Recent Developments in Physician-Assisted Suicide

June 2002

LITIGATION

1. *Cooley v. Granholm*, No. 99-CV-75484 (E.D. Mich.), appeal pending, No. 01-1067 (6th Cir.). On 11/12/99, Professor Robert Sedler filed a federal lawsuit against Attorney General Jennifer Granholm and the Michigan Board of Medicine on behalf of two Michigan physicians, Roy Cooley and M.W. El-Nachef. The plaintiffs claimed that MichiganÕs ban on assisted suicide violates the Fourteenth Amendment right Òto be relieved from unbearable pain and suffering.Ó On 12/20/00, Judge Nancy G. Edmunds granted the defendantsÕ motion for summary judgment and dismissed the complaint. On 1/12/01, plaintiffs appealed to the Sixth Circuit Court of Appeals. On 5/2/02, the case was argued before Judges Merritt, Suhrheinrich, and Gilman.

2. *Oregon v. Ashcroft*, 192 F.Supp.2d 1077 (D.Or. 2002)

    a. Case filed. On 11/7/01, in response to Attorney General John AshcroftÕs directive that prescribing lethal medication was not a legitimate medical purpose under the Controlled Substances Act (CSA), 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.

        (1) Intervenors. The court allowed several individual patient plaintiffs, a physician, and a pharmacist to intervene as plaintiffs supporting the position of the state of Oregon. A number of individual patient plaintiffs died after the suit was filed.

        (2) Defendants. Named defendants include 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.

        (3) Class action. On 11/16/01, plaintiff-intervenors filed a motion to certify the case as a class action.

        (4) Amicus briefs. The court allowed the following organizations to file amicus briefs: Physicians for Compassionate Care, Not Dead Yet, American Center for Law and Justice, National Right to Life Committee, Oregon Right to Life, the American Academy of Pain Management, Coalition of Distinguished Pain and Palliative Care Professionals, ACLU Foundation of Oregon, New York Physicians, Surviving Family Members in Support of OregonÕs Death with Dignity Act, Family Research Council, Association of the Bar of the City of New York, Autonomy, Inc., California Medical Association, American Geriatrics Society, San Francisco Medical Society, Society of General Internal Medicine, and Coalition of Mental Health Professionals.

    b. Temporary restraining order granted. After a hearing on 11/8/01, Judge Robert E. Jones granted a temporary restraining order preventing enforcement of AshcroftÕs directive for a period of 10 days.

    c. Temporary restraining order extended. On 11/20/01, Judge Jones conducted a second hearing. The parties then stipulated that the temporary restraining order could be extended to allow the court to proceed directly to consideration of the plaintiffsÕ motion for a permanent injunction. Judge Jones also ordered that AshcroftÕs directive would be unenforceable pending further court order.

    d. Permanent injunction granted. On 3/22/02, Judge Jones held a hearing on the motions for summary judgment filed by plaintiff and plaintiff-intervenors and the cross-motion for summary judgment and motion to dismiss filed by defendants. Judge Jones indicated during the hearing that he intended to decide the

case on a Òsubconstitutional levelÓ and would issue his decision between 4/17 and 4/19/02. On 4/17/02, Judge Jones issued his written decision in favor of plaintiff and plaintiff-intervenors. Judge Jones permanently enjoined defendants from Òenforcing, applying, or otherwise giving any legal effect toÓ AshcroftÕs directive and ordered that health care providers in Oregon Òshall 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.Ó

(1) Jurisdiction. Defendants argued that the district court lacked jurisdiction because AshcroftÕs directive constituted Òfinal determinations, findings, and conclusionsÓ of the Attorney General within the meaning of 21 U.S.C. ¤ 877, giving exclusive jurisdiction to the courts of appeals. As a result, defendants argued, Judge JonesÕ earlier orders in the case were void. Although Judge Jones said that Òthe correct answer to this question is by no means clear,Ó he rejected this argument on the ground that the statute seems to apply only to a quasi-judicial determination that resolves disputed facts in a specific case after some level of administrative proceedings that has produced an administrative record that can be considered by the court. However, because the Ninth Circuit Court of Appeals could decide otherwise on appeal, Judge Jones also noted that defendants had agreed at the hearing that plaintiff's suit was timely filed and that, if the district court lacked jurisdiction, transfer to the Ninth Circuit would be appropriate under 28 U.S.C. ¤ 1631.

