February 22, 1999

No. 8264

This opinion is issued in response to questions presented by Representative Lane Shetterly regarding The Oregon Death With Dignity Act, ORS 127.800 to 127.995 (the Act).

FIRST QUESTION PRESENTED

If a hospital or other health care facility has chosen by contract or policy to prohibit its employees and contract health care providers from participating in "death with dignity"[(1)] at the hospital or facility, but one of its employees or other health care providers under contract with the facility knowingly disregards the prohibition, does the hospital have the option to enforce the terms of the contract or policy, or is the employee or contract provider protected from any sanctions by the Act's "immunities" provision?

ANSWER GIVEN

The hospital or health care facility may take otherwise lawful disciplinary action against an employee or health care provider who participates in death with dignity procedures at the hospital or health care facility if the employee or health care provider knows or should know that such participation violates the terms of his or her contract or a hospital policy.

SECOND QUESTION PRESENTED

If a hospital or other health care facility owns a medical facility and, as part of a lease agreement with a health care provider, specifies that no tenant of the facility may participate in death with dignity procedures on the premises, but one of its health care tenants disregards the prohibition in the lease, may the hospital or health care facility enforce the prohibition in the lease by action up to and including termination of the lease, or is the tenant protected from any enforcement action by the Act's "immunities" provision?

ANSWER GIVEN

The hospital or health care facility may enforce the lease prohibition.

DISCUSSION

I. Statutory Background and Method of Analysis

These questions call for interpretation of two apparently contradictory subsections of the Act, ORS 127.885(2) and (4), which provide in relevant part:

(2) No professional organization or association, or health care provider, may subject a person to censure, discipline, suspension, loss of license, loss of privileges, loss of membership or other penalty for participating * * * in good faith compliance with [the Act].

* * * * *

(4) No health care provider shall be under any duty, whether by contract, by statute or by any other legal requirement to participate in the provision to a qualified patient of medication to end his or her life in a humane and dignified manner. * * *

A "health care provider" is either an individual practitioner or "a health care facility."

ORS 127.800(5). Thus, subsection (2) could be interpreted to mean that a facility cannot discipline a practitioner for participating in death with dignity procedures, even if the participation is on the facility's premises and in knowing violation of the facility's policy. At the same time, however, subsection (4) could be interpreted to mean that a facility may discipline or evict a provider who participates in death with dignity procedures on the facility's premises contrary to its policy; the facility would contend that tolerating death with dignity procedures on its premises amounts to the facility's participation in those procedures, and that subsection (4) declares the facility is under no statutory duty to do so.

In interpreting a statute, our goal is to discern the intent of the legislature.

ORS 174.020; ***PGE v. Bureau of Labor and Industries*** (***PGE***), 317 Or 606, 610, 859 P2d 1143 (1993). We first look at the text and context of the statute, which includes other provisions of the same statute and related statutes. In so doing, we consider dictionary definitions, rules of grammar and statutory and judicially developed rules of construction that bear directly on how to read the text, such as "not to insert what has been omitted, or to omit what has been inserted." *Id.* at 611. If the legislative intent is clear from the text and context, the search ends there. Only if the legislative intent is not clear from the text and context of the statute, will we look to the legislative history to attempt to discern that intent. *Id*. at 611-612. If, after considering text, context and legislative history, the intent of the legislature remains unclear, we may resort to general maxims of statutory construction to resolve any remaining uncertainty as to the meaning of the statute. *Id.* at 612. The same analysis applies to laws and constitutional amendments adopted through the initiative or referendum, *id.* at 612 n 4, with two exceptions. First, the intent we are attempting to discern is that of the voters, rather than the legislature. Second, since voter-generated initiatives do not have "legislative history" per se, the second level materials for discerning intent include ballot titles, explanatory statements and arguments in voters' pamphlets, news stories and editorials. ***Ecumenical Ministries v. Oregon State Lottery Comm.***, 318 Or 551, 560 n 8, 871 P2d 106 (1994).

