

# HOUSE RESEARCH ORGANIZATION

*focus report*

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## **Final Choices: Legislating End-of-Life Decisions**

*Modern medical advances can be a double-edge sword: the same techniques that rescue life from death also can prolong the suffering of those who are dying. The tough questions involved in end-of-life issues have demanded the attention of state legislators across the country.*

*In Texas, recent debate has focused on three statutory provisions addressing when and whether dying patients desire that life-sustaining procedures be used, withheld or withdrawn. Advance directives, often called “living wills,” and designated health care agents have been permitted, in various forms, under Texas law for 20 years. However, patients, family members, clergy, and health care providers continue to raise significant concerns about how they are used. Of special concern is the fact that these provisions are located in different parts of the legal code, creating potential for inconsistency and confusion in applying the law.*

*The 75th Legislature took a number of steps to clarify the law underlying these issues in Texas. One step was to approve SB 414 by Moncrief to amend and consolidate laws regarding directives issued by terminally ill patients or their families or agents to withhold or withdraw life-sustaining procedures. However, the bill was vetoed by Gov. George W. Bush on grounds that it would have permitted physicians to deny life-sustaining procedures to patients desiring them and replaced with a more subjective standard the objective negligence standard for reviewing whether a physician properly discontinued the use of life-sustaining procedures. Meanwhile, HB 880 by A. Reyna, also enacted by the 75th Legislature, included amendments similar to some proposed in SB 414. HB 880 took effect January 1, 1998.*

*Sen. Mike Moncrief, author of SB 414, said the governor’s decision was influenced by extremists who “wanted to gut existing advance directive procedures; abolish the current collaborative approach between care givers, patients and family members; undermine the professional and ethical judgment of trained physicians and prohibit the involvement of family members in the end of life event of their loved ones.” However, the governor and others found many provisions in the bill commendable and desirable, and Sen. Moncrief has said he plans to revisit in the 76th Legislature some of the issues raised during the last session.*

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### **Legal Precedents**

In the mid-1970s, the ethical, medical and legal problems inherent in the ability of modern medical technology to indefinitely prolong life in a vegetative state were brought to national attention by the case of Karen Ann Quinlan, a young New Jersey woman who suffered respiratory arrest and lapsed into a coma. Brain damaged, Quinlan was unable to breathe or eat without medical interventions, but exhibited sufficient brain activity to be considered legally alive.

Quinlan’s family petitioned state courts for permission to remove her from life support, but New Jersey

state laws did not explicitly authorize the withdrawal of life support, and the state claimed an overriding duty to protect human life. The Quinlan family argued that their daughter would not have wanted to be kept alive in her vegetative condition and that her constitutional right to privacy included the right to refuse treatment as expressed through a family member. The Supreme Court of New Jersey ruled that the right of privacy did include the right to terminate treatment, and that the state's interest in protecting life diminishes as the individual's right to privacy grows with the invasiveness of medical interventions (*In re Quinlan*, 355 A. 2d 647). In 1976, six weeks after the state Supreme Court ruling, Quinlan was taken off the artificial respirator. Although unconscious, she continued to breathe on her own until her death in 1985.

Another case, involving a young Missouri woman, was considered by the U.S. Supreme Court. In early 1983, Nancy Cruzan was severely injured in an automobile accident and lapsed into an unconscious vegetative state in which her heartbeat and breathing continued despite brain damage and lack of cognitive function. Her body was sustained by artificial nutrition, with the state of Missouri bearing the cost of her care. After Cruzan had been hospitalized for several years, her parents requested that the tube feedings be discontinued. In their court pleadings, the parents claimed that Cruzan had told a roommate she did not wish to be artificially sustained in the event of a terminal condition. Missouri's living will law, however, required more evidence of such intent. The state Supreme Court upheld the objection of the state to discontinuing tube feeding on the grounds that there was no clear and convincing evidence that Cruzan would have authorized termination of treatment, and consequently her parents had no right to assume the decision of withdrawing treatment for their daughter.

The U.S. Supreme Court affirmed the state court's decision, holding that Missouri could use the "clear and convincing evidence" standard to safeguard highly important individual interests. It also found that no constitutional error was committed in the state court's ruling that the evidence presented at the trial did not meet such standard (*Cruzan v. Director, Missouri Department of Health* (497 U.S. 261 (1990))). The court agreed that the right of a competent person to refuse unwanted medical care is a liberty protected by the U.S. Constitution and supported by common law rights of informed consent, but ruled that such

rights did not prohibit Missouri from choosing which rule of law to apply. "Although Missouri's proof requirement may have frustrated the effectuation of Cruzan's not-fully-expressed desires, the Constitution does not require general rules to work flawlessly." The case was remanded to the state courts, which subsequently allowed the discontinuation of tube feedings. Cruzan died on December 26, 1990.

## Legislative Responses

In the wake of the *Quinlan* case, Texas and every other state in the nation enacted laws to assist terminally ill patients and their family members and physicians. These laws authorized "advance directives" — either in the form of "living wills" or through legally designated individuals called health care "proxies" or "agents" — by which patients could express their desires concerning the use of life support in cases of terminal illness, mental incompetency, or inability to communicate. Most state laws are grounded on both constitutional rights to privacy and common law rights to consent to treatment. Under common law rights to consent, treating patients without or counter to their consent can be considered a tortious assault, even if the medical procedure is harmless, beneficial or life-sustaining. However, *Cruzan* upheld state authority to determine the evidence used to indicate a dying patient's consent or desires. In 1990, the federal government enacted the Patient Self-Determination Act, which requires hospitals, nursing homes, and other Medicare-funded facilities to inform patients upon admission about their right to issue an advance directive.

But while advance directives and health care proxies are generally accepted as valid means of communicating a patient's wishes, the process of crafting a state law can generate heated debate over such fundamental issues as the definition of terminal illness or life-sustaining procedures and the determination of who has authority to decide whether to withdraw or withhold life-sustaining treatments. In Texas, these and other issues surfaced during the last legislative session as lawmakers took on the challenge of consolidating related laws.

## Texas Law

In 1977, Texas enacted its Natural Death Act (Health and Safety Code, Chapter 672), authorizing physicians to honor advance directives, and Durable Power of Attor-

ney for Health Care (Texas Civil Practices and Remedies Code, Chapter 135). In 1995, the state enacted out-of-hospital do-not-resuscitate (DNR) provisions (Health and Safety Code, Chapter 674), authorizing emergency medical service personnel to comply with specially written advance directives forbearing life-sustaining procedures for terminally ill patients. These three statutes are the mainstay of Texas law governing a dying patient's decisions affecting medical treatment; while the provisions have similarities, complicating differences do exist.

