

No. 02-35587

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In the United States Court of Appeals for the Ninth Circuit

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OREGON, et al.,

Plaintiffs-Appellees,

v.

JOHN ASHCROFT, in his official capacity as  
United States Attorney General, et al.,

Defendants-Appellants.

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On Appeal from the United States District Court  
For the District of Oregon

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BRIEF OF *AMICI CURIAE* CHRISTIAN LEGAL SOCIETY  
AND CHRISTIAN MEDICAL ASSOCIATION  
IN SUPPORT OF DEFENDANTS-APPELLANTS  
AND REVERSAL OF THE DECISION BELOW

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## CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rule of Appellate Procedure 26.1, the *amici curiae*, Christian Legal Society and Christian Medical Association, state that they have no parent corporations and issue no publicly held stock.

TABLE OF CONTENTS

Corporate Disclosure Statement .....i

Table of Contents .....ii

Table of Authorities .....iv

Interest of the *Amici Curiae* ..... 1

Summary of the Argument..... 1

Argument.....5

I. The United States Attorney General’s Conclusion that Physician-Assisted Suicide Is Not a “Legitimate Medical Purpose” Is Reasonable, Given the Finding Of the United States Supreme Court in *Washington v. Glucksberg*, 521 U.S. 702 (1997), that Preserving the Integrity of the Medical Profession by Banning Its Participation in Physician-Assisted Suicide Is a Rational Government Interest.....5

II. Physician-Assisted Suicide Is Not a Legitimate Medical Purpose Because It Is Not Necessary for the Alleviation Of Terminally Ill Patients’ Pain .....7

A. The Oregon Death With Dignity Act Explicitly Allows Physician-Assisted Suicide for Patients Whose Pain Can Be Relieved by Conventional, Non-lethal Medical Treatment.....9

B. According to Leading Medical Authorities, Physician-Assisted Suicide is Not Needed to Provide Pain Relief for Terminally Ill Patients .....10

C. Many Persons Inevitably Will Die Through Physician-Assisted Suicide Who Should Not Have Been Assisted to Commit Suicide .....16

1.	The Act Fails to Ensure that Persons Suffering from Depression or Other Mental Illness Will Not Be Assisted to Commit Suicide .....	16
2.	Physician-Assisted Suicide Inevitably Will Become Euthanasia .....	20
	a. Physicians Who Have Illegally Assisted Suicide Are Unlikely to Obey Any Guidelines Established to Regulate Legalized Physician-Assisted Suicide .....	20
	b. Euthanasia Will Be Impossible to Detect Or Prevent .....	22
III.	Physician-Assisted Suicide Will Profoundly Affect the Ability To Obtain and Retain Employment for Health Care Professionals Who Have Religious Convictions Against the Intentional Killing of Oneself or Other Human Beings .....	24
IV.	The Early Christian Church Firmly Repudiated Suicide.....	28
	Conclusion.....	30
	Statements of Interest.....	32
	Certificate of Service .....	35
	Certificate of Compliance .....	36

## TABLE OF AUTHORITIES

### Cases

<i>Compassion in Dying v. State of Washington</i> , 79 F.3d 790 (9th Cir. 1996) ( <i>en banc</i> ), <i>rev'd sub nom. Washington v. Glucksberg</i> , 521 U.S. 702 (1997).	28, 29, 30
<i>Sampson v. State of Alaska</i> , 31 P.3d 88 (2001) .....	2, 6, 7, 18
<i>Vacco v. Quill</i> , 521 U.S. 793 (1997) (No. 95-1858) .....	3, 6
<i>Washington v. Glucksberg</i> , 521 U.S. 702 (1997).....	passim

### Statutes

§§ 127.800-127.995 .....	9
§ 127.800(7)(e) .....	10
§ 127.810(1) .....	23
§ 127.810(2)(b) .....	23
§ 127.815(1)(c)(E) .....	10
§ 127.825 .....	23
§ 127.835 .....	23
§ 127.840 .....	23
§ 127.865(2) .....	23
§ 127.885(1) .....	23
§ 127.885(3) .....	23
§ 127.885(4) .....	25

§ 127.897 .....	10
42 U.S.C. § 14401.....	8

**Other Authorities**

AMA Council on Ethical and Judicial Affairs, <i>Decisions Near the End of Life</i> , 267 JAMA 2229 (1992).....	7
American Medical Association Council on Ethical and Judicial Affairs, Opinion 2.211. ....	22
American Medical Association et al., Brief as <i>Amici Curiae</i> in Support of Petitioners, 1996 WL 656281, <i>Vacco v. Quill</i> , 521 U.S. 793 (1997) (No. 95-1858) .....	passim
American Medical Association, Code of Ethics Sec. 2.211 (1994).....	6
Darrel W. Amundsen, <i>The Significance of Inaccurate History in Legal Considerations of Physician-Assisted Suicide</i> , in <i>Physician-Assisted Suicide</i> (Robert F. Weir, ed., 1997).....	28
Back et al., <i>Physician-Assisted Suicide and Euthanasia in Washington State</i> , 275 JAMA 919 (1996) .....	12
Robert Barry, <i>The Development of the Roman Catholic Teachings on Suicide</i> , 6 Notre Dame J.L., Ethics & Pub. Pol'y 466-468 (1995).....	28, 29, 30
Ira R. Byock, <i>Physician-Assisted Suicide is Not an Acceptable Practice for Physicians in Physician-Assisted Suicide</i> (Robert F. Weir, ed., 1997) .....	15
Daniel Callahan & Margot White, <i>The Legalization of Physician-Assisted Suicide: Creating a Regulatory Potemkin Village</i> , 30 U. Rich. L. Rev. 1 (1996).....	22
David Cundiff, <i>Euthanasia Is Not the Answer</i> (1992) .....	15

Steven B. Datlof, <i>Beyond Washington v. Oregon's Death With Dignity Act Analyzed from Medical and Constitutional Perspectives</i> , 14 J.L. & Health 23 (2000) .....	16, 17, 18
DSM-IV <i>Diagnostic and Statistical Manual of Mental Disorders</i> 327 (4th Ed., 1994) .....	17
Ezekiel J. Emanuel et al., <i>Euthanasia and Physician-Assisted Suicide: Attitudes and Experiences of Oncology Patients, Oncologists, and the Public</i> , 347 Lancet 1805 (1996) .....	11
Kathleen Foley, <i>The Relationship of Pain and Symptom Management to Patient Requests for Physician-Assisted Suicide</i> , 6 J. Pain & Symp. Mgmt. 289 (1991) 13	
Willard Gaylin, et al., <i>Doctors Must Not Kill</i> , 259 JAMA (1988) .....	7
Carlos F. Gomez, <i>Regulating Death: Euthanasia and the Case of the Netherlands</i> , 104 (1991) .....	23
Herbert Hendin, <i>Seduced by Death: Doctors, Patients and the Dutch Cure</i> (1997) .....	20
Yale Kamisar, <i>Against Assisted Suicide--Even a Very Limited Form</i> , 72 U. Det. Mercy L. Rev. 735 (1995)        22	
Leon Kass & Nelson Lund, <i>Physician-Assisted Suicide, Medical Ethics and the Future of the Medical Profession</i> , 35 Duq. L. Rev. 395 (1996) .....	7
Lactantius, <i>Divine Institutes</i> 3.18, in 7 <i>Ante-Nicene Fathers</i> 89 (1951) .....	29
Edward J. Larson & Darrel W. Amundsen, <i>A Different Death: Euthanasia and the Christian Tradition</i> (1998).....	28, 29, 30
Thomas Marzen, et al., <i>Suicide: A Constitutional Right?</i> , 24 Duq. L. Rev. 1 (1985) .....	29
Justin Martyr, 2 <i>Apology</i> 4, in 6 <i>Fathers of the Church</i> 123 (1948) .....	29
New York State Task Force, <i>When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context</i> (1994).....	passim