II. Text and Context

The text and context of ORS 127.885 are ambiguous. Subsection (2) appears to bar a hospital from imposing any sanctions whatsoever on physicians[(2)] who participate in death with dignity procedures. Yet, the subsection does not explicitly state whether the physician is immune even if he or she participates on the hospital's premises, or if the immunity covers only off-premises participation, for example in the physician's own office. One of the "first level" rules of statutory interpretation counsels against inserting words that are not present. ***PGE*** at 611 (quoting ORS 174.010). Because subsection (2) does not contain words of limitation, the better interpretation of that provision clearly is the one that confers complete immunity. Indeed, if the inquiry were limited to the text of subsection (2) alone, the immunity would be absolute. However, the "first level" of interpretation calls for examination of context as well, including other provisions of the same statute. *Id.* at 610-11.

One such provision is subsection (4). The text of that provision declares that no hospital is under any statutory duty to "participate" in providing a lethal dose of medication to a qualified patient. "Participate" can be interpreted narrowly or broadly. Under the narrowest interpretation, it would encompass only physical activity along with others in a common pursuit; it would not violate accepted canons of usage to say, "He did not participate in the orchestra's performance of that piece because his instrument broke before the first measure and he just sat on stage doing nothing." *See* Webster's Third New International Dictionary at 1646 (unabridged 1993) ("to take part in something (as an enterprise or activity) usu. in common with others"). Under a broader interpretation, it would also include a more passive role that facilitates or supports the activity of another, even if only by shared presence or moral support; it would not violate accepted canons of usage to say, "The bystanders who stood by and did nothing while the victim was beaten participated in the beating." *See id.* ("to have a part or share in something your mother s in this ambition -- Edith Wharton").

Another "first-level" rule of statutory construction endorsed in ***PGE*** suggests that the broad definition applies. "Use of the same term throughout a statute indicates that the term has the same meaning throughout the statute." 317 Or at 611. Subsection (1) of

ORS 127.885 provides:

No person shall be subject to civil or criminal liability or professional disciplinary action for ***participating*** in good faith compliance with [the Act]. This ***includes being present*** when a qualified patient takes the prescribed medication to end his or her life in a humane and dignified manner."

ORS 127.885(1) (emphasis added). Since "participating" includes mere presence, it follows that a hospital "participates" in death with dignity procedures by passively permitting them on its premises.

Thus, when subsection (4) tells hospitals that no "statute" imposes a duty to "participate in the provision to a qualified patient of medication to end his or her life" that arguably means that no statute, including subsection (2), imposes on a hospital the duty to allow its premises to be used for the provision of life-ending medication. If subsection (2) does not require a hospital to allow the use of its premises, it must permit the hospital to take steps to prevent that use, including discipline or the withdrawal of hospital privileges for any physician who makes such use of the hospital. Thus, the context of subsection (2) -- that is, subsection (4) -- creates the possibility that subsection (2) does not provide immunity to physicians who provide life-ending medication on the hospital's premises. Because we cannot say that ORS 127.885 is unambiguous, we turn to the Act's history.

III. Legislative History

The Oregon Death with Dignity Act was enacted by initiative as Ballot Measure 16 at the 1994 General Election. As noted above, second level materials for discerning the voters' intent behind initiated measures include ballot titles, explanatory statements and arguments in voters' pamphlets, news stories and editorials. ***Ecumenical Ministries v. Oregon State Lottery Comm.***, 318 Or at 560 n 8. Our examination of those materials discloses nothing that might help resolve the textual and contextual ambiguity.

The "Explanatory Statement" in the 1994 Voters' Pamphlet informed the electorate that "Any physician or health care provider may decline to participate." 1994 Voters' Pamphlet at 124. Because this statement contains the same ambiguity as section (4) with respect to the meaning of "participate," we cannot discern the voters' intent from this statement. Beyond this insubstantial "evidence," there are no historical materials surrounding Measure 16 that are relevant to the questions we are asked.