## The Natural Death Act

The Natural Death Act authorizes a competent adult to execute an advance directive, or "living will," to withhold or withdraw life-sustaining procedures in the event of a terminal condition and at any time to change or revoke that directive. Parents, legal guardians, and spouses may issue advance directives for individuals younger than 18 years old who have a certified terminal illness. Any competent adult, regardless of health status, can execute a written advance directive; only adult "qualified patients" — competent individuals who have been certified by two doctors as having a terminal condition — may issue a non-written directive. Non-written directives are rare and subject to special requirements. One paralyzed, terminally ill hospital patient, for instance, issued a directive by blinking in response to a series of questions posed by his doctor.

A physician is obligated either to follow the directive or to transfer the patient to a physician who will agree to carry out the directive. The law protects physicians and other health care providers from civil and criminal penalties unless they negligently withhold or withdraw life-sustaining procedures.

The act requires witnesses to the issuance of all directives, both written and unwritten, and to some treatment decisions made solely by the attending physician for a terminally ill patient who is incompetent or incapable of communication. It specifically prohibits as witnesses blood relatives, spouses, anyone designated by the patient to make a treatment decision on his or her behalf, attending physicians and their employees, persons with financial interests in the patient's estate, and health care facility employees who provide care to the patient or who are officers, directors, partners, or business office employees.

Under new HB 880 amendments, witnesses are not required when physicians and family members make treatment decisions for terminally ill patients who have not executed or issued a directive and are incompetent or incapable of communication. HB 880 also authorized physicians to make treatment decisions for incompetent or incommunicative terminally ill patients who have not issued a directive absent the participation of a legal guardian, relative or spouse if such a person is not available, but the decision must be witnessed by another physician not involved in treating the patient.

## Durable power of attorney for health care

Provisions in the Texas Civil Practices and Remedies Code authorize an adult (the principal) to delegate to another adult (the agent or proxy) authority to make health care decisions in the event the principal lacks capacity to make them, as certified in writing by the principal's attending physician. Principals may revoke a durable power of attorney for health care at any time, without regard to their mental state, competency, or capacity to make health care decisions.

Designated agents are empowered to make treatment decisions for principals who are incapable of making such decisions. The principal does not need to be terminally ill, and treatment decisions are not limited to those involving life-sustaining procedures. Treatment may be neither withheld nor provided if the principal objects to such actions, regardless of whether the durable power of attorney is in effect.

A principal must execute a durable power of attorney for health care in the presence of at least two witnesses. Witnesses may not include the agent, health care provider or employee of the provider, the principal's spouse or heir, a person entitled to any part of the principal's estate, or anyone who has a claim against the estate.

## Out-of-hospital DNR

Under Chapter 674 of the Health and Safety Code, a competent person with a terminal condition may execute a written do-not-resuscitate (DNR) order directing health care professionals acting in such out-of-hospital settings as nursing homes to withhold cardiopulmonary resuscitation and other life-sustaining procedures designated by the Texas Board of Health. The order may be executed

## Forms of advance directives

A model advance directive appears in the Texas Health and Safety Code, sec. 672.004. The model directs the withdrawal or withholding of life-sustaining procedures should the signee have an incurable or irreversible condition certified to be terminal with death imminent. Individuals may alter the model to match their particular concerns about specific treatment methods used, withheld or withdrawn.

Some organizations and health care institutions recommend designating a health care agent as well as drafting a living will on the grounds that a living will may not cover every circumstance requiring a medical choice, regardless of how explicitly a patient's desires are stated. An agent can make sure that these desires, as expressed in the living will or through prior conversations, are carried out and that the patient receives the highest quality of care. In turn, a living will can help provide guidance to the agent in times of decision making, support any decisions questioned by doctors or family members, and serve as evidence of a patient's wishes in the event the designated agent or family members are not available.

One example of an alternative use of the living will is found in the model advance directive form, called "Will to Live," recommended by the Natural Right to Life Committee. The form makes a statement about a "general presumption for life" and directs health care providers and health care agents to use medical and pharmaceutical treatment and CPR to the full extent necessary to cure, improve or reduce or prevent deterioration in any physical or mental condition and to provide food and water and artificial nutrition to the full extent necessary to preserve life and ensure optimal health. It also directs that pain medication not be used to hasten death and rejects the use of certain types of donated organs or tissues, such as fetal tissues.

The NRLC model form includes space to designate a health care agent. Instead of a general authorization to withdraw or withhold life support as in the Texas model, it provides a space to specify the types of treatment that may be withheld or withdrawn when death is imminent or when the patient is in the final stage of a terminal condition. Advocates say the form provides better assurance that decisions made by health care providers or agents will reflect the desires of patients, dying or otherwise, to live as long and as well as possible. Critics say that the form unnecessarily presumes ulterior or negligent motives on the part of health care providers and agents to hasten death. It also puts an unnecessary and impossible burden on terminally ill and dying patients to specify those treatment modalities that may be withdrawn or withheld, when such treatments can be wide-ranging and produce varying outcomes.

Copies of the NRLC form are available from the Will to Live Project, 419 7th Street NW, Suite 500, Washington, D.C. 20004, (202)626-8815, or via the internet at [www.nrlc.org](http://www.nrlc.org).

either in a standard form issued by the board (25 TAC sec. 157.25), available only in quantities of 50 copies through the Texas Medical Association, or in a non-written manner. Both types of orders must be witnessed by the attending physician and two others who meet the witness qualifications in the Natural Death Act. If the instructions for an out-of-hospital order conflict with those contained in an advance directive or through a designated agent, the most recent execution controls. The order may be revoked at any time.

The chapter also authorizes a physician to rely on an

advance directive or a designated agent of the patient to issue an out-of-hospital DNR order for a patient who has become incompetent. Physicians must comply with DNR orders executed by adults who have since become incompetent unless they believe an order does not reflect the person's present desires. Parents, legal guardians, or managing conservators may execute an out-of-hospital DNR on behalf of a minor.

## Current Issues

In Texas, the three separate sections of the law contain similar provisions related to protecting and effectuating a dying patient's desires concerning medical treatment. Health care providers, however, say the differences are significant enough to cause confusion. Hospitals, especially, encounter problems because of inconsistencies among the three laws as to who may serve as a witness to an advance directive. Many advance directives are not issued until the patient is in the hospital in the final stages of dying.