New York Task Force on Life and the Law, <i>When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context (Supplement to Report)</i> 162 (1997).....	13
Christine Neylon O’Brien et al., <i>Oregon’s Guidelines for Physician-Assisted Suicide: A Legal and Ethical Analysis</i> , 61 U. Pitt. L. Rev. 329 (2000).....	passim
Oregon Dept. Health Services, <i>Oregon’s Death with Dignity Act Annual Report 2001 (2002)</i> .....	10, 11, 27
Oregon Task Force Guidebook .....	11, 27
The Pain Relief Promotion Act, S. Rep. No. 106-299 (2000).....	passim
Amy Sullivan et al., <i>Legalized Physician-Assisted Suicide in Oregon—The Second Year</i> , 342 <i>New Eng. J. Med.</i> 598 (2000) .....	10

## **INTEREST OF THE *AMICI CURIAE***

The Christian Medical Association (“CMA”) was founded in 1931 and today represents over 16,000 members—primarily practicing physicians representing the entire range of medical specialties. These members share a common commitment to the principles of biblical faith and the integration of those principles with professional practice. CMA members and their patients will be adversely affected by the legalization of physician-assisted suicide, a practice diametrically opposed to traditional and current medical ethical standards.

The Christian Legal Society (“CLS”), founded in 1961, is a nonprofit interdenominational association of Christian attorneys, law students, judges, and law professors with chapters in nearly every state and at over 140 accredited law schools. Since 1975, the Society’s legal advocacy and information division, the Center for Law and Religious Freedom, has worked for the protection of religious belief and practice, including health care providers’ rights of conscience. A more detailed statement of interest is found in the addendum.

The parties have consented to the filing of this brief. FRAP 29(a).

## **SUMMARY OF ARGUMENT**

In *Washington v. Glucksberg*, 521 U.S. 702, 731 (1997), the United States Supreme Court affirmed that protection of the medical profession’s integrity and ethics is a legitimate state interest justifying a governmental ban on physician-

assisted suicide. *See also Sampson v. State of Alaska*, 31 P.3d 88, 97 (Alaska 2001)(same). Agreeing with the American Medical Association, the Supreme Court stressed that “physician-assisted suicide is fundamentally incompatible with the physician’s role as healer.” 521 U.S. at 731. Given the *Glucksberg* rationale, the United States Government has taken an eminently reasonable position that physician-assisted suicide is not a legitimate medical purpose for which federally controlled substances may be used. The government’s position is rationally related to several important state interests, including: safeguarding the integrity and ethics of the medical profession, (*id.*); protecting persons who are depressed or mentally ill from self-destructive impulses, (*id.* at 730-31); and deterring physicians from practicing voluntary and involuntary euthanasia, (*id.* at 732-735). *See infra*, at pp. 5-7.

The proponents of physician-assisted suicide advance a single so-called “legitimate medical purpose” for physician-assisted suicide, *i.e.*, that assisted suicide is necessary to treat terminally ill persons’ pain. As a factual matter, this emotionally charged argument is fundamentally flawed. First, under the Oregon Death with Dignity Act, Or. Rev. Stat. §§ 127.800-127.995 (1997)(hereinafter “ODDA”), physician-assisted suicide is *not* limited to persons whose pain is untreatable. *See infra*, at pp. 9-10.

Second, effective, non-lethal pain treatments for terminally ill patients are available. According to leading medical authorities, including the AMA, terminally ill patients' pain can be controlled without resort to suicide. *See* Brief of the American Medical Association et al., as *Amici Curiae* in Support of Petitioners (hereinafter "AMA Brief"), at \*6, *Vacco v. Quill*, 521 U.S. 793 (1997)(No. 95-1858); New York State Task Force, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context* 40 (1994). And, indeed, most persons seeking physician-assisted suicide do so for reasons other than pain control. AMA Brief, *supra*, at \*6-7. *See infra*, at pp. 10-15.

Given that effective pain treatments exist, physician-assisted suicide serves no legitimate medical purpose. Indeed, it would seem self-evident that the intentional infliction of death ought not be considered an acceptable method of pain treatment. The proposition essentially is self-evident for "[i]n almost every State—indeed, in almost every western democracy—it is a crime to assist a suicide." *Glucksberg*, 521 U.S. at 710.

Instead, a terminally ill person who expresses suicidal desires should receive the same medical care that any other suicidal person would receive. *Id.* at 732. Many persons requesting physician-assisted suicide subsequently withdraw their request if their depression or fears are treated. *Id.* at 730. *See infra*, at pp. 16-20.

Troublingly, the ODDA fails to require adequate screening of patients who request physician-assisted suicide to determine whether they are suffering from depression or other mental illness. Quite simply, the ODDA fails to ensure that patients who are assisted to commit suicide are mentally competent, not depressed, not coerced, and not acting under undue influence. *See infra*, at pp. 16-20.

Physician-assisted suicide inevitably will lead to both voluntary and involuntary euthanasia. *Glucksberg*, 521 U.S. at 732-735. The AMA rejects physician-assisted suicide in part because it “would be difficult or impossible to control.” AMA Brief, *supra*, at \*5. Justice Souter emphasized this danger in *Glucksberg*:

Physicians and their hospitals, have their own financial incentives, too, in this new age of managed care. Whether acting from compassion or under some other influence, a physician who would provide a drug for a patient to administer might well go the further step of administering the drug himself; so, the barrier between assisted suicide and euthanasia could become porous, and the line between voluntary and involuntary euthanasia as well.

521 U.S. 752, 784-85 (Souter, J., concurring in the judgment). *See infra*, at pp. 22-24.

The ODDA is breathtaking in the naïve trust it reposes in the hands of the physicians who assist their patients to commit suicide. Given its strict confidentiality requirements and its minimal oversight of physicians who assist suicide, a commentator sympathetic to the ODDA, has conceded that “[i]n reality,

anything but extremely egregious malpractice will probably go unreported.”

