Recent Developments in Physician-Assisted Suicide

October 2004

LITIGATION

1. *Oregon v. Ashcroft*, 368 F.3d 1118 (9th Cir. 2004), aff'd 192 F.Supp.2d 1077 (D.Or. 2002)

   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 (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. The court allowed several individual patients, a physician, and a pharmacist to intervene as plaintiffs supporting the position of the state of Oregon.

   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 CSA, 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.

   c. Appeal to Ninth Circuit. On 5/24/02, defendants filed a notice of appeal to the Ninth Circuit Court of Appeals. The case was argued on 5/7/03 before a three-judge panel, which issued its decision on 5/26/04. *Oregon v. Ashcroft*, 368 F.3d 1118 (9th Cir. 2004).

   d. Ninth Circuit decision. The three-judge Court of Appeals panel affirmed the U.S. District Court by a vote of 2 to 1, holding that the Ashcroft directive was "unlawful and unenforceable" and ordering that the injunction of the U.S. District Court be "continued in full force and effect."

      (1) Jurisdiction. All three judges agreed that original jurisdiction was in the Court of Appeals, rather than in the District Court, but found that Judge Jones' order properly transferred jurisdiction.

      (2) Majority opinion. Judge Tallman wrote the majority opinion, with which Judge Lay concurred. The majority held that Congress did not authorize the Attorney General to determine that physician-assisted suicide violates the CSA. Specifically, (1) Congress did not clearly authorize the Attorney General to exercise control over regulation of medical care, which is an area traditionally reserved for state authority; (2) the Ashcroft directive contradicted the plain language of the CSA; and (3) the directive contravened the express intent of Congress. The majority opinion criticizes the Attorney General for failing to solicit input from the State of Oregon, imposing a sweeping and unpersuasive interpretation of the CSA despite lack of medical expertise, and interfering with the democratic debate about physician-assisted suicide.

(3) Dissenting opinion. Judge Wallace dissented on the ground that the Attorney General's directive was an interpretive rule entitled to substantial deference.

e. Ninth Circuit denies review. On 7/12/04, the Attorney General requested a rehearing by the three-judge panel or an en banc review by an 11-judge panel. On 8/11/04, the three-judge panel denied a rehearing by a vote of 2 to 1; en banc review also was denied because no active judge had requested it.

f. Further review. The Attorney General may request review by the U.S. Supreme Court within 90 days after final disposition by the Ninth Circuit (by 11/9/04). The Attorney General is expected to request review despite a 9/27/04 letter from Oregon Governor Ted Kulongoski urging him not to do so.

LEGISLATION

1. North Carolina. On 2/20/03, Senators Jim Forrester and Bill Purcell, both physicians, filed S.B. 145, which would make assisted suicide by a licensed health care professional a Class D felony. Subsequently, the Executive Council of the Elder Law Section of the North Carolina Bar Association adopted a resolution "oppos[ing] enactment of S. 145 or any other felony law that purports to bar 'assisted suicide,'" primarily due to concern that the bill might affect the quality of end-of-life care. The bill was referred to the Judiciary Committee and was not considered further in the 2003-04 session. The Health Law Section and the Estate Planning Section also voted to oppose the bill, and the North Caroline Bar Association's Board of Governors voted in April 2004 to oppose it when reintroduced in the 2004-05 legislative session.

2. Oregon.

   a. Deaths during 2003. On 3/10/04, the Oregon Department of Human Services issued a report on deaths during 2003 under the Oregon Death with Dignity Act. The complete report is available on-line at www.ohd.hr.state.or.us/chs/pas/ar-index.cfm. The report included the following information:

      (1) Prescriptions written. In 2003, 67 prescriptions were written for lethal doses of medication, an increase from 24 prescriptions in 1998, 33 in 1999, 39 in 2000, 44 in 2001, and 58 in 2002.

