Recent Developments in Physician-Assisted Suicide

March 2004

LITIGATION

1. *Oregon v. Ashcroft*, 192 F.Supp.2d 1077 (D.Or. 2002), appeal pending, No. 02-35587 (9th Cir.)

   a. Case filed. On 11/7/01, in response to Attorney General John Ashcroft's directive that prescribing lethal medication was not a legitimate medical purpose under the Controlled Substances Act, the State of Oregon filed a complaint in the U.S. District Court for the District of Oregon seeking a declaratory judgment and injunctive relief. The court allowed several individual patients, a physician, and a pharmacist to intervene as plaintiffs supporting the position of the state of Oregon. Named defendants included Attorney General John Ashcroft, Asa Hutchinson (Administrator of the Drug Enforcement Administration), Kenneth W. Magee (Director of the Portland DEA office), the United States of America, the U.S. Department of Justice, and the U.S. Drug Enforcement Administration. The court allowed several organizations to file amicus briefs.

   b. U.S. District Court decision. On 4/17/02, Judge Robert E. Jones issued his written decision in favor of plaintiff and plaintiff-intervenors. *Oregon v. Ashcroft*, 192 F.Supp.2d 1077 (D.Or. 2002). Judge Jones permanently enjoined defendants from "enforcing, applying, or otherwise giving any legal effect to" Ashcroft's directive and ordered that health care providers in Oregon "shall not be subject to criminal prosecution, professional disciplinary action or other administrative proceedings for any actions taken in compliance with the Oregon Death with Dignity Act." Although plaintiff and plaintiff-intervenors had made statutory, administrative, and constitutional arguments, Judge Jones based his decision on statutory grounds exclusively, holding that neither the plain language of the Controlled Substances Act, its legislative history, nor the cases cited supported defendants' argument that Congress intended to delegate to the Attorney General the authority to override a state's determination as to the "legitimacy" of a medical practice.

1. Arizona. In the 2003 session of the Arizona legislature, an Aid in Dying bill patterned after the Oregon Death with Dignity Act, which was introduced as H.B. 2454, died after a hearing was held. On 1/19/04, H.B. 2172 (known as the Patient Comfort and Control Act) was introduced

include the Vermont Coalition for Disability Rights, the Vermont chapter of the American Cancer Society, and the Hospice and Palliative Care Council of Vermont.

e. Vermont legislature. In light of the controversy over H. 318, Vermont Senator James Leddy and Representative Thomas Koch, chairs of the Senate and House Health and Welfare Committees, announced in January 2004 that their committees would not take up the bill this year. However, the House Health and Welfare Committee did hold hearings in February 2004 about ways to improve end-of-life care.

5. Wyoming. On 2/19/04, Senator Keith Goodenough attempted to introduce Senate File 7 (the Wyoming Death with Dignity Act) in the Wyoming Senate. The bill failed on introduction by a vote of 19 to 8; because the legislative session was a budget session, the bill could not be considered unless two-thirds of senators agreed. The bill was based on the Oregon Death with Dignity Act.

OTHER NATIONAL DEVELOPMENTS

1. Dr. Jack Kevorkian. In 1999, Dr. Jack Kevorkian was convicted of second-degree murder for giving a lethal injection to a Detroit man who had Lou Gehrig's disease. He is eligible for parole in 2007. In December 2003, Kevorkian's second petition to be released early for health reasons was rejected by Judge Rae Lee Chabot.

2. National poll. A national poll of 1,005 adults issued by Religious News Service in September 2003 showed that Americans find physician-assisted suicide more acceptable morally than suicide. As to physician-assisted suicide, 45% said it was morally acceptable and 49% that it was morally wrong. As to suicide, 14% said it was morally acceptable and 81% that it was morally wrong.