Christine Neylon O’Brien et al., *Oregon’s Guidelines for Physician-Assisted Suicide: A Legal and Ethical Analysis*, 61 U. Pitt. L. Rev. 329, 353 (2000).

## ARGUMENT

### **I. The United States Attorney General’s Conclusion that Physician-Assisted Suicide Is Not a “Legitimate Medical Purpose” Is Reasonable, Given the Finding of the United States Supreme Court in *Washington v. Glucksberg*, 521 U.S. 702 (1997), that Preserving the Integrity of the Medical Profession by Banning Its Participation in Physician-Assisted Suicide Is a Rational Governmental Interest.**

In its solid rejection of physician-assisted suicide as a constitutional right, the United States Supreme Court highlighted several state interests, each of which provided an independent legitimate state interest rationally related to a governmental ban on physician-assisted suicide. *Washington v. Glucksberg*, 521 U.S. 702, 728-35 (1997). The Supreme Court deemed each of these state interests “unquestionably important and legitimate,” (*id.* at 735): 1) preserving human life, (*id.* at 728-29); 2) preventing the serious public health problem of suicide, particularly protecting persons suffering from depression, mental illness, or untreated pain from suicide, (*id.* at 729-31); 3) “protecting the integrity and ethics of the medical profession,” (*id.* at 731); 4) “protecting vulnerable groups—including the poor, the elderly, and disabled persons—from abuse, neglect, and mistakes,” (*id.* at 731-32); and 5) avoiding “the path to voluntary and perhaps even involuntary euthanasia,” (*id.* at 732-35).

Of particular importance to *amici*, the Supreme Court agreed with the AMA that “physician-assisted suicide is fundamentally incompatible with the physician’s role as healer.” *Id.* at 731, *quoting*, AMA Code of Ethics § 2.211 (1994). In its compelling *amici* brief, the AMA explained to the Court that “[t]he power to assist in intentionally taking the life of a patient is antithetical to the central mission of healing that guides both medicine and nursing. It is a power that most physicians and nurses do not want and could not control.” Brief of the American Medical Association et al., as *Amici Curiae* in Support of Petitioners (hereinafter “AMA Brief”), 1996 WL 656281, at \*2, *Vacco v. Quill*, 521 U.S. 793 (1997)(No. 95-1858).

The Supreme Court affirmed that the protection of the integrity and ethics of the medical profession is a legitimate state interest justifying a governmental ban on physician-assisted suicide. *Glucksberg*, 521 U.S. at 731. *See also Sampson v. State of Alaska*, 31 P.3d 88, 97 (Alaska 2001)(Alaska’s ban on assisted suicide “furthers the state’s protective interests by promoting the integrity of the medical profession and fostering healthy physician-patient relationships”). The Court noted that the AMA’s Council on Ethical and Judicial Affairs had concluded that the “societal risks of involving physicians in medical interventions to cause patients’ deaths is too great.” *Glucksberg*, 521 U.S. at 731, *quoting* Council on Ethical and Judicial Affairs, *Decisions Near the End of Life*, 267 JAMA 2229,

2233 (1992). The AMA warned the Supreme Court that “[t]he ethical prohibition against physician-assisted suicide is a cornerstone of medical ethics.” AMA Brief, *supra*, at \*5.

The Court also expressed concern that “the trust that is essential to the doctor-patient relationship” would be harmed by “blurring the time-honored line between healing and harming.” *Id.* at 731. *See Sampson*, 31 P.3d at 97; AMA Brief, *supra*, at \*21, *citing* Leon Kass & Nelson Lund, *Physician-Assisted Suicide, Medical Ethics and the Future of the Medical Profession*, 35 Duq. L. Rev. 395, 408 (1996). Nor should the influential effect on a patient of a doctor simply supporting the option of suicide be underestimated. To many already distraught patients, the fact that their physicians even entertain their suicide as a rational option could convey the message that medical professionals view their lives as no longer worth living. *See* AMA Brief, *supra*, at \* 16.

## **II. Physician-Assisted Suicide Is Not a Legitimate Medical Purpose Because It Is Not Necessary for the Alleviation of Terminally Ill Patients’ Pain.**

“Neither legal tolerance nor the best bedside manner can ever make medical killings medically ethical.” Willard Gaylin et al., *Doctors Must Not Kill*, 259 JAMA 2139 (1988). Or, as the Alaska Supreme Court recently stated, “a physician who assists in a suicide undeniably causes harm to others.” *Sampson v. State of Alaska*, 31 P.3d 88, 95 (2001)(rejecting claim that state constitution provides a right to physician-assisted suicide for mentally competent, terminally ill adults).

It would seem self-evident that the intentional infliction of death ought not be considered an acceptable method of pain treatment. The proposition essentially is self-evident for “[i]n almost every State—indeed, in almost every western democracy—it is a crime to assist a suicide.” *Washington v. Glucksberg*, 521 U.S. 702, 710 (1997). *See id.* at 723 (“[w]e are confronted with a consistent and almost universal tradition that has long rejected the asserted right, and continues explicitly to reject it today, even for terminally ill, mentally competent adults”). Laws against physician-assisted suicide are “longstanding expressions of the States’ commitment to the protection and preservation of all human life.” *Id.*<sup>1</sup>

Thrown against this self-evident proposition is the mistaken belief, propagated by many proponents of physician-assisted suicide, that terminally ill persons endure untreatable, unbearable pain and, therefore, should be assisted by doctors to kill themselves. But these fears are medically unsupported because effective pain treatment does exist. AMA Brief, *supra*, at \*6.

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<sup>1</sup> At the federal level, the Assisted Suicide Funding Restriction Act of 1997, 42 U.S.C. § 14401 (1997), “prohibits the use of Federal funds to cause a patient’s death, effectively prohibits the practice of assisted suicide in Federal health facilities, removes it from the scope of ‘rights’ under State laws of which patients must be informed under the Federal Patient Self-Determination Act, and forbids Federal subsidies to health programs or benefit packages which include assisted suicide.” The Pain Relief Promotion Act, S. Rep. No. 106-299, at 10 (2000)(hereinafter “S. Rep. No. 106-299”). The Assisted Suicide Funding Restriction Act passed the House of Representatives, 398-16, and the Senate, 99-0. *Id.* Upon signing it, President Clinton said it “will allow the Federal Government to speak with a clear voice in opposing these practices,” and “to endorse assisted suicide would set us on a disturbing and perhaps dangerous path.” *Id.* at 11.

The existence of effective pain treatment is crucial because the only alleged legitimate medical purpose for physician-assisted suicide advanced by its proponents is the treatment of uncontrollable pain in the terminally ill. Given that effective pain treatments exist, physician-assisted suicide serves no legitimate medical purpose. *See, e.g.*, S. Rep. No. 106-299, at 6 (bill “finds that the dispensing and distribution of controlled substances...are not legitimate medical purposes when used to assist in a suicide or euthanasia”).