The 1997 Legislative Assembly referred to the people an initiative (Ballot Measure 51) that would have repealed the Act. The hearings on that referral, known at the time as HB 2954, and the Voters' Pamphlet for the Special Election on the repeal, both produced some statements that deal with the Act. However, even if those statements did reveal what legislators, interest groups and others believed in 1997, that material could shed no light whatsoever on the intention of the voters who enacted Measure 16 three years earlier.

Consequently, we find that the historical materials do not clarify the ambiguity in ORS 127.885(2) and (4).

IV. General Maxims of Statutory Construction

Since neither text, context nor historical materials enable a definitive interpretation, we turn to "general maxims of statutory construction to aid in resolving the remaining uncertainty." ***PGE***, 317 Or at 612. In particular, we invoke the maxim that a statute should be construed so as to avoid internal inconsistencies and to achieve harmony.

Todd v. Bigham, 238 Or 374, 395 P2d 163 (1964); ***Friends of Neabeack Hill v. City of Philomath***, 139 Or App 39, 911 P2d 350, *rev den* 323 Or 136, 916 P2d 311 (1996); 20 Op Atty Gen 124 (1940).

We could achieve reconciliation of subsections (2) and (4) in either of two ways. First, we could interpret subsection (2) to provide physicians a sweeping immunity from penalty, including immunity from discipline or termination by a hospital that prohibits on-premise and off-premise participation in death with dignity. To avoid conflict, we would then interpret subsection (4) using a very narrow interpretation of "participate," so that the subsection gave to hospitals the prerogative to refuse to actively participate, but did not give them the right to refuse passive participation. Under this interpretation, every physician would have the absolute right to "participate in the provision to a qualified patient of medication to end his or her life" at any location, including in an objecting hospital; hospitals would have no right to enforce their objections.

This reading of ORS 127.885 is strained and unlikely. It requires a narrow interpretation of "participate" that contradicts the broader definition of that term in subsection (1). Thus, this attempt to harmonize subsections (2) and (4) not only violates the maxim about consistent use of terms, but in doing so it also creates disharmony between subsections (1) and (4). Further, this interpretation would render subsection (4) meaningless, insofar as it applies to facilities; the kind of participation that facilities would gain the right to avoid -- active physical participation -- is the kind of participation that makes sense only with respect to persons. This, in turn, violates the maxim of construction that requires the interpretation that gives meaning to each part of a statute. ***Owens v. Maass***, 323 Or 430, 437, 918 P2d 808 (1996).

The preferred harmonization would interpret subsection (2) as giving physicians immunity from hospital discipline for participating in death with dignity off premises, but not for participating on the hospital's premises contrary to the hospital's policy or contract. Subsection (4), in turn, would be interpreted to give hospitals the right to refuse even passively to participate in death with dignity procedures by tolerating them on their premises.

Under this interpretation, the answers to the questions we are asked are clear. Subsection (2) does not prevent a hospital from enforcing the terms of an otherwise lawful contract so as to prohibit a physician from participating in a death with dignity procedure on hospital premises. In fact, subsection (4) empowers a hospital to do so. Nor do we see any

reason to distinguish a rental contract or lease from an employment contract; otherwise lawful provisions in such agreements prohibiting death with dignity procedures on hospital premises would be enforceable.

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1. The Act does not use the terms "assisted suicide" or "physician assisted suicide." Indeed, ORS 127.880 provides that "actions taken in accordance with [the Act] shall not, for any purpose, constitute suicide [or] assisted suicide * * *." For this reason, we use the statutory term "death with dignity" instead of the common phrase "physician assisted suicide" in this opinion.

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2. For convenience, we use the terms "hospital" and "physician" instead of the more inclusive and precise statutory terms "health care provider" and "health care facility," but our conclusions apply equally to covered providers who are not physicians and covered facilities that are not hospitals.

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