(2) Standing. Defendants earlier had argued that the state of Oregon lacked standing to bring the suit. Although defendants did not pursue this argument at the hearing, Judge Jones (in order Òto put this matter firmly to restÓ) found that the state of Oregon met the statutory and constitutional requirements for standing. Judge Jones also noted that the defendants had not challenged the standing of the patient plaintiff-intervenors and had agreed at the hearing to permit patients to join as parties if necessary due to additional deaths. Thus, in lieu of class certification, he enjoined defendants from objecting to future addition or substitution of patient plaintiff-intervenors.

(3) Statutory arguments. Judge Jones based his decision on statutory grounds exclusively. Defendants argued that the Attorney General was authorized to issue his directive by the federal Controlled Substances Act and its implementing regulations. Judge Jones, however, ruled that neither the plain language of the Act, its legislative history, nor the cases cited supported defendantsÕ argument that Congress intended to delegate to the Attorney General the authority to override a stateÕs determination as to the ÒlegitimacyÓ of a medical practice.

(4) Administrative arguments. Plaintiff and plaintiff-intervenors argued that AshcroftÕs directive was not an interpretive rule, but a substantive rule, and therefore was invalid for failure to follow the formal rule-making procedures required by the Administrative Procedures Act. Although Judge Jones said that ÒI tend to agree withÓ this argument, he found the argument to be moot in light of his ruling on the statutory issues.

(5) Constituional arguments. Plaintiff and plaintiff-intervenors argued that Congress has no constitutional authority under the Commerce Clause to regulate the medical practices of Oregon physicians and pharmacists, that any attempt by Congress to invalidate medical practices authorized by Oregon law would be unconstitutional under the Tenth Amendment, and that AshcroftÕs directive violated the Fifth Amendment due process right of patients to adequate palliative care, including terminal sedation. Judge Jones found these arguments to be moot in light of his ruling on the statutory issues.

e. Request for attorney fees. On 5/1/02, patient plaintiff-intervenors filed a motion requesting that they be awarded attorney fees and costs in the amount of $1,036,272.01. In an order issued on 5/3/02, Judge Jones sua sponte struck the request to the extent it sought fees at market rates, because the record did not support a finding of Òbad faithÓ on the part of the defendants, and gave counsel 20 days to submit a revised request using the hourly rates set forth in 28 U.S.C. ¤ 2412(d). The order also said, ÒCounsel should reconsider whether the services of 49 attorneys and legal assistants during less than five months of litigation can be justified as reasonably necessary to address the key issues in this case.Ó On 5/23/02, patient plaintiff-intervenors filed a revised application for attorneysÕ fees and costs in the amount of $741,835.97.

f. Appeal. On 5/28/02, defendants filed a notice of appeal to the Ninth Circuit Court of Appeals (a process which is likely to take at least 18 months). The losing side is expected to seek review by the United States Supreme Court.

LEGISLATION

1. Hawaii. On 3/7/02, the Hawaii House passed by a vote of 30-20 two bills relating to physician-assisted suicide. HB 2487 would adopt the Hawaii Death with Dignity Act, patterned after the Oregon Death with Dignity Act. HB 2491 would refer to the voters a proposed amendment to Article I of the state constitution, explicitly recognizing the legislatureÕs authority to pass legislation authorizing physician-assisted suicide. Senate Health Committee chair David Matsura initially refused to hold hearings on the bills, but the Senate voted 15-10 to recall HB 2487 to the floor. At the second reading of the bill on 4/30/02, the Senate voted 13-12 in favor of the bill. However, at the final reading on 5/2/02, the Senate voted 11-14 against HB 2487. The proposed legislation, which was supported by Governor Benjamin J. Cayetano, was consistent with the 1998 recommendations of the governorÕs Blue Ribbon Panel on Living and Dying with Dignity.

2. Ohio. On 5/21/02, the Ohio House passed HB 474 by a vote of 83-7. The bill would declare that assisting suicide is against the public policy of Ohio and create the Compassionate Care Task Force to study and make recommendations on pain and symptom control treatment for patients with terminal illness or severe chronic pain.