Some say such problems point to a need for consolidating the laws in order to both improve provider compliance and citizen understandings of their legal rights and options. SB 414 by Moncrief would have brought within a single chapter of the Health and Safety Code the Natural Death Act, the Durable Power of Attorney provisions, and out-of-hospital DNR provisions. Others, however, caution against a broad sweep of consolidation without careful evaluation of each provision, fearing the loss of favored or specifically crafted definitions and provisions in each of the three laws. For example, SB 414 also would have amended several key facets of the advance directive execution process, such as provisions governing provider liability, medical decision making in absence of an advance directive, witness requirements and qualifications, and the definitions of certain terms.

## Terminal condition

A terminal condition is defined in the Natural Death Act and the out-of-hospital DNR law as an incurable or irreversible condition caused by injury, disease or illness that would produce death without the application of life-sustaining procedures, according to reasonable medical judgment, and for which the application of life-sustaining procedures serves only to postpone the moment of the patient's death (Health and Safety Code, secs. 672.002(9) and 674.001 (20)).

A competent adult may issue a written living will under the Natural Death Act at any time. However, withholding or withdrawing life support per the instructions of a living will may only occur if the person has been certified as having a terminal condition and death is imminent without the application of life-sustaining procedures. Written out-of-hospital DNR forms may only be issued by persons diagnosed by a physician as having a terminal condition.

**Critics** say the current definition of terminal condition is too broad: the provision could be interpreted to include a diabetic who is otherwise healthy but who needs insulin on a daily basis to stay alive. From this perspective, a diabetic who has issued an advance directive to withhold medical care could be diagnosed as terminally ill and not receive medical care for a condition that otherwise would have been treated. The definition should be changed to apply only to a patient with an incurable medical condition who will die *regardless* of the application of life-sustaining procedures.

Other critics also say a patient should not be required to have a terminal condition to have an out-of-hospital DNR executed. They charge that such a requirement may be constitutionally questionable. State and federal courts both recognize a patient's right to accept or refuse medical treatment; if a person does not wish to be resuscitated or given other life-saving measures, that request should be honored regardless of the person's medical condition. For example, an 84-year-old woman with a congestive heart condition and osteoporosis and in chronic pain may prefer to die "naturally" of heart failure rather than suffer through an extended life with broken ribs and further pain from resuscitation.

**Supporters** say that the strict definition of terminal condition in Texas law is unlikely to be misused or misinterpreted, precisely because of the dual criteria: the patient must have an incurable or irreversible condition that would produce death without the application of life-sustaining procedures, *and* the use of life-sustaining procedures must serve *only* to postpone the moment of imminent death. Thus, a diabetic could not meet the definition of having a terminal condition if otherwise healthy, because the insulin dosage serves to maintain health and well-being, not just postpone death. In addition, physicians would not confuse or purposefully misrepresent diabetes and other chronic diseases sustained by otherwise healthy individuals with an end-of-life incurable or irreversible terminal condition.

Amending the law would not protect patients against the unlikely occurrence of a malicious doctor twisting the definition around to argue in favor of removing or withholding life support on the grounds that everyone eventually dies regardless of whether life-sustaining procedures are applied. Most doctors practice with the intent of maintaining life and curing illness or injury; those who act with malicious intent or negligence may be readily penalized through other laws.

## Special problems: advance directives in nursing homes

The federal Patient Self-Determination Act (PL 101-508) requires certain health care facilities to maintain and share with patients written policies about the use of advance directives. Facilities may refuse for conscientious reasons to carry out advance directives, if such conscientious objection is allowed by state law. The federal Health Care Financing Administration, which regulates Medicare and Medicaid, recently interpreted the law to hold that facilities may not conscientiously object to advance directives otherwise permitted by the state if state law is silent on such refusals.

Nursing homes in Texas that conscientiously refuse to carry out advance directives to withhold or withdraw life support now worry that they may be in violation of federal regulation. Neither the state Natural Death Act nor out-of-hospital DNR provisions *explicitly* allow facilities to refuse to carry out directives, say observers, even though the Health and Safety Code *anticipates* such occurrences. For example, physicians may refuse to comply with advance directives as long as they make reasonable efforts to transfer the patient to another physician (secs. 672.016 (c) and 674.017 (c)). Physicians and other health care professionals are absolved of civil or criminal liability for failing to carry out a directive (sec. 672.016 (b)), and health care professionals and facilities are absolved of similar liability for failing to carry out an out-of-hospital DNR order (sec. 674.017 (b)).

Under sec. 674.009 (i), if the policies of a health care facility preclude compliance with the out-of-hospital DNR order, “that facility shall take all reasonable steps to notify the person or persons having authority to make health care treatment decisions on behalf of the person, of the facility’s policy and shall take all reasonable steps to effect the transfer of the person to the person’s home or to a facility where the provisions can be carried out.”

Some hospitals complain that nursing homes unnecessarily transfer dying residents with out-of-hospital DNR orders to hospitals, causing extreme discomfort and upheaval during an individual’s final moments and needlessly increasing health care expenses by incurring hospital costs when the resident could have died in the nursing home. Nursing homes say they are under tremendous scrutiny by regulators and the general public; deaths in their facilities raise suspicion even under the best of circumstances. Because of liability and regulatory concerns, some nursing homes feel the safest alternative is to transfer residents to a hospital that offers full nursing, medical and surgical care and is experienced in handling advance directives.

Nursing home representatives also maintain that the use of advance directives in their facilities is hindered by the requirements surrounding the out-of-hospital DNR form. Fragile, dying patients are forced to endure medical interventions and emergency transfers against their desires, they contend.

Although an advance directive under the Natural Death Act may be copied from any model form and slightly altered to fit individual or institutional needs, an out-of-hospital DNR must be executed using a specific form stamped with the state seal and sold by the Texas Medical Association in packets of 50 or more. Nursing homes say this arrangement makes DNR orders less available within their facilities and limits the ability of residents to direct their medical treatment. The fact that only original forms are considered valid directives in out-of-hospital settings means that the original, stamped form must accompany the nursing home resident at all times, and is therefore frequently left behind or lost when residents are transferred to and from the facility to their home, or between the facility and a hospital. Copies of a valid form should also be viewed as valid, so that a resident’s stated desires for the withdrawal or withholding of medical treatment are obeyed, say nursing home officials.

Health department officials responsible for promulgating and distributing out-of-hospital DNR forms counter that the rules allow health care personnel to make appropriate choices in life-threatening situations. A standardized DNR form is necessary so that EMS and health care personnel do not have to spend valuable time assessing the validity of the form prior to making treatment decisions.