      (2) Number of patients. In 2003, 42 patients died after taking lethal medication, as compared to 16 patients in 1998, 27 in 1999, 27 in 2000, 21 in 2001, and 38 in 2002. However, the number has remained small compared to the total number of deaths in Oregon, with about 1/7 of 1% of Oregonians dying by physician-assisted suicide. Of the 67 persons who received prescriptions under the Act during 2003, 39 died after taking lethal medication, 18 died from their underlying illness, and 10 were alive as of the end of 2003. An additional two persons who received prescriptions during 2002 and one person who received a prescription during 2001 died after taking their medications in 2003.

      (3) Patient characteristics. Median age of the 42 patients who died was 73, 98% were white, 55% were female, 36% were married, 45% lived in the Portland metropolitan area, and 48% were college graduates. Eighty-three percent of the patients who died had cancer, 93% were enrolled in a hospice program (the other patients were offered hospice but declined), and all patients had health insurance.

      (4) Patient concerns. The most common reasons for choosing assisted suicide expressed by patients to their physicians were loss of autonomy (93%), inability to participate in activities that make life enjoyable (93%), loss of dignity (82%), loss of control of bodily functions (57%), and being a burden on family, friends, or caregivers (38%). Nine patients cited concerns about pain control, and one patient voiced concern about the financial implications of treatment.

      (5) Mental health evaluations. Two of the 42 patients (5%) received a psychiatric or psychological consultation.

      (6) Medical information. The lethal medications used were pentobarbital (88% of patients), secobarbital (10%), and tuinal (2%). The physician was present when the medication was ingested in 29% of cases, with other health care providers present in 48% of cases. Median time from taking the medication to unconsciousness was four minutes (individual times ranged from 1-20 minutes). Median time from taking the medication to death was 20 minutes (individual times ranged from 5 minutes to 48 hours). No patient regained consciousness after taking the medication. Three patients vomited after taking the medication, including one who lived for 48 hours after having ingested only about one-third of the intended dose. One patient fell asleep before taking the entire dose, but died 40 minutes later.

      (7) Physician characteristics. A total of 42 physicians prescribed lethal medications to 67 persons. The physicians' median years in practice was 21.5.

   Oregon Health Division statistics for 2003 generally were consistent with statistics for 1998-2002, although referral to a specialist for a psychiatric or psychological consultation has declined, falling from 31% in 1998 to 5% in 2003. Rates of participation in physician-assisted suicide decrease with age, but are higher among those patients who are divorced or never married, those with more years of education, and those with amyotrophic lateral sclerosis

(Lou Gehrig's disease), HIV/AIDS, or cancer.

b. Statistics from Compassion in Dying. Compassion in Dying of Oregon, which represents almost 80% of the patients who use the Oregon Death with Dignity Act, has additional statistics not charted by the state. Of the 131 people the organization has tracked who have used the law, 50 said they were Republicans, 49 Democrats, 15 other, and 17 unknown. As to religious affiliation, 41 said they were nonsectarian, 20 Protestant, six Jewish, six Catholic, 55 no preference, and three unknown.

c. New York Times. On 6/1/04, the New York Times published an article by John Schwartz and James Estrin on Oregon's experience under the Oregon Death with Dignity Act. The article quoted Ann Jackson, executive director of the Oregon Hospice Association, who said that the organization initially opposed the Act but that hospices now work directly with Compassion in Dying, after surveys showed that half the people who rejected hospice care did so because "they thought that hospice was condescending or arrogant."

d. Constitutional initiative. New Covenant Ministries, a religious organization formed by Oregon Citizens Alliance founder Lon Mabon in 2002, sought to sponsor a citizens' initiative (known as the Divine Sovereignty Life Amendment) to make abortion and physician-assisted suicide unconstitutional in Oregon. However, the organization failed to collect enough signatures to qualify the initiative for the November 2004 ballot.

e. Senator Don Nickles drops fight against Oregon law. Retiring Senator Don Nickles, who tried for years to block implementation of the Oregon Death with Dignity Act, has announced that he will forgo efforts to pass federal legislation similar to prior bills that Congress failed to pass. Senator Nickles said that he saw no need for federal legislation because he expects the law to be declared invalid by the U.S. Supreme Court.