3. Oregon.

    a. Directive issued by U.S. Attorney General John Ashcroft. On 11/6/01, Attorney General John Ashcroft sent a letter to the Drug Enforcement Administration (DEA) determining that assisting suicide is not a Òlegitimate medical purposeÓ under the Controlled Substances Act and that a physicianÕs license to prescribe is subject to suspension or revocation if the physician prescribes lethal medication for assisting suicide. The determination was to become effective as an interpretive rule on 11/9/01, when it was published in the Federal Register. 66 Fed. Reg. 56,607 (Nov. 9, 2001). The Attorney General directed the DEA to enforce and apply this determination notwithstanding the 6/5/98 letter from former Attorney General Janet Reno overruling an earlier determination by the DEA Administrator that assisting suicide was not a legitimate medical purpose. AshcroftÕs directive stated that the reinstated determination Òmakes no change in the current standards and practices of the DEA in any State other than OregonÓ and claimed that the Department of Justice has the authority to obtain copies of confidential documents filed with Oregon Health Services (formerly the Oregon Health Division) when an assisted suicide occurs. As a result of a lawsuit filed by the state of Oregon, however, enforcement of the Ashcroft directive was permanently enjoined by Judge Robert E. Jones on 4/17/02. Oregon v. Ashcroft, 192 F.Supp.2d 1077 (D.Or. 2002).

    b. Initiative abandoned. On 4/3/02, Oregon Citizens Alliance chairman Lon Mabon said that the OCA would not pursue an initiative called the Divine Life Sovereignty Amendment, which would have amended the Oregon constitution to ban abortion and physician-assisted suicide.

OTHER NATIONAL DEVELOPMENTS

1. Dr. Jack Kevorkian

    a. Criminal conviction affirmed. On 3/26/99, Dr. Jack Kevorkian was convicted by a jury of second-degree murder and illegal delivery of a controlled substance in connection with the death of Thomas Youk by lethal injection. Kevorkian will not be eligible for parole until May 2007. On 11/12/99, Kevorkian filed an appeal with the Michigan Court of Appeals to reverse his conviction and dismiss the case or order a new trial. A hearing on the appeal was held on 9/11/01 before a 3-judge panel of the Michigan Court of Appeals. On 11/20/01, the panel unanimously affirmed KevorkianÕs conviction, rejecting his claims that euthanasia is legal, that a prosecutor improperly referred to KevorkianÕs failure to testify, that he received ineffective assistance of counsel, and that the court improperly excluded the testimony of YoukÕs brother and sister-in-law. People v. Kevorkian, 248 Mich.App. 373, 639 N.W.2d 291 (2001). On 4/9/02, the Michigan Supreme Court declined to review the case by a 6-1 vote. People v. Kevorkian, 642 N.W.2d 681 (2002). KevorkianÕs attorney, Mayer Morganroth, has indicated that the case will be appealed to the federal courts.

    b. Request for release pending appeal. On 12/27/00, Jack KevorkianÕs attorney Mayer Morganroth filed a petition for writ of habeas corpus in U.S. District Court contending that Kevorkian should be released from prison while his murder conviction is appealed, because he is at risk of a stroke, he poses no threat to the public, and the issues on appeal have strong merit. On 6/22/01, U.S. District Judge Paul Borman denied KevorkianÕs request, finding that delay in hearing the appeal did not of itself require the federal courts to intervene. Kevorkian v. Ludwick, No. 00-CV-75557 (E.D. Mich.), appeal pending, No. 01-2010 (6th Cir.).

Briefing on the appeal was completed on 2/8/02, and the parties have requested oral argument.

2. Illinois physicianÕs license ordered reinstated. In November 1999, the Illinois medical board suspended indefinitely the medical license of Chicago cardiologist Dr. Lance Wilson. Wilson was charged with causing the death of Henry Taylor on 9/28/98 at Olympia Fields Osteopathic Hospital and Medical Center by an injection of potassium chloride, which Wilson claimed was intended merely to slow TaylorÕs heart so he would fall unconscious and not suffer through his own painful suffocation after his trachea collapsed. In April 2002, Cook County Judge Bernetta Bush ordered the reinstatement of WilsonÕs license, but the medical board is expected to appeal the ruling. A malpractice suit against Wilson is scheduled for a jury trial in June 2002.

