

Legal Regulation of Physician-Assisted Death — The Latest Report Cards

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In 2002, the government of the Netherlands explicitly legalized euthanasia and physician-assisted suicide. These controversial end-of-life practices had been openly tolerated and studied for many years before legalization, and Dutch physicians were expected to voluntarily report their participation in these acts, trusting that they would be acquitted of any legal wrongdoing provided that they had met the accepted criteria for “careful practice.” Not surprisingly, the reporting rates have increased since the law was passed — from 18% in 1990 to approximately 80% in 2005, as reported by van der Heide and colleagues in this issue of the *Journal* (pages 1957–1965). According to the authors, the majority of unreported cases now involve the use of opioids, or sedatives with uncertain lethal effects, making the physician’s intent more ambiguous.

What is most interesting in this report is a small decrease in the number of cases of euthanasia, physician-assisted suicide, and “life-ending acts without explicit request” and a concomitant increase in acts of continuous deep sedation (also called terminal sedation or sedation to unconsciousness for treatment-intractable symptoms). The first two Dutch studies, conducted in 1990 and 1995, did not have a category for terminal sedation, in which the clinician primarily intends to relieve severe suffering without

necessarily intending to hasten death, though the patient may hope that the intervention will accelerate death. In the past, such cases were probably recorded as euthanasia if the patient had decision-making capacity and as a “life-ending act without explicit

In Oregon, legalization of physician-assisted death has resulted in more open conversation and careful evaluation of end-of-life options.

request” if the patient did not. The difficulty of distinguishing among acts exclusively on the basis of physician intent is an inherent problem in research on end-of-life practices, so this use of descriptive definitions is helpful. The addition of this category may help us to understand the range of Dutch practice more clearly and accurately than was previously possible.

Over the past 17 years, the use of euthanasia and physician-assisted suicide in the Netherlands has remained stable — there is

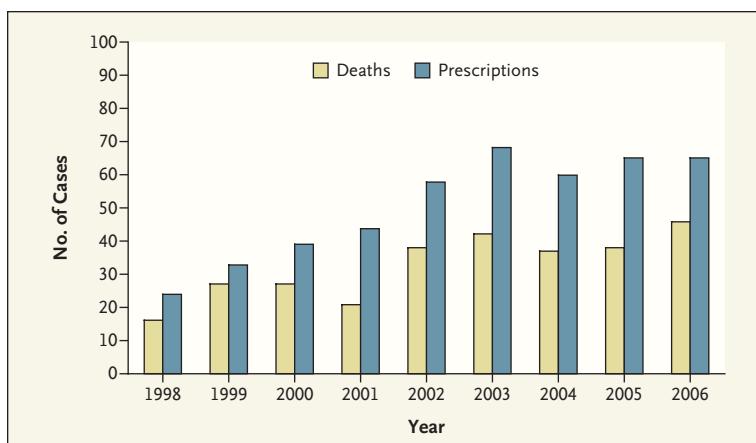
no evidence of “slippery slope” deterioration in terms of increased numbers of assisted deaths in the face of open acceptance and, now, explicit legalization of these practices. There is also evidence that during this period palliative care and hospice care have simultaneously grown stronger in the Netherlands, so the possibility that these last-resort practices are being chosen because of inadequate palliative care is lessening. Smaller numbers of cases of euthanasia and assisted suicide occur elsewhere in Western Europe,¹ though studies of such events are challenging to perform, since in most countries respondents who report engaging in such practices are admitting to a crime. In 2002, Belgium passed a “euthanasia law” with many of the same requirements and restrictions as those in the Dutch law, and data from their experience are just beginning to be reported.

