supra*, at 26. Most patients are alert and many are capable of independently caring for themselves. *See* Kamisar, *supra*, at 497.

DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT (SUPP. TO REPORT) 17 (1997); SMITH, *supra*, at 222.

Likewise, there is no evidence that pain medications will hasten death if such medications are taken correctly. The New York State Task Force labeled the fear of hastened death one of the "many myths . . . which have contributed to the undermedication of patients experiencing treatable pain." TASK FORCE SUPP., *supra*, at 17. Rather, an opioid can be administered safely in large doses when adjusted to control side effects. TASK FORCE, *supra*, at 39. *See also* Phillip D. Good, *Advances in Palliative Care Relevant to the Wider Delivery of Healthcare*, MED. J. OF AUSTRALIA 2003; 179: S44 (stating that recent research indicates that the use of opioids does not influence length of life).

Fears regarding addiction and tolerance are equally unjustifiable, and the AMA instructs that opioids should *never* be withheld from terminally-ill patients for fear of addiction. TASK FORCE, *supra*, at 44; AMA Module 11, *supra*, at 11. Addiction is extremely rare and occurs in only .04 percent of patients treated with morphine. TASK FORCE, *supra*, at 44; J.C. WILLKE, ASSISTED SUICIDE & EUTHANASIA: PAST & PRESENT 102-03 (1998). Physicians and patients must understand that there is a difference between physical dependence, or toleration, and psychological dependence, or addiction.[19] TASK FORCE, *supra*, at 160; Federation of State Medical Boards of the United

[19] Addiction is a "primary, chronic, neurobiologic *disease*" influenced by genetic, psychosocial, and environmental factors, while physical dependence and tolerance merely indicate a state of adaptation. AMA Module 3, *supra*, at 11 (emphasis added).

States, Inc., *Model Policy for the Use of Controlled Substances for the Treatment of Pain* § 7 (2004), *at* http://www.ama-assn.org/ama/pub/category/11541.html. Behaviors that may suggest addiction generally indicate an increase in pain from the progression of the underlying disease. TASK FORCE, *supra*, at 160. Even for patients with a history of addiction, opioids can be used safely and effectively to control pain.[20] AMA Report 4, *supra*, at ¶ 27.

Similarly, physicians and patients must be informed that there is no limit to tolerance of opioids. TASK FORCE SUPP., *supra*, at 162; AMA Module 11, *supra*, at 15. In fact, dosages can be increased without introducing any additional adverse consequences. AMA Report 4, *supra*, at ¶ 32. Therefore, patients need not delay using analgesic medications for fear that such medications will not be effective when "really needed." Larger doses are effective and safe. *Id*.

Finally, physicians and the very few patients who require it need not fear sedation. Most sedated patients die peacefully without suffering, and sedation will *always* work to control pain when a patient is nearing death. American Geriatrics Society Brief, *supra*, at Part III.D.; HENDIN I, *supra*, at 14; Byock, *supra*, at ¶ 6.

The second major barrier to proper pain management is the lack of training of most hospitals and health care

[20] Even if there was a risk of psychological dependence, the New York State Task Force found that the benefits of opioid use would simply outweigh the risks of addiction for patients experiencing significant pain, and especially for patients who are terminally-ill. TASK FORCE, *supra*, at 161.

professionals.[21] Very few physicians realize that it is possible to relieve all pain through proper pain management techniques.[22] HENDIN I, *supra*, at 259. Only a fraction of medical residency programs require a course in pain management, and even fewer teach palliative care.[23] Brownlee & Schrof, *supra*, at ¶ 8. Health care professionals have a limited understanding of the physiology of pain and the pharmacology of analgesics, and clinical care units in the past have had no systems in place to assure that

[21] The AMA asserts that the "ultimate reason" for undertreatment of cancer pain is that physicians and other health care professionals are inadequately educated on pain management. AMA Module 10, *supra*, at 8; *see also* AMA Report 4, *supra*, at ¶ 2 (citing guidelines from the Agency for Health Care Policy & Research as stating that inadequate pain management is widespread and that undertreatment by practitioners is a major cause). The APS agrees, stating that the most common reason for unrelieved pain in U.S. hospitals is the failure of hospital staff to routinely assess pain relief. TASK FORCE, *supra*, at 19.