**A. The Oregon Death With Dignity Act Explicitly Allows Physician-Assisted Suicide for Patients Whose Pain Can Be Relieved by Conventional, Non-lethal Medical Treatment.**

A particularly troubling aspect of the Oregon Death with Dignity Act, Or. Rev. Stat. §§ 127.800-127.995 (1997)(hereinafter “ODDA”), demands close attention: Physician-assisted suicide is not reserved for persons whose pain is untreatable. ODDA does not even require that patients be experiencing any pain in order to qualify for suicide assistance.

By its explicit language, ODDA assumes that persons for whom pain control is feasible may nonetheless receive physician assistance in committing suicide. ODDA states that “a qualified patient” may “request and obtain a prescription to end his or her life...after being fully informed by the attending physician of...the feasible alternatives, including ... pain control.”

§ 127.800(7)(e). *See also* § 127.815(1)(c)(E) (“[t]he attending physician shall...[i]nform the patient of...[t]he feasible alternatives, including...pain control); § 127.897 (the statutory “Form of the Request” requires the patient to affirm that he or she has been “fully informed of...the feasible alternatives, including...pain control”).

These provisions belie attempts by the proponents of physician-assisted suicide to cast ODDA as a narrow measure applicable only to those terminally ill persons who are in uncontrollable pain. As the Oregon Health Division’s annual reports on implementation of the Act demonstrate, the leading reasons for requesting physician-assisted suicide are patients’ fears of “losing autonomy” and “decreasing ability to participate in activities that make life enjoyable,” rather than a need to control pain. Or. Dept. Health Services, *Oregon’s Death with Dignity Act Annual Report 2001* (2002), Table 3, found at <<http://www.ohd.hr.state.or.us/chs/pas/ar-tbl-3.htm>> (last visited September 25, 2002)(hereinafter “Oregon Report 2001”). *See* S. Rep. No. 106-299, *supra*, at 27, *citing* Amy Sullivan et al., *Legalized Physician-Assisted Suicide in Oregon—The Second Year*, 342 *New Eng. J. Med.* 598 (2000).

**B. According to Leading Medical Authorities, Physician-Assisted Suicide Is Not Needed to Provide Pain Relief for Terminally Ill Patients.**

The AMA, in its powerful *amici* brief , informed the Supreme Court “that the demand for physician-assisted suicide does not come principally from those

seeking relief from physical pain.” Brief of the American Medical Association et al., as *Amici Curiae* in Support of Petitioners (hereinafter “AMA Brief”), *supra*, at \*6-7, *Vacco v. Quill*, 521 U.S. 793 (1997)(No. 95-1858), *citing* Ezekiel J. Emanuel et al., *Euthanasia and Physician-Assisted Suicide: Attitudes and Experiences of Oncology Patients, Oncologists, and the Public*, 347 *Lancet* 1805, 1809 & nn.6, 12 (1996).<sup>2</sup> Instead, according to the AMA, “[m]ost patients that request suicide do so out of concerns that, *in the future*, their pain may become intolerable, they may suffer a loss of dignity and become dependent upon others, or they will excessively burden their families.” AMA Brief, *supra*, at \*8, \*14-15 (emphasis added).

The AMA’s experience has been borne out in Oregon: Only one patient who requested physician-assisted suicide in the year 2001 did so because of “inadequate pain control.” Instead, the leading “end of life concerns” reported were “losing autonomy” and “decreasing ability to participate in activities that make life enjoyable.”<sup>3</sup> Oregon Report 2001, Table 3, <<http://www.ohd.hr.state.or.us/chs/pas/ar-tbl-3.htm>> (last visited Sept. 25, 2002).

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<sup>2</sup> The AMA brief was joined by 45 co-*amici* organizations representing a broad coalition of health care providers, including the American Nurses Association, the American Psychiatric Association, the American Academy of Pain Management, and the American Academy of Pain Medicine.

<sup>3</sup> In the four years in which ODDA has been implemented, the leading “end of life concerns” have been the same: “losing autonomy” and “decreasing ability to participate in activities that make life enjoyable.” “Inadequate pain control” has been one of the two least common concerns; a total of 18 persons in four years (out

The Supreme Court understood that “intolerable physical symptoms are not the reason most patients request physician-assisted suicide or euthanasia.” *Glucksberg*, 521 U.S. at 730, quoting Back et al., *Physician-Assisted Suicide and Euthanasia in Washington State*, 275 JAMA 919, 924 (1996). As the Supreme Court emphasized, under state law, patients in Washington and New York, like patients in most states, retain control over “decisions relating to the rendering of their own health care, including the decision to have life-sustaining treatment withheld or withdrawn.” *Glucksberg*, 521 U.S. at 707 n.2. See also *Quill*, 521 U.S. at 800.

In addition to refusing unwanted life-prolonging treatments, “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.” *Glucksberg*, 521 U.S. at 737 (O’Connor, J., concurring). Given that reality, Justice O’Connor determined that “the State’s interests in protecting those who are not truly competent or facing imminent death, or those whose decisions to hasten death would not truly be voluntary, are sufficiently weighty to justify a prohibition against physician-assisted suicide.” *Id.* See *id.* at 780 (Souter, J., concurring in the judgment); *id.* at 791-92 (Breyer, J., concurring in the judgment)(because

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of 91 persons) reportedly ended their lives because of “inadequate pain control.” *Id.*

palliative care was available, dying persons were not forced to undergo severe physical pain).

Thus, the Supreme Court, the AMA, and other leading authorities concur that “modern pain relief techniques can alleviate pain in all but extremely rare cases.” New York State Task Force, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context* 40 (1994)(hereinafter “NY Task Force Report”).<sup>4</sup> Moreover, contrary to common belief, most terminally ill patients’ pain “can be controlled throughout the dying process, without heavy sedation or anesthesia.” AMA Brief, *supra*, at \*6, citing Kathleen Foley, *The Relationship of Pain and Symptom Management to Patient Requests for Physician-Assisted Suicide*, 6 J. Pain & Symp. Mgmt. 289 (1991).

Nor do pain relief measures typically “hasten death,” as is sometimes believed. Indeed, the New York Task Force labeled the claim as “entirely unfounded,” if the pain relief is administered properly. New York Task Force on Life and the Law, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context* (Supplement to Report) 17 (1997). See S. Rep. No. 106-299,

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<sup>4</sup> The New York State Task Force on Life and the Law is “an ongoing, blue-ribbon commission composed of doctors, ethicists, lawyers, religious leaders, and interested laymen...convened in 1984...to recommend public policy on issues raised by medical advances.” *Glucksberg*, 521 U.S. at 719. In its report, heavily relied upon by the Supreme Court in *Glucksberg* and *Quill*, it unanimously recommended against legalizing assisted suicide and euthanasia because “the potential dangers of this dramatic change in public policy would outweigh any benefit that might be achieved.” *Id.*, quoting NY Task Force Report, *supra*, at 120.