3. Public opinion poll. In a national Gallup telephone poll of 1,012 adults conducted May 6-9, 2002, on moral values in the United States, 50% of respondents indicated that doctor-assisted suicide is morally acceptable and 44% that it is morally wrong.

MEDICAL DEVELOPMENTS

1. Medicare project to manage chronically ill patients. On 2/21/02, the Centers for Medicare and Medicaid Services announced the launching of a three-year project for disease management of chronically ill patients. The agency is soliciting proposals for projects for patients with advanced-stage congestive heart failure, diabetes, or coronary heart disease that will provide some prescription drug coverage and coordinate their care.

2. Pain and the Law website. On 2/28/02, the American Society of Law, Medicine & Ethics and the Center for Health Law Studies at St. Louis University announced the launching of the Pain and the Law Website, at http://www.painandthelaw.org, which was developed through a grant from the Mayday Fund. The website provides a comprehensive collection of materials and commentary on the legal and professional issues raised by the treatment of pain. Sections of the site include Statutes & Regulations, Malpractice & Civil Actions, Palliative Care & Criminal Action, and Entitlement Programs.

3. Quality of life questionnaire. Dr. Robin Cohen, assistant professor of oncology and medicine at McGill University in Montreal, Canada, and researcher at the Palliative Care service of the McGill University Health Centre, has developed the ÒMcGill Quality of Life (MQOL) QuestionnaireÓ with Dr. Balfour Mount, a professor and the Eric M. Flanders chair of Palliative Medicine at McGill. The questionnaire measures existential, physical, psychological, and social well-being of terminally ill patients.

4. Pain management recommendations. On 5/9/02, the American Geriatrics Society released new clinical guidelines on ÒThe Management of Persistent Pain in Older Persons.Ó The recommendations from a panel of pain experts are based on recent research and clinical experience and update earlier guidelines issued in 1998. Key recommendations include comprehensive assessment of pain, discontinuance of placebos in clinical practice, use of the most effective pain medications, individualized programs of physical activity, patient and caregiver education, and quality assurance in health care facilities. The guidelines will be published in the June Supplement Issue of The Journal of the American Geriatrics Society, Volume 50, No. 6, pp. 1-20. Information on the guidelines is available on two websites: http://www.americangeriatrics.org and http://www.healthinaging.org.

5. Recent articles

    a. Elliot D. Cohen, *Permitted Suicide: Model Rules for Mental Health Counseling*, 23 J. Mental Health Counseling 279 (2001) [author makes a case for permitting suicide for clients who rationally desire to end their lives due to serious, irremediable illness, and proposes ten model rules for permitting suicide in mental health practice].

    b. Pekka Mþntyselkþ et al., *PatientsÕ Versus General PractitionersÕ Assessments of Pain Intensity in Primary Care Patients with Non-Cancer Pain*, 51 J. Royal College Gen. Prac. 995 (2001) [data gathered from 738 patients who visited 28 general practitioners throughout Finland during 1996 because of pain showed that physicians tended to estimate their patientsÕ pain intensity significantly lower than the patients themselves, particularly in chronic and severe pain].

    c. Thomas A. Cavaliere et al., *Attitudes of Osteopathic Physicians Toward Physician-Assisted Suicide*, 102 J. Am. Osteopathic AssÕn 27 (2002) [national survey of 1,028 osteopathic physicians revealed greater opposition to physician-assisted suicide than shown in prior surveys of other physicians; 58% of those responding would not be willing to prescribe lethal medication to a terminally ill patient, and 55% would oppose legalization of physician-assisted suicide; if physician-assisted suicide were legal, 29% would comply with a patientÕs request for lethal medication, 34% would refer the patient to a physician who would be willing to write the prescription, and 37% would neither write the prescription nor refer the patient].

d. Ezekiel J. Emanuel, *Euthanasia and Physician-Assisted Suicide: A Review of the Empirical Data from the United States*, 162 Archives Internal Med. 142 (2002) [author reviews existing empirical data about attitudes and experiences of the public, physicians, other health care professionals, and patients in the United States and suggests questions in need of additional empirical research].