Requiring that a patient have a terminal condition in order to effectuate an out-of-hospital DNR order is a measure that best protects people who are unconscious, incompetent, or unable to communicate from medical or other decisions that could go against a person's potential desire to live. Even the elderly who are frail and sick may reconsider an earlier decision about resuscitation in the face of changed medical conditions. Medical decisions that could hasten death should be restricted to the narrowest of circumstances: people facing imminent death. People of any medical status who are able to communicate may refuse medical treatment at any time.

## Certification of terminal illness

**Critics** say the Natural Death Act imposes an unnecessary and costly burden, especially in rural and medically underserved areas, by mandating that advance directives be honored only if the patient is "qualified," i.e., certified by two physicians as having a terminal condition. They say the law should be changed to require the certification by only one physician. Diagnosing a terminal condition – an extreme medical condition – is within the range of skills of any licensed doctor. Such a change would also conform the Natural Death Act with requirements in the out-of-hospital DNR laws (Health and Safety Code, sec. 674.002 (a)).

Patients nearing the end of their lives should not have to experience the discomfort and delay nor suffer the invasion of privacy or cost of obtaining a substantiating diagnosis from another physician. Some counties or communities have no or only one physician within a reasonable travel distance. This is a special problem for patients dying in nursing homes, who are dependent upon physicians coming to them in the facility. Furthermore, because of liability concerns, a physician who has not had a long-standing personal interaction with the family or the patient may be hesitant to agree to participate in a certification.

Some critics also say the definition of terminal condition should be changed to include patients who have been admitted to a hospice program approved by the federal government and licensed by the state. They say federal hospice law already requires certification of terminal conditions, and the change would prevent patients from having to endure certification twice.

**Supporters** say current certification procedures in the Natural Death Act require the agreement of two doctors to ensure that no patient dies unnecessarily due to

ignorance or negligence. A second opinion is essential for many significant medical procedures and should especially be required for determinations that could halt the use of medical interventions with curative or restorative potential. Although certification by a second physician may be difficult to achieve in some circumstances, any possible inconvenience is far outweighed by the protection it provides. Accordingly, the out-of-hospital DNR laws governing certification of a terminal illness should be changed to require the involvement of two physicians, instead of one.

Because federal hospice programs require only one physician to certify a patient as terminally ill, including hospice certification within the definition also could harm patients by creating a risk of misdiagnosis and unnecessary death.

**Others** advocate a compromise that would require the attending physician to certify terminal illness conditioned upon the review of the patient's medical records by another physician. This would provide medical oversight without burdening the dying patient with travel or other discomforts.

## Life-sustaining procedures

Life-sustaining procedures are defined in the Natural Death Act as a medical procedure or intervention that uses mechanical or other artificial means to sustain, restore or supplant a vital function, and that only artificially postpones the moment of death of a patient in a terminal condition whose death is imminent or is likely to result within a relatively short time without the application of the procedure. The term does not include the administration of medication or the performance of a medical procedure considered to be necessary to provide comfort or care or to alleviate pain (Health and Safety Code, 672.002 (6)).

The definition used in the out-of-hospital DNR provisions is similar, with the notable addition of a statement saying the term does not include the provision of water or nutrition (Health and Safety Code, sec. 674.001 (13)).

Death is defined under the Health and Safety Code, Chapter 671, as occurring when there is irreversible cessation of a person's spontaneous respiratory and circulatory functions. When artificial means support res-

## Determining

Procedures for determining medical futility have been adopted by most Texas hospitals to address cases in which attending doctors believe continued aggressive medical or surgical interventions are inappropriate or futile for improving the health or well-being of a terminally ill individual, yet family members or surrogate decision makers insist on “everything” being done. The policy in Harris County, described in the August 21, 1996, issue of the *Journal of American Medical Association*, was cited by opponents of SB 414 as an example of how doctors and hospitals support procedures to “force death on patients against their will and the will of their families.”

The Harris County policy was designed by a task force composed of doctors, lawyers, nurses, social workers, and other health care professionals representing various health care institutions. The task force did not attempt to define medical futility, which, it said, will vary from patient to patient. Rather, it recommended procedures to be used when family members or health care agents insist on an intervention considered as over-treatment by the attending physician. The procedure requires the attending physician to include all responsible parties in decision making and explain that opting against the intervention in question does not mean abandoning appropriate medical and humane care to promote the comfort, dignity, emotional and spiritual support of the patient.

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“So live that when thy summons comes to join  
 The innumerable caravan that moves  
 To that mysterious realm, where each shall take  
 His chamber in the silent halls of death,  
 Thou go not, like the quarry-slave at night,  
 Scourged to his dungeon, but, sustained and soothed  
 By an unfaltering trust, approach thy grave  
 Like one who wraps the drapery of his couch  
 About him, and lies down to pleasant dreams.”

*Thanatopsis*, William Cullen Bryant

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The recommended policy states that when conflicts cannot be informally resolved through discussions with the physician and counseling by social workers or chaplains, the doctor must obtain a second medical opinion from another physician who has personally examined the patient. The situation then must be reviewed by a hospital ethics committee. Both the physician and the concerned parties are encouraged to attend the committee meeting. While the patient’s right to be transferred to another physician is upheld at all times, the patient may not be transferred within the institution to another doctor in order to receive an intervention that the committee had deemed medically inappropriate.

**Critics** say any decision about whether life is worthy of preserving for whatever length of time should be left to the patient or the patient’s family or agent because of very real differences in how different doctors may determine medical futility. Some doctors define the concept narrowly; they consider treatments to be futile if they are physiologically ineffective or unable to postpone death. At the other end of the spectrum, some define as medically futile treatments that, although beneficial, will not prolong a life for more than what they consider an insignificant amount of time.

Doctors and hospitals also will often be influenced by other, value-laden concerns that may conflict with those of their patients, such as whether the quality of a patient’s life after medical intervention would be worth the effort or whether the expense of keeping a patient alive for an extended period of time is a worthwhile use of financial and medical resources. Studies have shown that quality of life judgments, which usually reflect the values of the provider rather than the patient, are often an unconscious consideration in the determination of medical futility.

Physicians are sworn to preserve or improve life, and their decision-making authority should be limited to the medically technical areas in which they are trained in the same way that firefighters are relied on for their



## medical futility

expertise in putting out fires and preventing further loss of life and property, not for their opinion about whether a burning house is worth saving.