*supra*, at 40 (testimony by Dr. Kathleen M. Foley, attending neurologist in the Pain and Palliative Care Service at Memorial Sloan-Kettering Cancer Center, characterizing claim that proper use of morphine for pain relief hastens death as “entirely unfounded”); AMA Brief, *supra*, at \*6 (“for most patients the risk of respiratory depression that hastens death is minimal”).

The problem is not an inability to control pain but an inadequate “delivery of pain relief ...in clinical practice.” NY Task Force Report, *supra*, at 43. *See* AMA Brief, *supra*, at \*7; S. Rep. No. 106-299, *supra*, at 23. Educating doctors in the best methods of pain treatment is more enlightened than giving doctors a license to assist their patients’ suicide.

Physician-assisted suicide may actually hinder the provision of palliative care, including adequate pain medication, in at least three ways. First, terminally ill patients may be afraid to complain of pain or to ask for increased medication “for fear that the request for such medication will initiate a process that could lead to physician-assisted death.” AMA Brief, *supra*, at \*22. Second, some physicians may determine not to spend the extra time and effort to become better informed about new pain relief treatments and other palliative care for their patients. *Id.* Third, private and public financial resources spent on palliative care may decrease because physician-assisted suicide is a cheaper “treatment,” as may already be happening in Oregon as well as the Netherlands. *See* S. Rep. No. 106-299, *supra*,

at 28 n.65 (collecting newspaper reports indicating less state funding for antidepressants, mental health services, and pain medication for poor and disabled patients, as well as testimony that “some private Health Maintenance Organizations [in Oregon] have placed caps on in-home palliative care while fully funding assisted suicide”). *See also Glucksberg*, 521 U.S. at 792 (Breyer, J., concurring in the judgment)(citing British study “indicating that the number of palliative care centers in the United Kingdom, where physician-assisted suicide is illegal, significantly exceeds that in the Netherlands, where such practices are legal”).

Physicians must help patients address their fears rather than reinforce those fears by offering suicide as an acceptable medical alternative to life. According to the AMA, when their concerns are addressed, the patients’ “desire for death passes” as many patients report discovering “unexpected meaning in their lives that makes their final days worth living.” AMA Brief, *supra*, at \*8, citing David Cundiff, *Euthanasia Is Not the Answer* 29-39 (1992). Ironically, some persons would end the two thousand year-old proscription against euthanasia at the very moment in human history when “the most effective symptom-relieving modalities have come into being.” Ira R. Byock, *Physician-Assisted Suicide is Not an Acceptable Practice for Physicians*, in *Physician-Assisted Suicide* 107, 114 (Robert F. Weir, ed., 1997).

### **C. Many Persons Inevitably Will Die Through Physician-Assisted Suicide Who Should Not Have Been Assisted to Commit Suicide.**

“[I]nstitutionalizing physician-assisted suicide as a medical treatment would put many more patients at serious risk for unwanted and unnecessary death.”

AMA Brief, *supra*, at \*3. Quite simply, the ODDA fails to provide realistic assurance that the patient is not coerced into choosing physician-assisted suicide, is not under undue influence, and is mentally competent to make such a decision. Nor does the ODDA provide realistic assurance that physicians have acted in compliance with the law, as its only oversight consists almost entirely of self-reporting by the physicians who assist patients’ suicides.

#### **1. The Act Fails to Ensure that Persons Suffering from Depression or Other Mental Illness Will Not Be Assisted to Commit Suicide.**

The ODDA has been criticized, even by sympathetic commentators, for its failure to require adequate screening of patients who request physician-assisted suicide to ensure that they are not suffering from depression or other mental illness. *See, e.g.*, Steven B. Datlof, *Beyond Washington v. Glucksberg: Oregon’s Death With Dignity Act Analyzed from Medical and Constitutional Perspectives*, 14 J.L. & Health 23, 29-33, 44 (2000); Christine Neylon O’Brien et al., *Oregon’s Guidelines for Physician-Assisted Suicide: A Legal and Ethical Analysis*, 61 U. Pitt. L. Rev. 329, 344-347 (2000). Although favorably disposed toward physician-assisted suicide, Datlof recommends that ODDA be amended because it does not

adequately prevent physician-assisted suicide for persons who are depressed or mentally ill, explaining:

While the [Act] provides that the attending or consulting physician may refer a patient for counseling with a state licensed psychiatrist or psychologist, the Oregon legislature should amend the statute to mandate that a psychiatrist must evaluate every patient who requests assistance to end his life....[T]his change is needed because of concern in the medical community about the difficulty in understanding the complex meanings of the patient's request for suicide, as well as because of the difficulty in distinguishing depression from appropriate sadness. Moreover, the psychiatrist should be someone with special expertise in helping terminally ill patients make end-of-life decisions.

Datlof, *supra*, at 31. See O'Brien, *supra*, at 344-47 (recognizing possibility that "the number of actual physician-assisted suicides" would be "dramatically" reduced if a mental health consultation were obtained for each person requesting suicide assistance).

A fundamental question is whether a person who seeks suicide is ever acting rationally. According to "the authoritative manual of psychiatric diagnosis, suicidal ideation is a cardinal symptom of a "Major Depressive Episode." Datlof, *supra*, at 27 n.45 (referring to *DSM-IV Diagnostic and Statistical Manual of Mental Disorders* 327 (4<sup>th</sup> Ed., 1994), which lists the major symptoms necessary for a medical diagnosis of a major depressive episode). As Datlof admits, the ODDA "contradicts" basic medical training because "[p]hysicians are trained to view suicidal ideation as a symptom of depression" and "many psychiatrists"

understand “their job” to be “help[ing] patients make adjustments so that suicide no longer seems necessary.” *Datlof, supra*, at 27-28.

The Supreme Court in *Glucksberg* expressed grave concern that “legal physician-assisted suicide could make it more difficult for the State to protect depressed or mentally ill persons, or those who are suffering from untreated pain, from suicidal impulses.” 521 U.S. at 731. The Court explained that those seeking suicide “often suffer from depression or other mental disorders.” *Id.* at 730, *citing* NY Task Force Report, *supra*, at 13-22, 126-128.

According to the Alaska Supreme Court, “recent studies show a high correlation between depression and the desire of terminally ill patients to end life using physician-assisted suicide.” *Sampson*, 31 P.3d at 97 n.65 A person who has been recently diagnosed with a serious illness often will develop depression. AMA Brief, *supra*, at \*8; NY Task Force Report, *supra*, at 13, 177-181. Especially if a person is experiencing pain, he or she is likely to become depressed, even suicidal, until the pain is alleviated, particularly if the patient mistakenly believes the pain is untreatable. *See Glucksberg*, 521 U.S. at 730-31; *Sampson*, 31 P.3d at 96 (terminally ill are vulnerable to others’ pressure to commit suicide “because of chronic pain, depression, and the effects of medication”).