[22] Interestingly, support for PAS is highest among those health professionals who are the least knowledgeable about pain management – the more physicians know about palliative care, the less likely they are to support legalizing PAS and euthanasia. AMA et al., Brief of *Amici Curiae* in Support of Petitioners at Health Care Background Part D.2, *Washington v. Glucksberg*, 521 U.S. 702 (1997); Herbert Hendin, *The Slippery Slope: The Dutch Example*, 35 DUQ. L. REV. 427, 430-31 (1996).

[23] The AMA reports that in one study, 88 percent of physicians rated their medical school training in cancer pain management as fair or poor, and 73 percent rated their residency training in pain management as fair or poor. AMA Module 3, *supra*, at 9. In 1999, the National Cancer Institute spent less than one percent of its budget on any aspect of research or training in palliative care. Kathleen M. Foley, *Improving Palliative Care for Cancer: Summary and Recommendations* (June 19, 2001), *at* http://www4.nationalacademies.org/new.nsf/isbn/s0309075637?OpenDocument.

pain is recognized and treatments modified. TASK FORCE, *supra*, at 44, 193.[24]

The third major barrier involves the patients' own beliefs and lack of information regarding palliative care. Patients are subject to societal notions, as well as the reactions of their families, which generally disfavor the use of narcotics and other analgesic medications. AMA Report 4, *supra*, at ¶¶ 38-39. Many patients fail to acknowledge pain out of a denial that the disease is progressing. *Id*. at ¶ 34; AMA Module 3, *supra*, at 10. Others prize stoicism and believe that admitting pain is a sign of weakness. TASK FORCE, *supra*, at 46; AMA Module 3, *supra*, at 10; AMA Report 4, *supra*, at ¶ 33. The most reliable indicator of pain is a patient's own report, but pain goes undiagnosed and untreated when patients fail to discuss their pain. AMA, *Module 1: Pain Management: Pathophysiology of Pain and Pain Assessment* 8, 13, 19 (2003), *available at* http://www.ama-cmeonline.com/; AMA Module 10, *supra*, at 15.

On the other hand, patients may have received a negative response in the past after requesting an increased dose of analgesic medication. AMA Report 4, *supra*, at ¶ 35. Many physicians and other health care professionals never address the issue of pain with their

[24] The AMA explains that hospitals and health care professionals also fear potential harassment by state or local regulatory authorities. AMA Report 4, *supra*, at ¶ 16. The agencies most likely to investigate prescribing practices are state medical boards. AMA Module 3, *supra*, at 15. State laws are often more restrictive than federal regulations and even impose limits against medical practices that are fully within medical professional standards. AMA Report 4, *supra*, at ¶ 17. Health care workers also tend to hold misconceptions about regulations and how the restrictions work. Project on Death Brief, *supra*, at Part II.A.1.

patients or fail to do so in a timely, appropriate manner. TASK FORCE, *supra*, at 153; Moynihan, *supra*, at ¶ 8. Such ineffective communication leaves patients uninformed that pain management options and clinics exist. TASK FORCE, *supra*, at 122; SMITH, *supra*, at 206.

When this Court decided *Glucksberg* in 1997, the lack of effective pain relief was a problem that society had only just begun to undertake. *See* TASK FORCE, *supra*, at 137. The New York State Task Force concluded that "[t]he effective implementation of existing clinical knowledge and programs for pain management is almost certain to have an immediate impact on relieving suffering." *Id*. at 159. In 2004, Kathleen Foley, Director of Project on Death in America, stated that the "field of palliative care is definitely much stronger than it was ten years ago." Foley I, *supra*, at 11.

The goal of improving the way in which people die is being reached for more and more people *each day*. Gara Lamarche, *What We Have Learned from The Project on Death in America*, PROJECT ON DEATH IN AMERICA: JANUARY 2001 – DECEMBER 2003 REPORT OF ACTIVITIES 8 (Open Soc'y Inst., 2004). Thus, improvements have been made even since the Attorney General first issued the interpretive rule. As can be seen from the preceding discussion, the proper answer to uncontrolled pain is education and the wider use of effective palliative techniques – not the elimination of the sufferer.