Americans who traditionally have been subjected to racial, religious or other forms of discrimination or who depend on government-assisted health care are most vulnerable to medical futility decisions in which their best interests may not be fully considered. Procedures for determining medical futility also could be later used to decide to withhold treatment for non-terminal conditions in patients deemed less worthy because of their poverty, age, disability or lifestyle.

**Supporters** of medical futility determination processes emphasize that designating a patient or a treatment as medically futile does not mean the end to medical care but a switch in focus to treatment with patient comfort as the primary goal. Medical futility determination procedures have been used by hospitals for years, but only in the most extreme cases. Hospitals and doctors prefer to counsel and consult with family members and receive agreement on such important treatment decisions. To allow the general public to unilaterally exercise medical judgment without regard to medical efficacy or benefit would be taking the concept of patient autonomy to an extreme and could endanger the dying patient as well as other patients.

Insistence by family members on life-saving measures at any cost can be based on many issues that are not relevant to appropriate medical practice or even to the preferences of the dying individual. Family members may feel guilty about past interactions and therefore resist allowing the patient to die or may hold unrealistic hopes for miracles or emerging medical technologies. Faith in modern medicine has been heightened by hospital TV shows, which often paint unrealistically high success rates for many risky medical treatments.

Patients and their families or agents are not trained in the alternatives to nor the benefits, risks and limitations of medical interventions. By focusing only on the preservation of life, they overlook the pain and complications caused by the intervention itself. One egregious example involves a Houston infant born with multiple congenital abnormalities who was subject to sequential amputations of limbs because the parents insisted that the doctors “do everything” to keep the infant’s blood pressure up sufficiently to keep her alive. Even something as common as CPR can result in cracked ribs, punctured lungs and additional forms of invasive or mechanical treatments, heightening discomfort and isolation in a dying patient’s final hours.

While no medical futility determination can be totally value-free, it must be based on defensible values, and patient autonomy cannot always be valued over other legitimate competing values, such as the moral and medical ethics of the physician or institution and the stewardship of limited resources. Since the *Quinlan* and *Cruzan* cases, the trend has been to recognize patient autonomy over physician-driven over-treatment, but society must also guard against elevating patient or agent-driven over-treatment above medical knowledge. Family members and agents have no responsibility and often little concern for the care of other patients, which could be compromised by the misuse or imprudent use of medical resources. A well-constructed medical futility determination procedure provides an appropriate balance between patient autonomy and professional and institutional integrity.

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“ . . . Old age should burn and rave at close of day . . .  
 And you, my father, there on the sad height,  
 Curse, bless, me now with your fierce tears, I pray.  
 Do not go gentle into that good night.  
 Rage, rage against the dying of the light.”

*Do Not Go Gentle into That Good Night*, Dylan Thomas

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piration and circulation, the patient is considered dead when there is irreversible cessation of all spontaneous brain function.

**Critics** say that providing nutrition and water should be explicitly excluded from the definition of life-sustaining procedures under the Natural Death Act. With this change, an advance directive would not include permission to withhold or withdraw food and water. Alternatively, the law could require that nutrition and hydration be specifically declined in order to be withheld or withdrawn. Critics say that because the current definition does not specifically refer to nutrition and hydration, doctors may withhold the supply of food and water, thereby starving to death terminally ill patients who have issued advance directives to withhold or withdraw life-sustaining medical treatment. Doctors should not second-guess their patients' intentions; rather, patients issuing an advance directive should be given the opportunity to specifically state whether or not nutrition and hydration also should be withheld or withdrawn.

**Supporters** say the current definition properly leaves medical decisions to professional judgment. The issue, they say, confuses real food given to healthy patients with artificial nutrition — chemical sustenance and water delivered to the patient via “tube feedings,” such as through an intravenous device, to patients who are unable to chew, swallow or digest food. Artificial nutrition, when given to certain dying individuals, can actually prolong or make more painful the dying process.

In the final stages of dying the loss of thirst and hunger are natural occurrences. In some cases artificial

nutrition and hydration can contribute to medical complications because the body is not able to filter or process the extra fluid, causing extreme swelling and increased pressure on other vital organs, which in turn can cause pain, vomiting, increased wound drainage, and difficulties in breathing. The determination of whether nutrition and hydration would benefit the comfort and well-being of a dying patient depends on that patient's physical functioning and medical circumstances and is best left to the physician.

Most people also associate artificial nutrition with recognizable forms of food and sustenance, and are therefore loath to “take food away” from a loved one who is dying. Artificial nutrition is simply a chemical substance designed to keep the body functioning, just as an artificial respirator provides for patient respiration when lungs do not function properly, and can sustain a body physically even after the brain is dead.

## Treatment decisions

Treatment decisions to withhold or withdraw life support for a terminally ill patient who has issued a directive and becomes incompetent or unable to communicate may be made by the physician and the patient's agent, or by the physician alone.

Treatment decisions to withhold or withdraw life support for terminally ill patients who have *not* issued a directive but who are incompetent or unable to communicate may be made by the:

- attending physician and patient's legal guardian;
- attending physician and at least two family mem-

## Artificial feeding

In a December 1987 opinion (JM-837), the Texas attorney general concluded that physicians have authority to determine on a case-by-case basis whether artificial feeding constitutes a life-sustaining procedure that prolongs the moment of death against the wishes of a terminally ill patient who has executed an advance directive. The opinion noted legislative intent that the statute remain silent about what constituted a “life-sustaining procedure” because of changing medical technologies and standards of practice and because of patient characteristics. The opinion said that “while the resolution of the question is for the medical profession, the Legislature has made it plain that care should be taken” to observe a patient's wishes. The opinion was issued in response to questions about whether artificial feeding fell within the definition of a life-sustaining procedure and a hospital's obligation to artificially feed a terminally ill patient who had issued an advance directive.

bers, if there is no legal guardian for the patient; or

- attending physician alone, witnessed by another physician who is not involved in the treatment of the patient, if the patient does not have a legal guardian and a family member is not available.

HB 880 enacted provisions changing the involvement of authorized decision makers when terminally ill patients who have not issued a directive become incompetent or unable to communicate. It removed the requirement that two witnesses be present when family members are involved in such treatment decisions, and added the requirement that decisions be documented in the patient's record. HB 880 also added another provision allowing treatment decisions to be made by the physician only when a family member is not available.

**Critics** say that doctors should not be allowed to unilaterally make medical treatment decisions hastening death. The law is silent about what constitutes a valid effort by the physician or health care facility to consult with family members or proxies, and negligent or uncaring physicians could make such a decision too hastily. Having another physician merely as a witness is not the same as seeking another physician's opinion, and therefore provides little protection. The whole basis for enacting the Natural Death Act and related laws was to ensure that patients and their families or designated spokespersons maintained control over decisions affecting their death. The doctor's role should be limited to one of carrying out the patient's wishes.

