Recent Developments in Physician-Assisted Suicide

June 1997

LITIGATION

1. *Washington v. Glucksberg* (No. 95-1858) and *Vacco v. Quill* (No. 96-110). In these cases, the Second and Ninth Circuits held that the New York and Washington statutes criminalizing physician-assisted suicide were unconstitutional as applied to competent, terminally ill patients. The cases were argued before the Supreme Court on 1/8/97. Most commentators believe the Court will reverse.

2. *Lee v. Harcleroad*, 107 F.3d 1382 (9th Cir. 1997), cert. pending (U.S. No. 96-1824). On 2/27/97, a 3-judge panel of the Ninth Circuit held that the plaintiffs lacked standing to challenge Oregon's Death with Dignity Act and ordered U.S. District Judge Hogan to dismiss the case; the court did not rule on the merits as to the plaintiffs' arguments. On 4/18/97, the panel denied plaintiffs' petition for rehearing. On 4/22/97, Judge Melvin Brunetti of the Ninth Circuit granted plaintiffs a stay pending application to the U.S. Supreme Court for a writ of certiorari. On 5/16/97, plaintiffs filed their petition for writ of certiorari. Although the defendants had waived their right to file a response, the Court requested a response on its own motion. As a result, the Court will not act on the petition until after the October term begins.

3. *Kevorkian v. Arnett*, 939 F.Supp. 725 (C.D. Cal. 1996), appeal pending sub nom. *Kevorkian v. Lungren* (9th Cir. No. 96-56405). Dr. Kevorkian and an AIDS patient brought this suit to invalidate California's statute criminalizing physician-assisted suicide as applied to competent, terminally ill patients. On 9/11/96, U.S. District Judge Consuelo B. Marshall invalidated the statute on Fourteenth Amendment due process grounds. Judge Marshall dismissed Kevorkian's claims for lack of standing, declined to rule on the Fourteenth Amendment equal protection claim, and held that the statute did not violate either the right to privacy or equal protection under California's Constitution. California's Attorney General appealed to the Ninth Circuit; proceedings have been stayed until 7/1/97 pending resolution of *Washington v. Glucksberg* and *Vacco v. Quill*. On 11/4/96, the U.S. Supreme Court denied immediate review [*Lungren v. Doe*, No. 96-531; *Doe v. Lungren*, No. 96-547]. The "John Doe" AIDS patient, Thomas Edwards, died before the case was finally resolved; in May 1997, Edwards' partner and heir, John Guard, filed formal complaints with California's Osteopathic Board of Medicine and the Medical Board of California charging that Edwards' physician abandoned him by retiring without arranging for his level of care to continue.

4. *Kevorkian v. Thompson*, 947 F.Supp. 1152 (E.D. Mich. 1997), appeal pending (6th Cir. No. 97-1094). Dr. Kevorkian and Michigan activist Janet Good filed 13 lawsuits on 8/13/96 asking for an injunction forbidding prosecutors in Wayne, Oakland, or Macomb Counties from using Michigan's temporary criminal statute (now expired) to prosecute various assisted suicides that occurred from May 1992 to February 1993. On the same day, plaintiffs withdrew all the lawsuits except one that had been assigned to Judge Paul Borman; attorney Geoffrey Fieger later apologized to a panel of federal judges for judge-shopping and paid a $7,500 penalty and $8,207 in associated legal costs. On 1/6/97, U.S. District Judge Gerald Rosen (to whom the remaining case had been assigned) ruled against the plaintiffs, finding that: (1) the court should abstain under *Younger v. Harris* from deciding Dr. Kevorkian's claims because they could be raised by him in defending actions pending against him in state courts, (2) Janet Good had no constitutional right to assisted suicide under the Fourteenth Amendment, and (3) Michigan laws regarding assisted suicide were unconstitutionally vague prior to December 1992, when a state criminal statute was enacted. On 1/28/97, an appeal was filed in the Sixth Circuit Court of Appeals; the matter is in abeyance pending resolution of *Vacco v. Quill*, with status reports due every 45 days beginning 6/30/97.

5. *McIver v. Krischer*, No. CL-96-1504-AF (Fla. 15th Cir. Ct. Jan. 31, 1997), cert. granted sub nom. *Krischer v. McIver*, No. 89,837 (Fla. Feb. 11, 1997). Under the sponsorship of the Florida Hemlock Society and the ACLU chapter of Palm Beach County, Dr. McIver and three terminally ill patients (two of whom later died) brought this suit seeking an injunction allowing McIver to assist in the patients' suicides without being prosecuted under Florida's statute criminalizing physician-assisted suicide. The plaintiffs' claims were based on Fourteenth Amendment due process and equal protection grounds and on the Privacy Amendment to Florida's Constitution. On 1/31/97, Judge S. Joseph Davis, Jr. ruled in favor of plaintiffs on equal protection and Florida Privacy Amendment grounds while denying the due process claim; the ruling applies only to Dr. McIver and Charles Hall. The 4th District Court of Appeal forwarded the broad

question of physician-assisted suicide directly to the Florida Supreme Court as an issue "of great public importance." The Florida Supreme Court accepted jurisdiction on 2/11/97, issued a stay pending the appeal, and heard oral argument on 5/8/97. A second suit, brought by Hall in Leon County but now on hold, seeks an injunction to prevent the Florida Board of Medicine from disciplining Dr. McIver if he assists in Hall's suicide. On 2/8/97, the Board of Medicine voted 9 to 6 to oppose physician-assisted suicide and 14 to 1 to investigate Dr. McIver if he assists in Hall's suicide; however, the Board had previously stipulated to a court order providing that McIver would not violate medical practice standards by assisting Hall if the plaintiffs prevailed in their lawsuit.