In the United States, Oregon remains the only state in which physician-assisted suicide is legal. There are no states that permit euthanasia. Terminal sedation remains legally permissible but ethically controversial; it is used as a last-resort option in some very challenging cases, accounting for anywhere from 0 to 50% of deaths in hospice programs, depending on definitions, values, and providers’ practice patterns.²

The Oregon Department of

Human Services recently reported data from the ninth year of legal physician-assisted death (www.oregon.gov/DHS/ph/pas/docs/year9.pdf); it did so without much fanfare, largely because the practice has remained so stable (see graph). Roughly two thirds of the patients who receive a lethal prescription die as a result of taking it, and about one third die from other causes. As in past years, patients who received such prescriptions tended to be white, relatively educated, insured, and enrolled in hospice; they also tended to be at least as motivated by concern about losing autonomy, dignity, and control over their bodily functions as by any suffering from immediate intractable physical symptoms. One in 100 terminally ill patients asked their physician for assistance in dying, and some of these patients were clinically depressed, but among the 1 in 1000 who actually received such assistance, none were found by their physician to have clinical depression.³ Some did have feelings of hopelessness characterized by an inability to envision a meaningful future given the limits imposed by their disease, but such feelings are often distinct from clinical depression. Deaths under Oregon's Death with Dignity Act are not considered suicides, so the state no longer uses the designation "physician-assisted suicide" to describe the practice. The American Academy of Hospice and Palliative Medicine has also changed its terminology and now uses the more morally neutral and descriptive "physician-assisted death."

It is difficult to compare assisted death in Oregon with whatever may be going on in the rest



Numbers of Patients Who Received Prescriptions for Drugs to Be Used in Assisted Death and Numbers of Assisted Deaths under the Oregon Death with Dignity Act, 1998–2006.

Data are from the Oregon Department of Human Services (www.oregon.gov/DHS/ph/pas/index.shtml).

of the country, because any covert use of such practices is hard to study. Oregon has therefore become the laboratory in which we can learn about the risks and benefits of open practice and legalization. Although physician-assisted death accounts for only 1 in 1000 deaths in Oregon, 1 in 50 dying Oregonians now talk with their physician about the possibility and 1 in 6 talk to family members about it — in other words, legalization has resulted in more open conversation and careful evaluation of end-of-life options.⁴ Rather than undermining other aspects of palliative care, legalization in Oregon has been associated with national leadership in terms of opioid prescriptions per capita, hospice referral rates, numbers of deaths occurring at home rather than in medical facilities, the training of physicians in palliative care, and organized statewide approaches to a protocol called Physician Orders for Life-Sustaining Treatment.

The palliative care movement

continues to grow dramatically in the United States. Most academic medical centers now have palliative care consultation services, and other hospitals are launching such programs at an increasing rate.⁵ Palliative care was recently recognized as a subspecialty by the American Board of Medical Specialties and certified by the Accreditation Council for Graduate Medical Education, and the number of fellowship programs is increasing rapidly to help meet the demand. Although physician-assisted death remains illegal outside Oregon, there has been considerable movement within the field in terms of acknowledging that difficult cases exist and that health care professionals have a responsibility to help patients find acceptable responses to intractable suffering. In addition to wide acceptance of a legal and moral right to pain management and a right to forgo potentially life-prolonging therapies, other last-resort options in the most troubling cases, including

terminal sedation and voluntary cessation of eating and drinking, are gaining increasing acceptance.²

Although legislative efforts to legalize physician-assisted death in Vermont, Hawaii, and California have run into significant roadblocks, the practice in Oregon has survived several legal assaults from former Attorney General John Ashcroft and the Bush administration. A citizen-sponsored ballot initiative to adopt an Oregon-style law is under consideration in the state of Washington and may have a better chance at passage than such initiatives in other states, given this state's proximity to Oregon and its sim-

ilar demographics. Perhaps more important, the growing availability of palliative care and increasingly creative thinking about other last-resort options are allowing us to better address the needs of almost all patients who face the end of their lives. The challenge remains to make palliative care and hospice standard for patients who are dying and to provide predictable, accountable last-resort options for the relatively few patients who ultimately need them. We are making progress toward this goal, but we still have a long way to go.

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