Elderly, disabled, impoverished and minority individuals are especially vulnerable to decisions that may not reflect their values or attitudes about an acceptable quality of life and are often subject to inadequate care in routine medical situations. The law should be constructed so that if any error in judgment is made, it is one that prolongs life instead of hastening death. Unlike death, treatment decisions to sustain life can subsequently be reversed if new information warrants.

**Other critics** say the number of family members required to be involved in a treatment decision to remove or withhold life support should be reduced from two to one so that appropriate medical steps can be taken within a timely fashion in order to maximize patient comfort and compliance with end-of-life wishes. The requirement that two family members be involved is often difficult for a hospital or nursing facility to achieve; elderly patients frequently have few living

relatives. The requirement also does not ensure that the patient's wishes will be better carried out. For example, a dying patient's spouse will probably know as well if not better than anyone else how the patient would like to be treated at the end-of-life, and the additional involvement of "a majority of the patient's adult children" or "nearest living relative," as currently required, can cause delays and family turmoil, increasing the patient's discomfort.

**Supporters** say the law needed to be changed to respond to the difficulties of tracking down authorized decision makers and appropriate witnesses. The change does not relieve physicians of the duty to consult with authorized decision makers but rather allows compassionate and appropriate decisions in cases where an incapacitated individual has no known family or friends. Patients will continue to be protected from inappropriate or inadequate decisions because doctors tend to prefer to consult with family members to avoid any unnecessary liability. In cases where the physician alone decides to withhold or withdraw life support, patients will receive protection by the requirement that another physician witness such a decision.

In most other cases, the current requirement that two family members be involved ensures that decisions reflect the values of the family and the patient. It also better protects health care providers and family members against lawsuits claiming that the family member involved was not the appropriate person to make a decision to withhold or withdraw life support.

Former requirements that witnesses be present when physicians and family make treatment decisions created unnecessary delays and invaded family privacy. Such decisions, while often difficult and heart-wrenching for family members to make, are based on their knowledge of the patient's desires and history of discomfort, medical conditions, and treatments. Forcing the presence of two individuals, usually strangers to the patient and the family, in such a difficult time does not ensure that the patient's desires will be followed. Witnesses do not offer advice to either the doctor or the family, but simply witness that a decision was made.

However, in cases where a physician must make a decision alone without the presence of family members to voice an opinion or knowledge of the patient's desires, requiring another physician to be a witness creates the opportunity for additional medical oversight and for a discussion of a dissenting point of view, thus providing at least a safety net of protection from negligence or

malice. Few doctors would agree to witness an act they could not support medically or ethically.

**Others** say the law should be amended to specifically authorize the patient's agent to make treatment decisions. This would ensure the participation of a spokesperson specially designated by the patient and provide continuity between the Natural Death Act and the durable power of attorney provisions.

## Provider liability

Health and Safety Code, sec. 672.015, states that a physician or a health care facility that causes life-sustaining procedures to be withheld or withdrawn in accordance with the Natural Death Act is not civilly or criminally liable for or guilty of unprofessional conduct because of that action, unless it is negligent.

**Critics** say this section should be changed to remove references to a cause of action based on negligence and instead protect *good faith* actions by physicians and health care facilities withholding or withdrawing life-sustaining procedures in accordance with the death act. The change is needed to protect physicians from lawsuits filed by dissenting family members for carrying out directives of dying patients.

Physicians are vulnerable to lawsuits rooted in a desire to establish blame or receive financial compensation for an unfortunate circumstance or to alleviate family remorse for having agreed to certain medical decisions. Such lawsuits typically question the physician's medical treatment of the patient from the outset of illness through the patient's death or dying state and claim the patient was not fully competent or was unduly influenced by the physician when issuing the directive. Because these lawsuits can last for years and incur considerable costs, doctors are often pressured to accede to family members despite the instructions of an advance directive, even though the family members may have never discussed the patient's wishes, are estranged from the patient, or have divided opinions about appropriate actions.

A good faith standard would require plaintiffs to prove malice, thus limiting lawsuits to situations where a doctor intentionally performed a wrongful act without just cause or excuse. Any risk associated

with doctors negligently, but in good faith, carrying out a patient's directive is small and outweighed by the benefits that protection from liability would bring in ensuring that the wishes of patients were carried out. Doctors could still be sued for negligent practices under common law or other statutes.

**Supporters** of the current provision say that replacing an objective standard of negligence with a more subjective "good faith" standard would diminish the doctor's responsibility for inappropriately withholding or withdrawing life-sustaining procedures. Proving "bad faith" is extremely difficult, because the plaintiff would have to prove the doctor's state of mind, i.e., that the doctor acted with intentional malice. Doctors who intentionally try to kill their patients are already liable for punishment under criminal law. Also, doctors could be negligent while acting in good faith and inadvertently hasten a patient's death. For example, by misdiagnosing a medical condition, the doctor could inappropriately advise the patient to execute an advance directive.

Decision processes that may result in hastening death need strong checks and balances; threat of a lawsuit is an effective, non-regulatory way of creating incentives for delivery of appropriate medical care. The more precise public policy standard of negligence better protects patients and should not be changed because some people file or threaten to file frivolous lawsuits likely to be dismissed anyway.

## Patient transfers

Current statutory provisions impose no liability on physicians for failing to carry out the directives of a terminally ill patient. Attending physicians who refuse to comply with a directive or treatment decision must make a reasonable effort to transfer the patient to another physician (Health and Safety Code, sec. 672.016).

**Critics** say doctors should be compelled to uphold advance directives, but that patient transfer provisions in current law allow them to ignore an advance directive by delaying or stalling the transfer of a patient to another doctor. The critics come from two distinct camps: those who fear doctors will more likely ignore a dying patient's desires to live as long as possible and those who fear doctors are more likely to keep a patient alive against a patient's desire to allow the dying process to continue unimpeded

by medical interventions.

From the first perspective, most notably expressed by the National Right to Life Committee (NRLC), an advance directive encompasses clear direction to provide all possible medical, surgical and pharmaceutical care. This group says that current practices at some Houston hospitals authorize doctors to deny lifesaving measures to patients who want to continue to receive medical treatment by determining that further treatment would be medically futile (see pages 8-9). Allowing doctors to make such determinations, they say, runs counter to the whole notion of patient autonomy, the underpinning of the Natural Death Act, and ethical medical practice. A patient who goes into cardiac arrest and is denied cardiopulmonary resuscitation could easily die before a transfer to another physician is completed. The law should require doctors to sustain until transfer patients who say that they want to be kept alive at all costs.