f. Families report greater pain or distress in dying Oregonians. A telephone survey of family caregivers of Oregonians who died during November 1996-December 1997 and June 2000-March 2002 in private homes, nursing homes, and other community-based settings showed that the prevalence of family-reported moderate or severe pain or distress (compared to comfortable or mild pain or distress) in Oregon decedents during the last week of life increased from 30.8% in 1996-97 to 48% in 2000-02. Erik K. Fromme et al., Increased Family Reports of Pain or Distress in Dying Oregonians: 1996 to 2002, 7 J. Palliative Med. 431 (2004). The surveys were conducted two to five months after decedents' deaths with 340 respondents in 1996-97 and 1,384 respondents in 2000-02. The median age of decedents was 81, and the median age of family caregivers was 59-60.5. Decedents were more likely to be reported to be in greater pain or distress if they were female, were younger, died of cancer, died at home, or were enrolled in hospice. Researchers indicated that the increase in reports of pain or distress might be due to higher expectations of patients and families about pain control due to the "media effect" from publicity about physician-assisted suicide and end-of-life care, or to the fact that resources available to patients have been stretched more thinly.

g. Oregonians who consider physician-assisted suicide. A telephone survey of 1,384 family caregivers of Oregonians who died during June 2000-March 2002 asked questions to determine how many dying patients supported physician-assisted suicide, how many considered it as a possibility for themselves, and how many actually requested it. Susan W. Tolle et al., Characteristics and Proportion of Dying Oregonians Who Personally Consider Physician-Assisted Suicide, 15 J. Clinical Ethics 111 (2004). Families reported that 44% of patients favored physician-assisted suicide, 41% opposed it, and 15% were neutral. Seventeen percent of patients personally considered physician-assisted suicide as an option during their terminal illness, but only 2% of patients formally requested a prescription for lethal medication. Patients who considered but did not use physician-assisted suicide were remarkably similar to the 171 Oregonians who have used physician-assisted suicide during the six years since it was legalized, although patients who actually used it tended to have a significantly higher level of education than those who merely considered it.

h. POLST use in Oregon nursing facilities. During 2002, researchers conducted a telephone survey of 146 Oregon nursing facilities and a records review of 356 nursing facility residents aged 65 and older at seven nursing facilities to assess statewide use of the Physician Orders for Life-Sustaining Treatment (POLST) form. Susan E. Hickman et al., Use of the Physician Orders for Life-Sustaining Treatment Program in Oregon Nursing Facilities: Beyond Resuscitation Status, 52 J. Am. Geriatrics Soc'y 1424 (2004). The telephone survey showed 82% of nursing facilities used the POLST program for at least some residents, while 71% used it for at least 50% of residents. In the records review at seven facilities, POLST forms were present in 92% of medical charts. Eighty-eight percent of forms indicated do-not-resuscitate (DNR) orders; 89% limited medical interventions, 42% limited use of antibiotics, and 87% limited artificial nutrition and hydration. DNR status alone did not predict preferences for level of aggressiveness in other categories of treatment. Advanced age was associated with more limits on life-sustaining interventions.

i. POLST use by emergency medical technicians. During 2002, researchers administered an anonymous survey to 572 Oregon emergency medical technicians to evaluate their experiences with the Physician Orders for Life-Sustaining Treatment (POLST) form. Terri A. Schmidt et al., The Physician Orders for Life-Sustaining Treatment Program: Oregon Emergency Medical Technicians' Practical Experiences and Attitudes, 52 J. Am. Geriatrics Soc'y 1430 (2004). Seventy-three percent of respondents had treated a patient with a POLST, and 74% reported receiving education about POLST. When a POLST form existed, treatment changed in 45% of cases. Seventy-five percent of respondents agreed that the POLST form provides clear instructions about patient preferences. While 93% said that the POLST form is useful in determining which treatments to provide when a

patient is in cardiopulmonary arrest, only 63% found it useful in determining treatments when a patient has a pulse and is breathing. Twenty-five percent of respondents reported difficulty in locating the patient's POLST form.