e. Ceiran OÕNeill et al., *Attitudes to Physician and Family Assisted Suicide: Results from a Study of Public Attitudes in Britain*, 28 J. Med. Ethics 52 (2002) [data extracted from the 1994 British Social Attitudes Survey showed that 84% of the nearly 1,000 respondents supported legalization of physician-assisted suicide and 54% supported legalization of family-assisted suicide for patients with a painful incurable disease].

f. Susan C. Miller et al., *Does Receipt of Hospice Care in Nursing Homes Improve the Management of Pain at the End of Life?*, 50 J. Am. Geriatrics SocÕy 507 (2002) [researchers compared pain management of nursing home residents based on hospice enrollment by analyzing Minimum Data Sets (MDS) assessments of 2,644 hospice and 7,929 nonhospice residents who died in over 800 nursing home in five states before April 1997; 15% of hospice residents and 23% of nonhospice residents who were in daily pain received no pain medication, 51% of hospice residents and 33% of nonhospice residents received regular treatment for daily pain, and hospice residents were more likely than nonhospice residents to receive morphine derivatives].

g. Terri R. Fried, *Understanding the Treatment Preferences of Seriously Ill Patients*, 346 New Eng. J. Med. 1061 (2002) [questionnaire about treatment preferences administered to 226 persons who were 60 years of age or older and who had limited life expectancy due to cancer, congestive heart failure, or chronic obstructive pulmonary disease showed that treatment preferences were affected by the burden of treatment, the possible outcomes, and their likelihood; 74.4% of those surveyed did not want low-burden treatment if the outcome was survival with severe functional impairment, and 88.8% did not want low-burden treatment if the outcome was survival with severe cognitive impairment; many patients would refuse low-burden treatment with even a 50% chance of severe functional or cognitive impairment].

h. Jan H. Veldink et al., *Euthanasia and Physician-Assisted Suicide Among Patients with Amyotrophic Lateral Sclerosis in the Netherlands*, 346 New. Eng. J. Med. 1638 (2002) [questionnaire completed by physicians of 203 patients in the Netherlands with a diagnosis of ALS who died during 1994-98 showed that 17% of patients died by active euthanasia and an additional 3% by physician-assisted suicide, a rate much higher than that for cancer patients; an additional 24% of patients died after their symptoms were treated with doses of medication that probably shortened the patientÕs life; patients who chose physician-assisted death were similar to other ALS patients except that the patients choosing assisted death were more likely to die at home, less likely to place importance on religion, and less likely to feel anxious].

i. Linda Ganzini & Susan Block, Editorial, *Physician-Assisted DeathÑA Last Resort?*, 346 New Eng. J. Med. 1663 (2002) [suggesting that the high rate of physician-assisted death among ALS patients warrants studies of symptom management, quality of life, the experience of patients, and interventions to reduce suffering].

INTERNATIONAL DEVELOPMENTS

1. Australia

a. Claim of botched euthanasia attempts. In March 2002, Dr. Roger Magnusson, a senior lecturer in law at Sydney University, claimed that 19% of euthanasia cases involving HIV/AIDS patients of 49 physicians did not work out as planned, requiring the patient to be strangled or suffocated instead.

b. Nancy Crick, a 69-year-old resident of Queensland with bowel cancer, established a website (http://www.protection.net.au/nancycrick/) to chronicle the rest of her life by diary entries and photographs. After announcing her intention to end her life with lethal medication on April 10, she later delayed the date to see if better palliative care could relieve her pain. However, she ended her life on 5/22/02 in the presence of 21 family, friends, and supporters of voluntary euthanasia (ÒNancyÕs FriendsÓ) with the intent of challenging laws against assisting a suicide. Police are investigating the case for possible criminal prosecution. Queensland Premier Peter Beattie said he sympathized with Crick but would not support changing the law.

c. Other public suicides. Following Nancy CrickÕs death, a number of terminally ill patients are considering

going public with their planned suicides to keep up pressure over euthanasia reform. On 5/24/02, the niece of 85-year-old Arthur Schilperoord announced that he took his life by maneuvering his wheelchair off a Perth jetty on 4/29/02 because he suffered from throat cancer but could not get physicians to help him die.