Most physicians are not mental health specialists and “are ill-equipped to detect depression in their patients at all, much less to determine what level of

clinical depression is sufficient to cause “impaired judgment.” S. Rep. No. 106-299, *supra*, at 28. “[M]ak[ing] a determination of competency more difficult,” the physical symptoms of many terminal illnesses match the symptoms for depression. O’Brien, *supra*, at 346. The elderly are particularly at risk for not having their depression recognized and treated. NY Task Force Report, *supra*, at 32.

Even if an Oregon physician refers a patient for a mental health consultation pursuant to §127.825 of the ODDA, the mental health professional is likely to meet only once with the patient due to time and financial constraints. O’Brien, *supra*, at 345. The “‘ideal’ case in which ‘patients would be screened for depression and offered treatment, effective pain medication would be available, and all patients would have a supportive committed family and doctor is not the usual case.’” *Glucksberg*, 521 U.S. 738, 749 (Stevens, J., concurring in the judgment), *quoting* NY State Task Force Report, *supra*, at 120. Or, in the words of a commentator sympathetic to the ODDA’s purpose, “[i]t is unclear whether most physicians will have the resources to provide patients with the extensive therapeutic involvement” that physician-assisted suicide necessitates. O’Brien, *supra*, at 353.

Instead, the terminally ill patient who is suicidal should be treated for depression just as physicians surely would treat a suicidal patient who is not terminally ill. AMA Brief, *supra*, at \*9-10; NY Task Force Report, *supra*, at 13. The Supreme Court was adamant that “the lives of terminally ill, disabled, and

elderly people must be no less valued than the lives of the young and healthy, and that a seriously disabled person’s suicidal impulses should be interpreted and treated the same way as anyone else’s.” *Glucksberg*, 521 U.S. at 732, *citing* NY Task Force Report, *supra*, at 101-102. *See* 521 U.S. at 747 (Stevens, J., concurring in the judgment)(“the State has a *compelling interest* in preventing persons from committing suicide because of depression”)(emphasis added).

As the Supreme Court observed, “[r]esearch indicates...that many people who request physician-assisted suicide withdraw that request if their depression and pain are treated.” *Glucksberg*, 521 U.S. at 730, *citing* Herbert Hendin, *Seduced by Death: Doctors, Patients and the Dutch Cure* 24-25 (1997). *See* AMA Brief, *supra*, at \*2 (“a desire for physician-assisted suicide does not persist in patients who receive good palliative care”); O’Brien, *supra*, at 346. The AMA urged the Court to reject physician-assisted suicide because “[o]nce established, the right to physician-assisted suicide would create profound danger for many ill persons with undiagnosed depression and inadequately treated pain, *for whom physician-assisted suicide rather than good palliative care could become the norm.*” 1996 WL 656281, at \*2 (emphasis added).

## **2. Physician-Assisted Suicide Inevitably Will Become Euthanasia.**

### **a. Physicians Who Have Illegally Assisted Suicide Are Unlikely to Obey Any Guidelines Established to Regulate Legalized Physician-Assisted Suicide.**

Proponents of physician-assisted suicide argue that its legalization will not lead to voluntary or involuntary euthanasia because strict guidelines for its administration will be implemented. Yet, according to several sources, some doctors admit that they have engaged in physician-assisted suicide despite its being illegal. *See, e.g., Glucksberg*, 521 U.S. at 749 n.12 (Stevens, J., concurring in the judgment); AMA Brief, *supra*, at \*11; Task Force Report, *supra*, at 140-41. Physicians who are assisting patients to commit suicide when it is illegal are hardly likely to conform their individual practice of physician-assisted suicide to comply with governmental restrictions once it is legalized. Instead, those doctors likely will increase their activities and provide physician-assisted suicide as they see fit, rather than abiding by bureaucratic regulations that they may see as too restrictive and “less humane” than their own personal code for assisted suicide.

It is certainly “within the realm of plausibility, that physicians simply would not be assiduous to preserve the line” between patients who knowingly and voluntarily seek physician-assisted suicide and those not competent to make such a decision. *Glucksberg*, 521 U.S. at 784 (Souter, J., concurring in the judgment). Physicians “who would be willing to assist in suicide at all might be the most susceptible to the wishes of a patient, whether the patient was technically quite responsible or not.” *Id.* This danger was enough to convince Justice Souter that physician-assisted suicide could easily become euthanasia, as he explained:

Physicians, and their hospitals, have their own financial incentives, too, in this new age of managed care. Whether acting from compassion or under some other influence, a physician who would provide a drug for a patient to administer might well go the further step of administering the drug himself; so, the barrier between assisted suicide and euthanasia could become porous, and the line between voluntary and involuntary euthanasia as well.

*Id.* at 784-85. See NY Task Force Report, *supra*, at xiii, 102-103, 120, 141.

**b. Euthanasia Will Be Impossible to Detect or Prevent.**

The AMA's Code of Medical Ethics rejects physician-assisted suicide in part because it "would be difficult or impossible to control." AMA Brief, *supra*, at \*5, \*22-24, citing Code of Medical Ethics § 2.211. See Daniel Callahan & Margot White, *The Legalization of Physician-Assisted Suicide: Creating a Regulatory Potemkin Village*, 30 U. Rich. L. Rev. 1 (1996). The confidentiality of the physician-patient relationship essentially "precludes any effective monitoring of physician-assisted suicide." AMA Brief, *supra*, at \*25. Opponents of physician-assisted suicide reasonably fear that, if the practice is legalized, then it will lead to cases where patients are put to death without their full and free consent. See, e.g., Yale Kamisar, *Against Assisted Suicide--Even a Very Limited Form*, 72 U. Det. Mercy L. Rev. 735 (1995). Indeed, in the Netherlands, the only country where physician-assisted suicide is openly practiced, many cases have been documented in which involuntary euthanasia has occurred despite rules against it and procedures

theoretically designed to prevent its occurrence. *See* Carlos F. Gomez, *Regulating Death: Euthanasia and the Case of the Netherlands* 104-13 (1991).

The ODDA is breathtaking in the carelessly naïve trust it reposes in the hands of the physicians who assist their patients to commit suicide. For example, the ODDA authorizes physician-assisted suicide within fifteen days of the initial oral request and forty-eight hours of the written request. § 127.840. The request need be witnessed by only two persons, one of whom may be a person who will benefit financially by the patient's death. § 127.810(1) & (2)(b). The physician need not refer a patient who is requesting suicide to a mental health professional. § 127.825. *See supra*, at 10-11. Even if deaths mistakenly occur, the physician is held only to a "good faith" standard of conduct. § 127.885(1)-(3).