3. Vermont

    a. Reported abuse. At the American Psychiatric Association meeting in May 2004, psychiatrist N. Gregory Hamilton (a vocal opponent of the Oregon Death with Dignity Act) and his wife Catherine presented a paper claiming that the case of Michael Freeland illustrated the potential for serious abuse under the Act.

    b. Prevention of elderly suicides. Oregon is launching a new program aimed at preventing elderly suicide. The Department of Human Services is holding a series of community meetings around Oregon focusing on the issue and seeking to increase awareness of the problem. Program administrators emphasize the difference between elderly suicide and physician-assisted suicide, which is legal in Oregon.

4. Vermont

    a. Two bills introduced. Two bills relating to assisted suicide were introduced in the Vermont General Assembly in February 2003. H. 275 would criminalize assisted suicide. H. 318 was patterned after the Oregon Death with Dignity Act. After considerable public debate, both bills were carried over to the 2004 legislative session.

    b. Current status. 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, supporters of H. 318 are expected to introduce it again next year.

    c. Hearings held. Legislative hearings were held during February 2004 on H. 318 and on ways to improve end-of-life care. In response, the legislature agreed to support an effort by Attorney General William Sorrell to draft a comprehensive end-of-life policy for Vermont. The legislature asked Sorrell to finish his report by 11/15/04.

    d. Legislative research. A letter signed by 78 members of the Vermont House has asked the Legislative Council's office to analyze Oregon's experience with physician-assisted suicide, but to refrain from making any policy recommendations on the matter. William Russell, who heads the Legislative Council, said that his staff would go forward with the analysis despite orders to the contrary from the House Health and Welfare Committee.

OTHER NATIONAL DEVELOPMENTS

1. Organizations to merge. The boards of the Compassion in Dying Federation and End-of-Life Choices (formerly the Hemlock Society) voted in June 2004 to continue negotiating a formal merger, which probably will take place early in 2005. An initial board was formed with equal representation from both organizations. The working name for the new organization is Compassion and Choices. End-of-Life Choices brings 30,000 members and national legislative expertise to the merged organization, while Compassion in Dying brings Oregon's experience with the Oregon Death with Dignity Act and other approaches to good palliative care. One of the goals of the merged group will be to lobby state legislatures to consider proposals for legalizing physician-assisted suicide. A final decision about the proposed merger is expected in late October 2004.

2. Catholic health care providers. On 3/20/04, Pope John Paul II reversed prior Catholic doctrine by announcing that Catholics are "morally obligated" to continue artificial feeding and hydration for patients in a persistent vegetative state, even if they remain so for years. The pope declared that removing feeding tubes is "euthanasia by omission." The decree could affect more than 565 Catholic hospitals, as well as Catholic health care professionals. Compassion in Dying Federation, together with the National Women's Law Center, are conducting a survey to determine the extent to which church doctrine affects respect of patients' wishes about end-of-life care. A copy of the survey can be obtained by calling (503) 221-9556 or downloading it from www.compassionindying.org/nwlc.

3. Film on Dr. Kevorkian. Oscar-winning director Barbara Kopple plans a film on Dr. Jack Kevorkian, which will be based on a 300-page, unpublished manuscript by Michigan authors and Kevorkian friends Neal Nicol and Harry Wylie. Kopple and producer Steve Jones plan to begin shooting in Michigan by early 2005. Jones says his first choice to play the part of Kevorkian is actor Ben Kingsley.

4. Montana physician faces criminal charges. Dr. James Bischoff of Ennis has been charged with homicide in connection with the death of 85-year-old Kathryn Dvarishkis, who died at the Madison Valley Hospital on 7/16/00. Dvarishkis had suffered a heart attack and was suffering from advanced Alzheimer's disease when Bischoff allegedly gave her shots of the drugs Fentanyl and Verced, which stopped her heart. Bischoff claims that Dvarishkis was already brain dead and that her family had asked for four days that she be given a shot to relieve her suffering, but her daughter says that Bischoff initially suggested the shots. Bischoff's medical license was suspended on 8/5/04. Questions about Dvarishkis' death were raised during an investigation by the Drug Enforcement Administration into allegations that Bischoff ordered 48,000

doses of narcotics from a wholesale drug distributor over a year without proper documentation of their intended use. As a result of the DEA investigation, Bischoff's controlled substance registration was suspended in June 2004 and he is charged with three felony counts for the fraudulent obtaining, possession, and illegal distribution of prescription drugs.