Other groups fear that patients who have directed that life-sustaining procedures be removed or withheld will be subject to further treatment and discomfort against their wishes by doctors who disagree with the directive and postpone or delay their transfer to another doctor who will comply. They say the law should be amended to specify what constitutes a reasonable and timely effort to ensure that such an effort is made.

**Supporters** of the current provisions call the fear doctors will force death on patients overblown. Doctors are more likely to disagree with or be morally against carrying out directives to *withhold or withdraw* life support than to use all life-sustaining treatments and procedures. Allowing patients to die goes against a doctor's training and personal commitment to heal. Hospitals have been sued for following what they construed to be their legal and moral obligation to provide care. For example in January 1998, Columbia/HCA was ordered to pay a Houston couple \$42.9 million because one of its hospitals refused to honor their request to withdraw life support on their brain-damaged premature baby.

Advance directives specifying that all procedures must be used to sustain life in all cases are extremely rare. Some experts say they have never handled such a directive; the basis for developing advance directives was to provide a means for patients to direct the withdrawal or withholding of life-support or medical treatment. The claim that current transfer provisions allow doctors to subvert

directives to keep dying patients alive is a false argument that does not reflect actual use of advance directives or considerations in medical practice.

Although some doctors may disagree with a patient's desire to withhold or withdraw certain forms of medical treatment, the current provisions strike a good balance between caring for patients and effectuating their directives. What constitutes "timeliness" and "reasonableness" in the arrangement of a transfer will vary from situation to situation and cannot be defined in law without later compromising the care of many patients or the ethics of many doctors.

## Pronouncement of death

Chapter 671 of the Health and Safety Code permits a registered nurse (RN) or physician's assistant (PA) employed by a home health agency or hospice to determine and pronounce death in patients under their care so long as the patients are not on artificial life-support that would make death difficult to determine. This provision may be superseded, however, by local requirements. Some communities have required hospice patients who do not wish to be resuscitated to pre-register with local law enforcement officials; others require the local sheriff or justice of the peace to investigate before death is officially pronounced.

**Supporters** say the law can be of great benefit to hospice patients and their families because it allows them to experience a quiet death without the intrusion of law enforcement and emergency personnel. However, the invasions of privacy insisted on by some jurisdictions may heighten distress over a naturally occurring death and raise questions of suspicious activity or guilt in the home. The law should be changed so that the state provision supersedes local laws causing unnecessary intrusion.

Dying patients and their families are adequately protected under the Health and Safety Code because death certificates still must be signed by the attending physician and RNs and PAs can lose their licenses if a suspicious or questionable death is not recognized. Unlike law enforcement personnel, RNs and PAs also have training to make accurate pronouncements of death.

**Others** say local control is critical in investigations and pronouncements of death. Although nurses and PAs are trained in medical aspects of death, they may not recognize suspicious activity or foul play that is non-medical in nature. Local law enforcement can be

sensitive to a family's loss and at the same time provide valuable criminal or legal perspectives on the circumstances surrounding the death.

## Assisted Suicide

The 1990s have showcased persistent efforts to make assisted suicide a socially and legally acceptable form of medical treatment for the terminally ill. Public interest was heightened with the 1991 publication of *Final Exit* by Derek Humphrey, outlining strategies to hasten death, and the highly publicized efforts of Dr. Jack Kevorkian to assist terminally and chronically ill individuals commit suicide. The state of Michigan, where Kevorkian resides, has spent considerable resources attempting, so far unsuccessfully, to prosecute him for these efforts. In 1994, Oregon became the first and thus far only state to legalize assisted suicide. Most states, including Texas, criminalize assisted suicide.

In Texas, bills introduced in the 73rd and 74th legislative sessions would have authorized assisted suicide for certain terminally ill individuals. None were reported out of committee. SB 1264 by Barrientos and HB 2135 by Combs, both proposed in the 74th session, would have authorized physicians under certain conditions to prescribe a sufficient dosage of medication to relieve pain, even if it would hasten death, if requested by a terminally ill patient. Similar proposals were enacted into law by Iowa and Rhode Island in 1996 and South Dakota and Virginia in 1997, and have been introduced in about 14 other states in 1998.

## The debate

**Supporters** of assisted suicide say that dying people want to control their own lives and deaths. They cite the suffering and indignities experienced by terminally ill patients who wish to avoid a long, painful, drawn-out process of dying but who can only refuse medical interventions or ask that they be withdrawn. While hospice treatment offers valuable services to help ease the discomfort of the dying, not all people want to approach death in this fashion. Even if a comprehensive and compassionate health care delivery system were structured and available to all people, some of the dying would still prefer to forego further medical care or

end pain and indignity by dying on their own terms. If assisted suicide were an option, terminally ill patients could die with dignity and grace after they had arranged their affairs and said their good-byes while they were still competent and communicative. Legal assisted suicides also could help prevent "botched" suicides.

Harris and Gallup poll results released in late 1997 showed clear majorities of Americans believe that terminally ill people should be allowed to obtain a doctor's prescription for a lethal dose of drugs to end their lives. Many religious individuals say that ending an agonizing existence can be condoned and forgiven.

Most studies of suicide focus only on individuals who kill themselves out of despair and mental illness and do not address the special circumstances of mentally competent, terminally ill individuals and so do not provide sound arguments for condemning assisted suicide. Statutory provisions would specify certain parameters, e.g., psychological evaluations, to prevent suicide attempts by sick people also suffering from depression.

**Opponents** say legalizing assisted suicide would presume a "right to suicide" founded on the false presumption that a person wishing to commit suicide is rational and sane. Studies show that almost everyone who commits suicide has mental health problems; suicide attempts are often desperate steps taken when individuals are without hope, and can be "cries for help" by people with very treatable problems.

Many terminally ill individuals who turn to suicide do so not because they are ill but because they are depressed. Taking any innocent human life, even one's own, is morally wrong; legalizing suicide would signal that less than perfect lives are not worth living.

Any "right to die" may very well become in practice a "duty to die"; both the seriously and the terminally ill could feel pressured to opt for suicide to avoid burdening their families or society. If assisted suicide were legalized, people dependent upon publicly funded health care – the elderly, poor and disabled – could even be influenced or directed toward suicide options in state and local government programs with cost containment agendas. Terminally ill patients need assurance that their lives are still important rather than feeling unworthy or pressured to die.

