Recent Developments in Physician-Assisted Suicide

October 2003

2. Oregon

    a. Survey of Oregon physicians. An article published in June 2003 reported the results of interviews conducted during 2000 of 35 Oregon physicians who had at least one patient who had requested physician-assisted suicide. Linda Ganzini et al., *Oregon Physicians' Perceptions of Patients Who Request Assisted Suicide and Their Families*, 6 J. Palliative Med. 381 (2003). The physicians described these patients as having strong and vivid personalities characterized by determination and inflexibility. These individuals wanted to control the timing and manner of death and to avoid dependence on others, preferences which reflected long-standing coping and personality traits. The patients' requests for lethal medication were forceful and persistent, could occur at any point after diagnosis of terminal illness, and were paralleled by refusal of medical interventions including palliative treatments.

    b. Intractable pain legislation. On 6/20/03, Oregon's governor signed into law Senate Bill 436, which amends existing law by eliminating the requirement that a patient be evaluated by a specialist before the patient's attending physician can prescribe controlled substances to control a patient's intractable pain. Before commencing treatment, however, the physician must provide, and the patient must sign, a written notice provided and approved by the Oregon Board of Medical Examiners, disclosing the material risks associated with the controlled substance. 2003 Or. Laws ch. 408.

    c. Oregon Death With Dignity. On 8/1/03, Oregon Death With Dignity, the group that was instrumental in passage of the Oregon Death with Dignity Act, merged with the Death With Dignity National Center, an advocacy group founded in California in 1994 but headquartered in Washington, D.C., where the merged organization will be located. Scott Swenson of Oregon Death With Dignity, the new organization's executive director, said that plans are to add two or three staff members to the seven full-time and four part-time employees at the two organizations, which have a combined budget of $1.1 million. The merged organization will have two arms, the Death With Dignity National Center (which will focus on education about end-of-life care and pain management) and the Oregon Death With Dignity Political Action Fund (which will focus on raising money and promoting Oregon's law in other states). The initial efforts of the latter arm will concentrate on Hawaii and Vermont.

3. Vermont

    a. Two bills introduced. Two bills relating to assisted suicide were introduced in the Vermont General Assembly in February 2003, both of which were referred to committee. H. 275, which was introduced by nine representatives, would criminalize assisted suicide. H. 318, which was introduced by 39 representatives, is patterned after the Oregon Death with Dignity Act. Both bills are being carried over until the legislative session resumes in January 2004.

    b. President of Vermont Medical Society disciplined. On 7/2/03, the Vermont Board of Medical Practice issued a decision reprimanding Dr. Lloyd "Tim" Thompson III, the president of the Vermont Medical Society, for giving a dying woman Norcuron, a powerful paralyzing drug, which hastened her death after she was removed from a respirator in August 2002. One-third of the 21-page ruling stated the Board's position on end-of-life care (see www.healthyvermonters.info/bmp/recent.shtml). Thompson also agreed that his practice would be monitored for a period of one year. Thompson apologized to the Board, the woman's family, and his co-workers for his error in judgment in failing to use other medication to relieve her distress. Attorney General William Sorrell declined to prosecute Thompson for manslaughter, and he resigned from his position as president of the Vermont Medical Society on 7/26/03.

    c. Public debate over proposed legislation. Vermont groups supporting physician-assisted suicide legislation include a state chapter of the Hemlock Society founded in 2002 and Death with Dignity, a group formed in early 2003 that has circulated a mailing with the endorsement of 125 Vermont physicians. Groups opposing the legislation include the Roman Catholic Diocese of Vermont and the Vermont Alliance for Ethical Health Care, a physician-led organization. A series of public debates began in September 2003.

    d. Position of Vermont Medical Society. In 1997, the ethics committee of the Vermont Medical Society (which was chaired by Dr. Thompson) responded to an assisted suicide bill before the Vermont House by concluding that Vermont should have no law governing whether physicians may hasten patients' deaths. During September 2003, the society sponsored a series of seven forums to permit physicians to debate the new proposed legislation among themselves. The question also will be debated at the society's annual meeting in October 2003. Physician polls conducted by Death with Dignity and the Vermont Alliance for Ethical Health Care have produced conflicting results as to physician attitudes.

OTHER NATIONAL DEVELOPMENTS

1. Dr. Jack Kevorkian. On 7/17/02, Jack Kevorkian's attorney Mayer Morganroth filed a petition for writ of habeas corpus in U.S. District Court , alleging ineffective assistance of counsel and multiple violations of Kevorkian's

constitutional rights at his original trial in connection with the death of Thomas Youk by lethal injection. Kevorkian

g. Nikkie B. Swarte et al., *Effects of Euthanasia on the Bereaved Family and Friends: A Cross Sectional Study*, 327 Brit. Med. J. 189 (2003) [questionnaire was completed by 189 bereaved family members and close friends of terminally ill cancer patients who died by euthanasia in the University Medical Center Utrecht, the Netherlands, between 1992 and 1999 and by 316 bereaved family members and friends of comparable patients who died a natural death; bereaved family members and friends of patients who died by euthanasia reported less traumatic grief symptoms, less current feeling of grief, and less post-traumatic stress reactions].

h. Agnes van der Heide et al., *End-of-Life Decision-Making in Six European Countries: Descriptive Study*, 362 Lancet 345 (2003) [physicians in Belgium, Denmark, Italy, the Netherlands, Sweden, and Switzerland completed questionnaires about medical decisionmaking that preceded 20,480 deaths between June 2001 and February 2002; the proportion of deaths preceded by end-of-life decisions ranged from 23% in Italy to 51% in Switzerland; all countries reported euthanasia or physician-assisted suicide, but the proportion ranged from about 1% or less in Denmark, Italy, Sweden, and Switzerland, to 1.82% in Belgium and 3.40% in the Netherlands; euthanasia took place most frequently in the Netherlands (2.59%), while physician-assisted suicide occurred most often in Switzerland (0.36%); ending of life without the patient's explicit request happened more frequently than euthanasia in all countries except the Netherlands; the end-of-life decision was discussed with the patient and relatives most often in the Netherlands and least often in Italy and Sweden].

INTERNATIONAL DEVELOPMENTS

1. Australia

Northern Territory. Chief Minister Clare Martin has indicated that the idea of the Northern Territory becoming Australia's seventh state is back on the political agenda, despite a resounding rejection of a