5. Gallup poll. In a survey of 1,000 Americans conducted by the Gallup Organization in early May 2004, 53% of respondents said that physician-assisted suicide is morally acceptable, while 41% disagreed. The poll results were released on 6/22/04.

6. Poll of Catholic voters. In a recent poll of Catholic voters on social issues, which was conducted by Catholics for Free Choice, 70% of respondents said that U.S. bishops have little influence on most Catholics in the current political season. Fifty-three percent supported "making it legal for doctors to assist in the death of a terminally ill patient."

MEDICAL DEVELOPMENTS

1. Revised pain treatment policy approved by Federation of State Medical Boards. In May 2004, the House of Delegates of the Federation of State Medical Boards (FSMB) approved revised pain management guidelines, called the Model Policy for the Use of Controlled Substances for the Treatment of Pain. The revised Model Policy replaces FSMB's Model Guidelines, which were approved in April 1998 and subsequently adopted in whole or part by 24 state medical boards. The Model Policy stresses the importance of pain management in the practice of medicine, updates criteria for evaluating the appropriate management of pain, and revises definitions of terms such as addiction, chronic pain, and physical dependence to reflect current consensus in the medical community. Beginning in fall 2004, a series of regional workshops will be offered on "Promoting Balance and Consistency in the Regulatory Oversight of Pain Care."

2. New DEA guidelines on prescribing painkillers. On 8/11/04, the federal Drug Enforcement Administration and top pain specialists jointly issued detailed new guidelines spelling out proper prescribing of morphine-based painkillers, including how to diagnose severe pain. The guidelines, which will be distributed to law enforcement agencies and to all physicians who apply for DEA approval to prescribe controlled substances, are intended to reassure physicians that they will not be prosecuted for prescribing high doses to patients in intractable pain.

3. Margaret Furlong. On 9/8/04, lawyers representing the son of Margaret Furlong argued before the California Second District Court of Appeal that a trial court improperly dismissed claims of elder abuse and unfair business practices in connection with Mrs. Furlong's death on 3/12/02 at St. John's Regional Medical Center in Oxnard, which is operated by Catholic Healthcare West. Ventura County Superior Court Judge Steven Hintz held that the action could only be based on medical negligence. Patrick Furlong claims that the hospital and three physicians acted recklessly in resuscitating Mrs. Furlong after she suffered respiratory and cardiac arrest, and in then maintaining her on life support for 10 days while she was in significant untreated pain. Mrs. Furlong, who was lucid when admitted to the hospital, brought with her advance medical directive documents indicating her wish not to be resuscitated.

4. Recent articles

    a. Angela Fagerlin & Carl E. Schneider, *Enough: The Failure of the Living Will*, 34 Hastings Center Rep. 30 (Mar.-Apr. 2004) [argues that living wills (but not durable powers of attorney for health care) are a failure].

    b. Erik K. Fromme et al., *Increased Family Reports of Pain or Distress in Dying Oregonians: 1996 to 2002*, 7 J. Palliative Med. 431 (2004) [SEE DISCUSSION ABOVE].

    c. Steven B. Hardin & Yasmin A. Yusufaly, *Difficult End-of-Life Decisions: Do Other Factors Trump Advance Directives?*, 164 Archives Internal Med. 1531 (2004) [treatment decisions about six hypothetical seriously ill patients made by 117 internal medicine physicians and residents at three California medical centers revealed that decisions were inconsistent with the patient's advance directive in 65% of cases; respondents appeared to consider other factors such as prognosis, perceived quality of life, and the wishes of family or friends as more determinative than the directive].