3. Catholic church. At the U.S. Conference of Catholic Bishops in Washington, D.C., held in November 2003, church leaders criticized adherents' practice of picking and choosing which Catholic doctrines to follow. A task force of bishops is weighing whether to recommend sanctions for Catholic politicians who support policies contrary to church teachings, such as the prohibition against abortion and euthanasia. In January 2004, New Orleans Archbishop Alfred C. Hughes and Wisconsin Bishop Raymond Burke (now Archbishop of St. Louis) told diocesan priests to withhold communion from lawmakers who refuse to support the church's position on such issues.

MEDICAL DEVELOPMENTS

1. Recent articles

a. Joseph J. Gallo et al., *Life-Sustaining Treatments: What Do Physicians Want and Do They Express Their Wishes to Others?*

b. Susan L. Mitchell et al., *Clinical and Organizational Factors Associated with Feeding Tube Use Among Nursing Home Residents with Advanced Cognitive Impairments*, 290 JAMA 73 (2003) [in a 1999 nationwide study of feeding tube use among nursing home residents with advanced cognitive impairment that considered both resident and facility characteristics, 33.8% of residents had feeding tubes, with a wide variation among states and among facilities within a single state; resident characteristics associated with a greater likelihood of feeding tube use included younger age, nonwhite race, male sex, divorced marital status, lack of an advance directive, a recent decline in functional status, and no diagnosis of Alzheimer disease; residents living in facilities that were for profit, located in an urban area, had more than 100 beds, and lacked a special dementia care unit had a higher likelihood of having a feeding tube].

c. David J. Doukas & John Hardwig, *Using the Family Covenant in Planning End-of-Life Care: Obligations and Promises of Patients, Families, and Physicians*, 51 J. Am. Geriatrics Soc'y 1155 (2003) [authors propose a process by which a patient's physician facilitates discussion of the patient's end-of-life care preferences between the patient and his or her family members, leading to mutual promises as to what each party will do if certain situations arise].

d. Bregie D. Onwuteaka-Philipsen et al., *Euthanasia and Other End-of-Life Decisions in the Netherlands in 1990, 1995, and 2001*, 362 Lancet 395 (2003) [authors use physician interviews and death-certificate studies to present new data on the rate in 2001 of euthanasia, physician-assisted suicide, and other end-of-life decisions in the Netherlands, as well as a longitudinal analysis of decisionmaking practices during 1990-2001; the rate of euthanasia and physician-assisted suicide remained stable over this period, although physicians became somewhat more restrictive in their practices; euthanasia remained much more common than physician-assisted suicide].

e. Charles L. Sprung et al., *End-of-Life Practices in European Intensive Care Units: The Ethicus Study*, 290 JAMA 790 (2003) [researchers who studied 31,417 patients admitted to intensive care units in 17 European countries during January 1999 through June 2000 found that 10% had a limitation of life-sustaining treatment; however, substantial variation was found among countries, associated with region and religion; seven countries reported active shortening of the dying process in a total of 2% of deaths].

f. Alberto Giannini et al., *End-of-Life Decisions in Intensive Care Units: Attitudes of Physicians in an Italian Urban Setting*, 29 Intensive Care Med. 1902 (2003) [2001 survey of 225 intensivists in all 20 ICUs in Milan, Italy, showed that the decision to forgo life-sustaining treatment was less frequent than in other countries, generally was made by the medical team, often was not noted in the patient's clinical record, and was not preceded by ethical consultation; that most respondents were unfamiliar with advance directives; and that deliberate use of lethal doses of drugs was admitted by 3.6% of respondents and considered ethically acceptable by 15.8%].

INTERNATIONAL DEVELOPMENTS

1. Australia

a. West Australia. In 2002, Robin Chapple of the Greens party introduced in the West Australian Upper House a private member's bill that would legalize voluntary euthanasia. In October 2003, Chapple predicted that the Upper House would vote on the bill early in 2004 and said that Upper House views appeared to be equally divided. The bill provides for an 18-month medically-supervised voluntary euthanasia trial.

b. New South Wales. In November 2003, the New South Wales Upper House rejected, by a vote of 28-4, a Greens party bill to allow a referendum on voluntary euthanasia.