Furthermore, the ODDA's "confidentiality requirements, [§ 127.865(2)], and its provision barring notification of family members without a patient's express consent, [§127.835], make it very unlikely that abuses will be discovered." S. Rep. No. 106-299, *supra*, at 28. The annual reports required by the statute, ostensibly to protect against abuses, consist almost entirely of self-reporting by the very physicians whose conduct theoretically is being examined. *Id.* at 27-28. Abuses of physician-assisted suicide will be uncovered only if other health care professionals report suspected abuses. But given the vagaries of determining whether a patient has given consent, and the vulnerability to retaliation that a

nurse, for example, has in reporting legitimate concerns about a physician's actions, even commentators who support the ODDA's purpose have conceded that "[i]n reality, anything but extremely egregious malpractice will probably go unreported." O'Brien, *supra*, at 353.

Euthanasia may already have occurred in Oregon. According to the Senate Judiciary Committee, "[a]n Oregon physician generally acknowledged to have performed active euthanasia without his patient's consent...was declared 'unprosecutable' by State officials because of the climate created by the Oregon law permitting assisted suicide." S. Rep. No. 106-299, *supra*, at 28 n.61.

Certainly, the only other Western nation currently permitting physician-assisted suicide has come to tolerate both voluntary and involuntary euthanasia by its doctors. The Supreme Court rejected physician-assisted suicide, in part, because the Netherlands experiment bears witness that physician-assisted suicide inevitably transmutes into euthanasia. *Glucksberg*, 521 U.S. at 734.

### **III. Physician-Assisted Suicide Will Profoundly Affect the Ability to Obtain and Retain Employment for Health Care Professionals Who Have Religious Convictions Against the Intentional Killing of Oneself or Other Human Beings.**

Legalizing physician-assisted suicide is certain to affect physicians who object for religious reasons to the intentional termination of another human being's life. For legal as well as economic reasons, physicians will find it increasingly difficult to refuse to assist patients in committing suicide. Instead, the practice of physician-

assisted suicide will become the norm, the standard of care expected from a physician. It is likely that a positive duty to perform this "service," and assist patients to commit suicide, will be recognized and become a potential source of malpractice claims against physicians who refuse to perform physician-assisted suicides.

Physicians with religious objections to killing oneself or other human beings will be forced either to aid directly in suicide or, at a minimum, to be an accomplice to the suicide by arranging referrals to physicians who are willing to participate. Under some forms of managed care organizations, physicians who refuse to assist a patient in killing herself are likely to be required to pay another physician's charges for killing the patient. *Cf., Washington v. Glucksberg*, 521 U.S. 752, 784-85 (Souter, J., concurring in the judgment)(physician-assisted suicide could easily become euthanasia, in part, because “physicians, and their hospitals, have their own financial incentives, too, in this new age of managed care”).

The ODDA implicates all physicians in physician-assisted suicide regardless of their religious, philosophical, or ethical opposition. Although the ODDA exempts a health care provider from “any duty...to participate in the provision to a qualified patient of medication to end his or her life,” §127.885(4), the Oregon Task Force Guidebook states that a doctor “must transfer care” to a doctor willing to participate in the patient’s suicide because “[t]o do otherwise would be abandonment” of the patient. Task Force to Improve the Care of Terminally-Ill Oregonians, *The Oregon*

*Death With Dignity Act: A Guidebook for Health Care Providers*, Chapter 3

“Conscientious Practice,” at \*2, (hereinafter “Oregon Task Force Guidebook”)

<http://www.ohsu.edu/ethics/chapter3.htm> (last visited September 25, 2002). Even assistance in transferring care would be too much involvement in the suicide for many objecting physicians.<sup>5</sup>

Objecting physicians face financial pressure to participate. Many managed care organizations use a strict capitation model for care, in which patients initially see their primary physician for all complaints and are referred to a specialist only if the primary physician feels it is necessary and authorizes the funding for this care. The organization adopts this model of care in order to decrease expenditures for specialty care and realizes a profit only if actual expenditures are less than or equal to those planned for during the term of the physician’s contract. Physicians who refuse to participate in assisted suicide but focus their efforts—and the financial resources of the managed care organization—on palliative care, are more likely to exceed their “caps” than are physicians willing to utilize the cheaper “treatment” of assisted suicide. Physicians who repeatedly exceed their “caps” are unlikely to have their contracts renewed.

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<sup>5</sup> Perhaps recognizing the advisory nature of its guidelines, the Oregon Task Force does seem to concede that a physician might be allowed to refuse to assist a transfer. *Id.* The concern, of course, is that the guidelines may assume a quasi-legal status for interpreting the ODDA or be seen as defining the “standard of care” against which all doctors’ actions will be judged.

Physician-assisted suicide will also substantially affect nurses, medical students, pharmacists, emergency medical technicians (“EMTs”), and other health care providers with religious objections to the intentional killing of other human beings. *See Oregon Task Force Guidebook, supra*, at \*2.; O’Brien, *supra*, at 350. The Oregon Task Force Guidebook takes a particularly troubling approach to the ability of nurses, pharmacists, and EMTs to avoid participation in assisted suicide. On one hand, the guidelines recognize that they “have a right to know whether their care of patients involves actions that would be morally objectionable for them.” *Oregon Task Force Guidebook, supra*, at \*2. Simultaneously, however, the guidelines acknowledge that objecting health care providers will not necessarily be told that they are assisting in a suicide, because “attending physicians must respect the confidentiality of the patient’s request unless otherwise waived.” *Id. See O’Brien, supra*, at 348.

Even with physician-assisted suicide, death may take hours to occur. *See Oregon Report 2001, supra*, at Table 3. The patient may change his or her mind after taking the medication, or the family may call “911” if the patient’s death is not an easy one or the family has second thoughts. Conscientiously objecting nurses or EMT’s responding to such situations are placed in an intolerable dilemma. *See O’Brien, supra*, 351-52. Again, the ODDA’s myopic view of physician-assisted

suicide does not fit reality, causing problems for health care providers who cannot simply shut their eyes and ignore their medical training and duty.

#### **IV. The Early Christian Church Firmly Repudiated Suicide.**

In a prior decision regarding physician-assisted suicide, this Court suggested that early Christians approved suicide and utilized that idea to support physician-assisted suicide as a constitutional right. *Compassion in Dying v. State of Washington*, 79 F.3d 790, 808 (9th Cir. 1996)(*en banc*), *rev'd sub nom. Washington v. Glucksberg*, 521 U.S. 702 (1997). *Amici* respectfully and briefly address this mistaken view.