II. MEDICAL REASONS ARE NOT MOTIVATING FACTORS OF TERMINALLY-ILL PATIENTS SEEKING PHYSICIAN-ASSISTED SUICIDE

As quoted by certain *amici* in their Ninth Circuit amicus brief, the ordinary meaning of "medical" is "[p]ertaining to . . . medicine, or the science and art of investigation, prevention, cure, and alleviation of disease." Amer. Acad. of Pain Mgmt. et al., Brief of *Amici Curiae* in Support of the Patient Plaintiff-Appellees and in Affirmance of the District Court's Grant of Summary Judgment to Appellees at 7, *Oregon v. Ashcroft*, 368 F.3d 1118 (9th Cir. 2002) (No. 02-35587) (quoting BLACK'S LAW DICTIONARY 982 (6th ed. 1990)). The *amici* go on to state that the ordinary meaning of "alleviate" is "[t]o make (pain, for example) more bearable." *Id*. (quoting AMERICAN HERITAGE DICTIONARY OF THE ENGLISH LANGUAGE 49 (3rd ed. 1992)). The *amici* erroneously conclude that PAS is legitimate because the ordinary meaning of "medical purpose" includes treatment conducted with the purpose of alleviating disease-related pain. *Id*.

Yet, nowhere in the seven annual reports compiled by the Oregon Department of Human Services[25] is there evidence that any patients sought PAS because their pain was "untreatable" or "uncontrollable." As discussed above,[26] the state of Oregon cannot represent that any patient ever sought PAS because of "untreatable" or "uncontrollable" pain. "Concerns about inadequate

[25] These annual reports are mandated by the Death with Dignity Act. *See Seventh Annual Report*, *supra*, at 4.

[26] *See supra* n.4 & accompanying text.

pain control" or "inadequate pain control"[27] cannot support a claim that PAS is medically-necessary to alleviate pain. There is simply no evidence that PAS is ever medically required to alleviate pain. Consequently, nothing in Oregon's experience undermines the Attorney General's interpretive rule.[28]

Instead, the most frequently cited concerns across *all seven years* of Oregon's annual reports are the loss of autonomy and the decreased ability to participate in activities that make life enjoyable.[29] *Id*. at 16. Both U.S. and Dutch studies reveal that nonphysical factors and depression are more important than pain and other physical or medical symptoms. Susan M. Wolf, *Physician-Assisted Suicide in the Context of Managed Care*, 35 DUQ. L. REV. 455, 466-68 (1996). Intolerable physical symptoms are simply not the reason most patients request PAS or euthanasia. AMA Brief, *supra*, at Health Care Background Part C.1.

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[27] *See Seventh Annual Report*, *supra*, at 24 (listing "inadequate pain control or concern about it" as a factor in a very small minority of PAS deaths). *But see supra* n.4 & accompanying text.

[28] Contrary to the Patient-Respondents' claim that the Attorney General ignored the data collected by the State of Oregon, the interpretive rule actually reflects the fact that the "medical purpose" of alleviating "uncontrollable" pain does not appear in any of Oregon's annual reports. *See, e.g.*, *Seventh Annual Report*, *supra*, at 24; *see also* Patient-Respondents' Brief in Opposition at 20, *Ashcroft v. Oregon* (No. 04-623). The findings of the New York State Task Force confirm that loss of control and feelings of helplessness may be the most significant factors leading to PAS requests. TASK FORCE, *supra*, at 25.

[29] These concerns were cited by physicians, family members, hospice nurses, and social workers caring for PAS patients in Oregon. *Seventh Annual Report*, *supra*, at 16-17.

What is more common, however, is the *dread* of what *may* happen in the dying process. Herbert Hendin, *Suicide and the Request for Assisted Suicide: Meaning and Motivation*, 35 DUQ. L. REV. 285, 290 (1996); *see also Seventh Annual Report*, *supra*, at 24. The AMA, American Nurses Association, and American Psychiatric Association confirm that the demand for PAS does *not* come primarily from patients *in actual and untreatable pain*, but from those patients who are depressed or fear the possibility of future pain, loss of dignity, or burdening their families. AMA Brief, *supra*, at Part C.

Clearly, these patients are motivated by unjustified fears that could be alleviated with an increased awareness of the effectiveness of palliative care and with the education of their physicians in pain management techniques. The fact that pain itself does not lead patients to request PAS demolishes the argument that PAS is needed to control pain, leaving proponents with no underlying medical need for physician-assisted suicide.

As indicated by the fact that end-of-life pain can be controlled and the fact that pain is not a motivating factor of those patients requesting PAS, the Attorney General's interpretive rule that the prescription of controlled substances for PAS is not a legitimate medical practice is supported by substantial medical evidence and the record in the State of Oregon. As such, the rule should be upheld and enforced.

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CONCLUSION

The judgment of the court below should be reversed.

Respectfully submitted,

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