Physician-assisted suicide is counter to the historical

role of physicians as healers, and patient trust would be eroded by physician's dual authority to "prescribe" both death-inducing and healing measures. Furthermore, even the best laid plans for assisted suicides can go awry, causing further harm or injury to a dying individual or an unnecessarily painful death.

Compassionate alternatives, such as hospices, are needed to address the pain and psychological and spiritual needs of the dying. Suicide cheats individuals of opportunities to tie up their unfinished business by resolving old disputes, mending relationships, and considering the ultimate meaning of their lives. The U.S. health care system needs to be restructured to provide continuous, comprehensive, reliable and effective care and eradicate problems experienced by elderly and other vulnerable populations who suffer waiting lists, inexperienced practitioners, and other difficulties in obtaining needed and compassionate treatment.

## Supreme Court action

In June 1997, the U.S. Supreme Court affirmed the right of competent patients to refuse unwanted medical care and to receive pain treatment at the end of life even if it could hasten death. Allowing a patient to die by withdrawing life support or refusing medical treatment, the court noted, is widely recognized as acceptable by state legislatures and courts and the medical profession.

Most importantly, however, the court distinguished between assisted suicide and a patient's right to refuse

unwanted medical treatment, ruling that terminally ill individuals have no constitutionally protected right to assisted suicide. Upholding such a "right," the court said, would go against U.S. traditions, centuries of legal doctrine, and the policy choices of almost every state. The states have clear interests in drawing a line between allowing individuals to refuse treatment and assisting them in committing suicide. These interests include prohibiting intentional killing; preserving life; maintaining the role of physicians as healers; and protecting vulnerable people from indifference, prejudice and psychological or financial pressure to end their lives.

The decision, in the joined cases of *Washington et al. v. Glucksberg et al.* (117 S.Ct. 2258), and *Vacco, Attorney General of New York, et al. v. Quill et al.* (117 S.Ct. 2293), overturned lower court rulings. The former case involved a challenge to Washington state law that made assisting a suicide attempt a felony. The suit — brought by three patients, four doctors and a non-profit group called Compassion in Dying — claimed that the law violated individuals' constitutional rights to due process. The plaintiffs maintained that this right extended to personal choice by competent individuals on how and when to die. The federal district court and the 9th U.S. Circuit Court of Appeals agreed and said that the 14th amendment guaranteed individuals a "constitutionally protected liberty interest in determining the time and manner of one's own death." Washington state law, both lower courts had ruled, placed an undue burden on the exercise of liberty in making such a choice.

In *Vacco*, plaintiffs had challenged two New York

## Other resources

Many states have examined health care, legal, personal and other issues surrounding aging, terminal illnesses and dying, including: assisted suicide; treatment of intractable pain; hospice utilization; palliative care; education of health care professionals; spiritual care giving for the dying; advance directives; public opinion and education about end-of-life care; use of life-prolonging medical procedures; role of family and community in caring for the dying and terminally ill; expression of grief and loss; and economic impacts of terminal illnesses and dying. Detailed information on end-of-life issues and activities in other states is provided in a report by the National Conference of State Legislatures, *End-of-Life Care, A Guidebook for State Legislators*, scheduled for publication in the summer of 1998. For copies of the 60-page report (item number 6742), contact NCSL at (303)830-2054 or at [www.ncsl.org/programs/pubs/endoflife.html](http://www.ncsl.org/programs/pubs/endoflife.html).

The Robert Wood Johnson Foundation is funding "Last Acts," an initiative designed to improve the care of dying patients and to advocate changes in the medical profession, insurance industry, and public attitudes to make pain control and home care for the dying more widely available and thereby assisted suicide unnecessary. The initiative, which includes participation by more than 70 medical, religious and consumer groups, is headed by former first lady Rosalynn Carter. Information concerning Last Acts is available from the organization at P.O. Box 2316, Princeton, NJ, 08543-2316, (609)452-8701, or via the Internet at [www.rwjf.org/main.html](http://www.rwjf.org/main.html).

state statutes prohibiting assisted suicide on grounds that they violated the rights of terminally ill patients to equal protection under the law. The plaintiffs — Compassion in Dying along with a terminally ill patient and several doctors — charged that the state allowed terminally ill individuals on life support to hasten their deaths by withdrawing life-sustaining equipment but forbade terminally ill individuals not on life support similar relief through assisted suicide. While the federal district court ruled against the plaintiffs, the 2nd U.S. Circuit Court of Appeals decided that unequal treatment of terminally ill patients was not rationally related to any legitimate state interest.

## The Oregon experience

In 1994, Oregon became the first state to legally authorize physician-assisted suicide. The Death with Dignity Act — narrowly adopted in a voter initiative by 51 to 49 percent — authorizes certain terminally ill individuals to obtain lethal doses of medication to hasten death. The patient must first consult with two doctors and then wait 15 days. Dosages must be self-administered, and doctors are not required to honor requests.

Opponents of the law sued to overturn the act in 1994, claiming insufficient protection for mentally incompetent patients. The plaintiffs included two doctors and a woman with muscular dystrophy. In 1995, a federal district court enjoined the state from implementing the act on the grounds that it violated rights of terminally ill people to equal protection. That ruling was overturned in 1997 by the 9th U.S. Circuit Court of Ap-

peals, which said the plaintiffs had suffered no injury from the act's adoption and therefore had no basis for a lawsuit. In October 1997, the U.S. Supreme Court declined to hear an appeal of the ruling.

In the meantime, the Oregon legislature in November 1997 held a second referendum on whether the act should be repealed. In perhaps the biggest voter turnout in 34 years, 60 percent of Oregon voters chose to retain the law, despite heavy campaign spending by opponents. Some observers said public opinion had grown more comfortable with the idea of assisted suicide in the three years since the initiative had first been adopted, and that quite a few voters cast ballots against repeal in protest over holding the second vote. Others said the Oregon voting results do not reflect the national trend of increased opposition to assisted suicide with increased knowledge of the subject.

In March 1998, the Oregon Task Force to Improve the Care of the Terminally Ill released guidelines to health care providers about complying with the Death with Dignity Act and a companion document identifying Oregon resources for information pertaining to end-of-life care. Task force members represent a wide spectrum of health care professionals and organizations, as well as clergy, ethicists, attorneys and social workers. At least two people are known to have used the act to end their lives; statistics and records of deaths under the act are maintained as confidential information by the Oregon Division of Health.

In June 1998, U.S. Attorney General Janet Reno announced that the Justice Department would not interfere — *by Kristie Zamrazil*

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