d. Australian Medical Association. In a secret ballot at the national conference of the Australian Medical Association on 5/27/02, members rejected 34-79 a proposal that the organization adopt a neutral position on the issue of voluntary euthanasia. However, the conference passed by a vote of 65-48 a resolution that the AMA support physicians whose Òprimary intent is to relieve the suffering and distress of terminally ill patients in accordance with patientsÕ wishes and interests, even though a foreseen secondary consequence is the hastening of death.Ó The wording of the draft resolutions could still be changed before being adopted by the federal council.

e. National parliament. Greens Senator Bob Brown has announced that he will introduce a private memberÕs bill to allow voluntary euthanasia sometime after the Senate begins meeting on 8/19/02.

f. New South Wales. In March 2002, the upper house of the New South Wales parliament rejected by a vote of 26-9 the Rights of the Terminally Ill Bill, which would have permitted voluntary euthanasia.

g. South Australia. On 5/8/02, Sandra Kanck, deputy leader of the South Australian Democrats, introduced voluntary euthanasia legislation in the South Australian parliament. The Dignity in Dying Bill, which is essentially the same as a bill Kanck introduced without success the prior year, would allow the terminally ill to choose to end their lives but only under the strict guidance of a monitoring committee.

h. West Australia. Following Nancy CrickÕs suicide, Greens MP Robin Chapple announced that the West Australian Greens will introduce a voluntary euthanasia bill in the state parliament before the end of 2002. Chapple said that any bill probably would not be debated for up to two years because of the already-packed legislative agenda.

2. Belgium

a. Euthanasia bill passes. On 5/16/02, the Belgian House of Representatives approved by a vote of 86-51, with 10 abstentions, a bill legalizing euthanasia for competent adults with an incurable illness causing unbearable and constant suffering, as well as for patients in a persistent vegetative state who had made a request within the prior five years before two witnesses to have their life ended in such circumstances. A national evaluation committee of physicians and lawyers will be set up to ensure that the law is followed. The opinion of a second physician will be required for a terminally ill patient. In the case of a patient who is not terminally ill, the opinion of a third physician (either a psychiatrist or a specialist in the patientÕs illness) will be required, and at least one month will have to elapse between the patientÕs request and the act of euthanasia. The Belgian Senate had approved the bill on 10/25/01 by a vote of 44-23, with two abstentions. The Christian Democrats have announced that they will fight the new law in court.

b. Newspaper poll. Despite BelgiumÕs strong Catholic culture, the newspaper La Libre Belgique found that 72% of Belgians were in favor of adopting the new euthanasia law.

3. Canada

a. Robert Latimer. Supporters of Robert Latimer continue to protest his life sentence, without possibility of parole for 10 years, for the mercy killing of his disabled 12-year-old daughter. In March 2002, the Supreme Court of Canada announced that it would treat the letters and other documents received from Latimer as a motion for rehearing.

b. Jim Wakeford. On 2/7/01, provincial Justice Katherine Swinton dismissed a constitutional lawsuit filed by AIDS activist Jim Wakeford, who had sought the right to die with the help of a physician. Justice Swinton found that it was Òplain and obviousÓ that the suit could not succeed in light of the Supreme CourtÕs decision in the Sue Rodriguez case. In April 2002, the Supreme Court refused to consider WakefordÕs appeal.

c. New technology. John Hofsess, research coordinator for NuTech, has reported on development of a device known as the Òblue boxÓ that can be used by patients wishing to end their lives. Like the ÒDeBreather,Ó the blue box can be placed inside an ÒExit BagÓ and makes death by oxygen depletion a comfortable process.

4. Denmark. A poll carried out by PLS Ramboell for the Danish newspaper Jyllands-Posten showed that 68% of the 999 respondents were in favor of euthanasia, 20% were opposed, and 12% were undecided. In addition, the following percentages of respondents favored allowing euthanasia to help terminally ill patients (93%), patients with incurable illnesses (82%), the aged (41%), handicapped persons (30%), and mentally ill individuals (20%).

5. France. On 5/19/02, Dominique Knockaert, a 44-year-old Frenchwoman with motor neurone disease, called for

the French parliament to debate euthanasia in the hope that France will become the third European country to legalize it.