    d. Susan W. Tolle et al., *Characteristics and Proportion of Dying Oregonians Who Personally Consider Physician-Assisted Suicide*, 15 J. Clinical Ethics 111 (2004) [SEE DISCUSSION ABOVE].

    e. Susan E. Hickman et al., *Use of the Physician Orders for Life-Sustaining Treatment Program in Oregon Nursing Facilities: Beyond Resuscitation Status*, 52 J. Am. Geriatrics Soc'y 1424 (2004) [SEE DISCUSSION ABOVE].

    f. Terri A. Schmidt et al., *The Physician Orders for Life-Sustaining Treatment Program: Oregon Emergency Medical Technicians' Practical Experiences and Attitudes*, 52 J. Am. Geriatrics Soc'y 1430 (2004) [SEE DISCUSSION ABOVE].

INTERNATIONAL DEVELOPMENTS

1. Australia. Greens party member Robin Chapple is sponsoring a private member's bill in the West Australian parliament that would permit terminally ill patients to choose to die by lethal injection, and would protect from prosecution anyone who witnessed their deaths. The bill is modeled after a bill sponsored by Norm Kelly, a former member of parliament, that failed to pass seven years ago. The Liberal and Labor parties will allow members to make a conscience vote on the issue, but the bill is unlikely to be considered by the parliament in the near future because of other controversial legislation that will be considered first.

2. Belgium. The first report of the Belgian euthanasia supervising committee about the new law legalizing euthanasia, which went into effect in September 2002, showed that 259 terminally ill patients had elected euthanasia through 12/31/03. Eighty-three percent of these patients were from the Flemish-speaking parts of Belgium that border the Netherlands. Forty-eight percent of the patients were age 60-79, 32% age 40-59, 16% above age 79, 3% age 20-39, and 0.5% less than age 20. Senators Jeannine Leduc and Paul Wille, who are members of the ruling Flemish Liberal party, have proposed that Belgium's euthanasia law be extended to terminally ill minors and expanded to cover assisted suicide.

3. Canada. On 6/26/02, Vancouver Island police arrested 71-year-old Evelyn Martens of Langford, British Columbia, on charges of counseling suicide and aiding and abetting suicide in the deaths of Monique Charest on 1/7/02 in Duncan and Leyanne Burchell on 6/26/02 in Vancouver. On 6/27/02, police seized from Martens' home a computer and publications, videos, "exit bags," and other supplies belonging to the Right to Die Network of Canada and Last Rights Publications. Preliminary arguments in Martens' trial began in Duncan on 9/20/04, and the jury trial began on 10/12/04. Trial is expected to last three weeks, and the judge has ordered a publication ban until the jury has reached a verdict. The maximum penalty on each charge is 14 years imprisonment. Right-to-die groups across Canada have raised about $170,000 for a defense fund for Martens.

4. China. A subcommittee of the Law Reform Commission in South China (Hong Kong) recommended in a report in July 2004 that citizens be permitted to execute living wills and that the Mental Health Ordinance be amended to permit family members of comatose patients to seek legal guardianship to make medical decisions. However, legislators decided that the subcommittee should focus on educating the public about advance directives and only consider legislation when there was a demand. The public is being consulted for three months about the report, which is available at www.info.gov.hk/hkreform.

5. France. France's Health Minister Philippe Douste-Blazy is supporting new laws to assure patients a dignified and painless death after issuance of a parliamentary report commissioned following the highly publicized death of 22-year-old Vincent Humbert, whose mother allegedly gave him a lethal injection after President Jacques Chirac denied his request to die. The report said that France should not legalize voluntary euthanasia as Belgium and the Netherlands had done, but instead should allow patients or their families to choose to end treatments that simply delay death. Jean Leonetti, former chief of the parliamentary commission on euthanasia and a member of the majority UMP party, said that legislation proposed by his party would respect the autonomy of patients and provide legal protection to physicians. The draft law would change the code of medical ethics and the public health code. The measure is expected to be discussed in the National Assembly by the end of 2004. Faut qu'on s'active! (We have to take action!), an association backed by Humbert's mother, says that the proposal is not sufficient and has presented its own initiative that would authorize euthanasia under the French penal code.