There was no moral acceptance of suicide within the early Christian church. *See generally* Edward J. Larson & Darrel W. Amundsen, *A Different Death: Euthanasia and the Christian Tradition* (1998). “No recognized historian has documented instances of early Christian church leaders condoning suicide, as that term is commonly understood—the voluntary taking of one's own life. To the contrary, they uniformly condemned self-murder.” Larson, *supra*, 215. *See, e.g.*, Robert Barry, *The Development of the Roman Catholic Teachings on Suicide*, 6 Notre Dame J.L., Ethics & Pub. Pol'y 466-468 (1995); Darrel W. Amundsen, *The Significance of Inaccurate History in Legal Considerations of Physician-Assisted Suicide*, in *Physician-Assisted Suicide* 3 (Robert F. Weir, ed., 1997).

Various early Church leaders, including Clement of Alexander (ca.155 - ca.220 A.D), Tertullian (ca.160 - ca.220 A.D.), Basil of Caesarea (ca.330 - 379 A.D.), Jerome (ca.342 - 419 A.D.), Bishop John Chrysostom (349 - 407 A.D.), and Ambrose (ca. 339-397), condemned the practice of suicide. Larson, *supra*, 103-115. The second century Church Father, Justin Martyr, (ca.100 - 165 A.D.) condemned suicide as "opposing the will of God."<sup>6</sup> Another early Church Father, Lactantius (ca.240 - 320 A.D.), stated that "nothing can be more wicked than" suicide.<sup>7</sup>

As Christianity spread throughout the Roman world, the practice of suicide rapidly lost public tolerance. A leading authority explains:

The gradual dominance of Christianity in the Roman Empire, culminating in the conversion of the Emperor Constantine in the 4th century A.D., worked a transformation in the cultural attitude toward suicide. Imbuing all strata of the Roman world with its spiritual principles, Christianity provided a view of life that was itself inimical to suicide.

Thomas Marzen et al., *Suicide: A Constitutional Right?*, 24 Duq. L. Rev. 1, 26 (1985).<sup>8</sup>

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<sup>6</sup>Justin Martyr, 2 *Apology* 4, in 6 *Fathers of the Church* 123 (1948). See Larson, *supra*, 103.

<sup>7</sup>Lactantius, *Divine Institutes* 3.18, in 7 *Ante-Nicene Fathers* 89 (1951). See Larson, *supra*, at 108-109.

<sup>8</sup> For its support of its historical treatment of early Christian attitudes toward

Nor does the Biblical text support suicide. “Of the five Biblical suicides identified by [this Court in *Compassion in Dying*, 79 F.3d at 808 n.25], all but Samson were by persons utterly alienated from God, and Samson died as a captured warrior in an act intended to kill Israel's enemies.” Larson, *supra*, at 216. See Barry, *supra*, at 456-57. There simply was no acceptance of suicide in early historical Christian tradition.

### CONCLUSION

The practice of physician-assisted suicide does not have a legitimate medical purpose, under traditional or current medical ethical standards. The only “legitimate medical purpose” urged by its proponents--pain control for the terminally ill--ignores the fact that effective, non-lethal pain treatments for terminally ill patients are available. Nor does the Oregon Death With Dignity Act restrict the practice of physician-assisted suicide to persons suffering pain. Quite simply, the ODDA fails to ensure that persons who are assisted to commit suicide are mentally competent, not depressed, not coerced, and not acting under undue influence. Physician-assisted suicide inevitably will lead to voluntary and involuntary euthanasia.

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suicide, this Court cited Alfred Alvarez’s and Emile Durkheim’s writings on suicide, 79 F.3d at 807 & n.22, “[n]either of whom was either a theologian or a historian.” Larson, *supra*, at 216.

Therefore, *amici* respectfully request this Court to reverse the district court decision below.

Respectfully submitted,

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September 30, 2002

## STATEMENTS OF INTEREST

**The Christian Legal Society**, founded in 1961, is a nonprofit interdenominational association of Christian attorneys, law students, judges, and law professors with chapters in nearly every state and at over 140 accredited law schools. Since 1975, the Society's legal advocacy and information division, the Center for Law and Religious Freedom, has worked for the protection of religious belief and practice, as well as for the autonomy from the government of religion and religious organizations, in the Supreme Court of the United States and in state and federal courts throughout this nation.

The Center strives to preserve religious freedom in order that men and women might be free to do God's will. Using a network of volunteer attorneys and law professors, the Center provides information to the public and the political branches of government concerning the interrelation of law and religion. Since 1980, the Center has filed briefs *amicus curiae* in defense of individuals, Christian and non-Christian, and on behalf of religious organizations in virtually every case before the Supreme Court involving church/state relations.

The Society is committed to religious liberty because the founding instrument of this Nation acknowledges as a "self-evident truth" that all persons are divinely endowed with rights that no government may abridge nor any citizen waive,

Declaration of Independence (1776). Among such inalienable rights are those enumerated in (but not conferred by) the First Amendment, the first and foremost of which is religious liberty. The right sought to be upheld here inheres in all persons by virtue of its endowment by the Creator, Who is acknowledged in the Declaration. It is also a "constitutional right," but only in the sense that it is recognized in and protected by the U.S. Constitution. Because the source of religious liberty, according to our Nation's charter, is the Creator, not a constitutional amendment, statute or executive order, it is not merely one of many policy interests to be weighed against others by any of the several branches of state or federal government. Rather, it is foundational to the framers' notion of human freedom. The State has no higher duty than to protect inviolate its full and free exercise. Hence, the unequivocal and non-negotiable prohibition attached to this, our First Freedom, is "Congress shall make no law. . . ."

The Christian Legal Society's national membership, years of experience, and available professional resources enable it to speak with authority upon religious freedom matters before this Court.

The **Christian Medical Association** ("CMA") was founded in 1931 and today represents over 16,000 members – primarily practicing physicians representing the entire range of medical specialties. These members share a common commitment to the principles of biblical faith and the integration of those

principles with professional practice. Among other functions, the CMA Medical Ethics Commission brings together member experts in the field of medical ethics who formulate positions on vital issues. These positions are subsequently voted upon for adoption, amendment, or rejection by over 100 elected representatives to the national convention of the Association.

## CERTIFICATE OF SERVICE

I hereby certify that on this 30th day of September, 2002, I filed and served the foregoing Brief for *Amici Curiae* by causing the original and 15 copies to be sent to this Court by United Parcel Service overnight, and by causing two copies to be served upon the following counsel by United Parcel Service overnight:

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CERTIFICATE OF COMPLIANCE PURSUANT TO  
FED. R. APP. P. 32(a)(7)(C) AND CIRCUIT RULE 32-1  
FOR CASE NUMBER 02-35587

I certify that, pursuant to Fed. R. App. P. 29(d) and 9<sup>th</sup> Cir. R. 32-1, the attached Brief *Amici Curiae* is proportionately spaced, has a typeface of 14 point Times New Roman, and contains 6981 words according to the “Word Count” feature in the Words software, not including the Cover Page, Corporate Disclosure Statement, Table of Contents, Table of Authorities, Addendum, and Certificates of Counsel.

Date: \_\_\_\_\_, 2002

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Kimberlee Wood Colby