6. Great Britain

    a. Diane Pretty. In June 2001, Brian Pretty wrote a letter to Prime Minister Tony Blair asking that a physician be allowed to help his 42-year-old wife Diane die because of her motor neurone disease. When Blair declined to help and Mrs. PrettyÕs condition deteriorated further, she appealed to Director of Public Prosecutions David Calvert-Smith to guarantee that her husband would not be prosecuted if he assisted her to take her own life. In August 2001, after Calvert-Smith refused to give any guarantee, Mrs. Pretty appealed to the High Court in London arguing that his refusal violated her rights under the European Convention on Human Rights. After a hearing, the High Court ruled on 10/18/01 that the law did not allow a family member to help a loved one to die. On 11/29/01, the five law lords of the House of Lords affirmed the High CourtÕs decision. On 3/19/02, Mrs. PrettyÕs appeal was argued before the European Court of Human Rights, which had given expedited consideration to the case. On 4/29/02, a seven-judge panel of the court unanimously ruled against Mrs. Pretty. The decision is reported at http://www.echr.coe.int/Eng/Judgments.htm. With the backing of the Voluntary Euthanasia Society, the couple asked the public to sign an Internet petition (http://www.Justice4Diane.org.uk) to encourage a change in the law. Mrs. Pretty died of her disease on 5/11/02.

    b. Phil Such. In February 2002, Phil Such, a 37-year-old man from Somerset who suffers from motor neurone disease, began a hunger strike in an effort to change the law banning voluntary euthanasia.

    c. Court grants womanÕs request to have ventilator withdrawn. On 3/22/02, Dame Elizabeth Butler-Sloss, judge of the High Court, held that a 43-year-old quadriplegic woman (identified only as ÒMiss BÓ) was competent to direct that her ventilator be withdrawn so that she could be allowed to die. In addition, the judge awarded her 100 pounds nominal damages and 55,000 pounds in agreed costs. The womanÕs lawyers argued that the woman had the right to refuse life-prolonging treatment under the European Convention on Human Rights, but her treating physicians said it would be against their professional ethics to turn off the ventilator. The hospital involved said that it would not appeal the decision, and the woman died on 4/24/02 after the ventilator was withdrawn.

    d. Possible parliamentary debate. A cross-party parliamentary group, Compassion in Dying, is pressing for a debate in parliament on the issues raised by the Diane Pretty case.

    e. General Medical Council guidelines. BritainÕs General Medical Council is considering a draft code of practice that would clarify the ethics of withdrawing and withholding treatment from patients with little chance of recovery. On 4/30/02, the councilÕs working group issued draft guidance stating that physicians are legally bound to accept the decisions of a competent patient. The council said that the case of ÒMiss BÓ was one where the guidelines would be particularly applicable.

    f. Public opinion poll. A survey of 1,000 British adults conducted for Channel 4Õs Powerhouse and released on 3/19/02 showed that 65% believed that family physicians should be able to assist in ending the life of terminally ill patients who wish to die, while 29% disagreed. In addition, 55% approved of a close relative being given the same right, while 37% disagreed.

7. Japan. On 4/19/02, officials at Kawasaki Kyodo Hospital, south of Tokyo, said that a female physician killed a man in his 50Õs in 1998 by injecting a muscle relaxant after the patient suffered a cardiac arrest and lapsed into a coma following an asthma attack. The hospital reported the case to the Kanagawa prefectural police after concluding that the physician had not complied with the requirements set out in a 1995 ruling of the Yokohama District Court involving a hospital affiliated with the School of Medicine at Tokai University. In particular, the patient had not expressed his clear approval of the euthanasia. An in-house hospital committee later concluded that a nurse, acting under the physicianÕs orders, had administered the injection.

8. Thailand. A draft National Health Bill includes the following language: ÒA person has the right to decide on treatment methods or reject treatment in the last period of his or her life, in order to die in peace and with dignity as a human being.Ó Amphon Jindawatthana, director of the Health Systems Reform Office responsible for drafting the bill, has said that the bill would not allow euthanasia but merely permit end-stage patients to choose whether to accept or reject treatment. The proposal is raising controversy in the legal and medical communities in Thailand.

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* Some information obtained from media reports has not been independently verified.