6. Great Britain

    a. Proposed assisted suicide legislation. In September 2004, a select committee of the House of Lords began considering testimony on the issues raised by the Patient (Assisted Dying) Bill (HL 37) introduced on 2/20/03 by Lord Joffe. One of the experts submitting evidence was Dr. Hazel Biggs, director of medical law at the University of Kent and one of the country's leading experts on euthanasia, who claimed in an article submitted to the European Journal for Health Law that British physicians help at least 18,000 terminally ill patients to die each year. The Royal College of Nursing agreed to reconsider its opposition to voluntary euthanasia after pressure from members, but decided not to change its position after a large majority of its members voted against doing so. The Church of England House of Bishops and the Roman Catholic Bishops' Conference of England and Wales made a joint submission to the select committee arguing that Lord Joffe's bill was misguided and unnecessary. Win Crew, the widow of a motor-neurone patient who flew to Switzerland to commit assisted suicide, presented a petition to the committee signed by more than 80,000 supporters of the bill. The Voluntary Euthanasia Society also released the results of a poll of 790 adults conducted by National Opinion Poll showing that 47% would help a loved one die if they were suffering unbearably, 35% said they would not, and the rest were undecided; 82% of those polled supported a change in the law on medically-assisted dying, 11% disagreed, and the remainder were undecided; and 50% of all respondents and 58% of those living in the northwest would be willing to travel abroad to seek assisted suicide, 40% would not be willing, and the rest were undecided. Regardless of the findings of the select committee, the House of Lords is not expected to pass Lord Joffe's bill.

    b. Guernsey. On 9/26/02, the States of Deliberation, the governing body for the Channel Island of Guernsey, voted 38 to 17 in favor of an investigation into the desirability of legislation legalizing voluntary euthanasia. The vote followed introduction of a private member's bill by Deputy Pat Mellor. In September 2004, after considering the views of 296 members of the public and interest groups, the Death with Dignity working party concluded that

current law should not be changed.

c. Scotland. Liberal Democrat Jeremy Purvis has announced that he intends to draft a bill patterned after the Oregon Death with Dignity Act for introduction in the next term of the Scottish parliament. Legalization of euthanasia has not been considered in Scotland for more than a decade.

d. Mental Capacity Bill. On 6/18/04, Constitutional Affairs Minister Lord Filkin published the Mental Capacity Bill, which for the first time would set forth laws governing medical decisionmaking for persons who lack mental capacity. The bill has been subject to scrutiny by a Joint Parliamentary Committee, and its recommendations have been taken into account in revising the bill. Among other things, the bill would allow appointment of an agent to make medical decisions and execution of a living will. The bill, which would come into force in 2007, continues the law's prohibition against euthanasia. During a stormy second reading debate on 10/11/04, MPs of all parties raised concerns that the bill would lead to euthanasia.

e. Leslie Burke. Leslie Burke, who suffers from a degenerative brain condition known as cerebellar ataxia, challenged the General Medical Council guidelines on withholding and withdrawing life-sustaining treatment that were published in 2002. He argued before the High Court in London that domestic and European human rights law is violated by the guidelines' provisions allowing physicians to withhold or withdraw artificial nutrition and hydration under certain conditions without court approval. Justice Mumby recently upheld Burke's claim and ordered the GMC to redraft its guidelines. However, despite finding that Burke was entitled to treatment, Justice Mumby also recognized the right of patients to refuse treatment. The GMS has indicated that it will appeal the High Court ruling.

f. Baby Charlotte. On 10/7/04, High Court Justice Hedley ruled that physicians for baby Charlotte Wyatt, who was born three months premature with severe brain damage and injuries to her lungs and kidneys, could discontinue further treatment despite the objections of Charlotte's parents. Justice Hedley found that it was in Charlotte's best interests to allow her to die "a good death." Mr. And Mrs. Wyatt have said that they will not appeal the decision.

7. Indonesia. In September 2004, Indonesian Health Minister Achmad Sujudi said that euthanasia would not be allowed because it is contrary to Law Number 23 of 1992 and humanitarian principles; instead, a patient suffering from any illness must be given maximum medical treatment until he or she has recovered. In October 2004, the Indonesian Doctors' Association (IDI) issued a circular on euthanasia calling on physicians to inform the patient and/or his relatives truthfully in cases of incurable and painful disease, and suggesting that the medical committees of each hospital develop more detailed guidance on what to do if a request for euthanasia is received.

8. Israel. On 7/13/04, Judge Uri Goren, President of the Tel Aviv District Court, authorized disconnecting a 71-year-old man in a persistent vegetative state from life support at his family's request, even though he had not executed a written advance directive. The man had gone into cardiac arrest seven months previously after having a stroke, but was resuscitated. Judge Goren stressed that his decision was limited to the facts of the case, in which he was convinced the man would have wanted life support discontinued. More than two years have passed since the Steinberg Committee recommended legislation that would apply in such cases, but the Ministerial Committee on Legislation did not approve a proposed bill until 5/23/04 and had not yet finished drafting the bill when Judge Goren issued his decision.

9. Japan. The World Federation of Right to Die Societies ended a world conference in Tokyo on 10/3/04 by adopting a declaration calling on countries and physicians to follow the patient's will at the end of life. Akihiro Igata, chairman of the Japan Society for Dying with Dignity, said that his organization will step up lobbying for legislation on dignified death. Japan's Health, Labor, and Welfare Ministry has begun drafting guidelines on when and how treatment to prolong life may be terminated. Some Japanese legislators also have formed a group calling for the drafting of legislation on dignified death.

10. The Netherlands

a. Euthanasia reporting. Health minister Clémence Ross has expressed concern that reporting of euthanasia cases remains low despite laws legalizing the practice, with the rate of reporting having increased since 1996 only from 41% to 54%. She would like to authorize the Healthcare Inspectorate to reprimand, suspend, or fine physicians who disregard the law's procedural guidelines, as well as to create an anonymous databank reporting the decisions of regional euthanasia committees and to strengthen the national network of 500 general practitioners who have been specially trained to act as expert consultants on euthanasia. The level of reporting is highest among general practitioners (who carry out 77% of cases of euthanasia), where it has increased from 44% to 60%. Ross has ordered a follow-up study in 2005 to clarify whether the level of reporting is declining, or euthanasia itself, and also to determine why some physicians do not report.

b. Application of euthanasia to children. Dutch authorities and the Groningen University Clinic have entered into an agreement authorizing a protocol of experimentation extending the practice of euthanasia to children under age 12 in cases where physicians believe a child is suffering unbearably from a terminal condition. The protocol is likely to be used primarily for newborns, and official investigations reportedly have found so far that physicians made appropriate decisions in the cases of four newborns.

11. Spain. The premiere of Alejandro Amenabar's popular film Mar Adentro (The Sea Within), based on the real-life story of euthanasia activist Ramon Sampedro, has rekindled the debate in Spain over the right to die. Senior members of the

Socialist party of Spanish prime minister Jose Luis Rodriguez Zapatero, backed by some opposition groups, wanted him to deliver on an election pledge and set up a parliamentary commission to investigate legalizing euthanasia, but a motion to do so was withdrawn after it was opposed by the opposition Popular party. Spanish law currently penalizes euthanasia and assisted suicide with prison sentences of five to 10 years.

12. Switzerland. The canton of Zurich is considering introducing a law in the regional parliament that would limit assisted suicide in that canton to Swiss residents, require patients to see two physicians rather than one and get a certificate of mental fitness, mandate testing of staff at suicide clinics, and require organizations assisting in a suicide to contribute towards the forensic medical costs incurred. A debate on the issue is expected in the regional parliament before the end of 2004. On 9/3/04, the Zurich prosecution office confirmed that 22 people from Great Britain have gone to Zurich to end their lives with the help of the controversial group Dignitas following the huge interest of British media in the Diane Pretty right-to-die case.

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