LEGISLATION

1. Connecticut. Although no bill to permit physician-assisted suicide was introduced during the most recent legislative session, Senator George Jepsen sponsored such bills in the two prior sessions. In April 1997, a coalition of health care providers and Catholic groups announced they were mounting a preemptive strike to prevent future enactment of such legislation.

2. Illinois. Illinois House Bill 0691, introduced by Rep. Doug Scott on 2/18/97, would legalize physician-assisted suicide under the Dignity in Dying Act. The bill is not expected to be debated or voted on during the current legislative session, but Rep. Scott wants to hold public hearings on the question during summer 1997.

3. Maine. The Catholic church has assumed a more active role on legislative matters, including opposing a bill that would permit physician-assisted suicide. The legislature is expected to delay action on the bill until next year. A survey of Maine residents by Strategic Marketing Services early in 1997 showed that almost two-thirds supported a terminally ill patient's right to seek help in committing suicide.

4. Massachusetts. For the second time, Rep. Douglas W. Petersen filed a bill that would legalize physician-assisted suicide for terminally ill patients. The bill was modified from prior bills to require that patients be evaluated by a psychiatrist, a pain management specialist, and a social worker and be referred to a hospice. Catholics and other opponents testified against the bill at hearings during May, and the bill is expected to die in committee.

5. Michigan

a. Bills. On 2/11/97, Sen. William Van Regenmorter, chairman of the Senate Judiciary Committee, reintroduced a bill in the legislature that would make helping a person commit suicide a crime punishable by two years in prison. A package of pain management bills in the House of Representatives would relieve physicians from liability for prescribing medications to control intractable pain and encourage use of national standards to certify physicians and accredit institutions in pain management techniques; the only mandate in the bills, however, would be to require health and insurance companies to tell consumers whether they offer pain management. Hearings on the pain management bills were held by the House during May, but full debate may not come until fall.

b. Voter initiative. The group Merian's Friends, which supports physician-assisted suicide for the terminally ill, intends to gather voter signatures between June and November 1997 in an attempt to put the issue before the legislature or, if the legislature fails to act, to a vote of the people in November 1998. Safeguards in the proposed legislation include a mandatory mental health evaluation, a 7-day waiting period, and continuing education for physicians on palliative care.

6. Oregon

a. Oregon Death with Dignity Act referred back to voters. At the request of opponents of Oregon's Death With Dignity Act, the Oregon House Judiciary Committee introduced eight bills that would repeal, delay, refer back to the voters for a new vote, or restrict application of the Act. On 4/23/97, the Family Law Subcommittee of the House Judiciary Committee voted 4-3 in favor of a "do pass" recommendation on HB 2954, which would refer the Act back to the voters for a revote on 11/4/97; a minority report urged that the Act be amended to correct certain perceived flaws. On 5/13, the House of Representatives refused to amend the Act and voted 32 to 26 to refer the unchanged Act back to Oregon voters in November 1997 to decide whether the Act should be repealed; on 6/9, the Senate voted 20 to 10 in favor of referral back to Oregon voters.

b. Polls of Oregon voters. A statewide GLS Research survey of 600 randomly selected Oregon voters released in March showed that 61% supported physician-assisted suicide, as compared to the 51% of voters who voted in favor of the Act in November 1994. A telephone poll of 600 likely voters conducted for The Oregonian in April showed that 52% opposed a revote on physician-assisted suicide; 40% favored a revote and 8% expressed no opinion.

7. Pennsylvania. Pennsylvania chapters of the Hemlock Society have abandoned efforts to introduce legislation authorizing physician-assisted suicide. Only eight of 253 legislators responded to a questionnaire sent to them in 1996, and only three said they supported the idea.

8. Virginia. Virginia's SB 788, which had passed the Senate by a vote of 27-12, was killed in the House after opponents

added an amendment requiring the legislature to reconsider it in 1998 before it could take effect. Under the bill, a health care provider who assisted in a suicide could be fined up to $100,000 and permanently lose his or her license to practice medicine.

9. Wisconsin

a. Bills. On 1/28/97, Senators Risser and Jauch, with co-sponsorship by Representatives Boye, Baldwin, and Kunicki, introduced the Wisconsin Aid in Dying Bill, which would authorize physician-assisted suicide for the terminally ill. Rep. Gregg Underheim, chair of the Assembly Health Committee, allowed six invited opponents and six proponents to testify at a public hearing on 4/29/97 but announced that he would not allow the bill to come up for a vote. A similar bill was introduced during the prior legislative session but was never debated by either the Assembly or Senate.

b. Poll of Wisconsin residents. A telephone survey of 433 randomly selected adults was conducted by the Wisconsin Survey Research Laboratory of the UW-Extension early in 1997. The poll found that 55% thought that physician-assisted suicide should be legal, while 37% said it should be against the law.

10. Hemlock Society campaign. The 25,000-member Hemlock Society plans to proceed with an agressive, grass-roots campaign to legalize physician-assisted suicide in 20 states.

11. Federal legislation. On 4/10/97, the House passed (by a vote of 398 to 16) a bill, known as the "Assisted Suicide Funding Restriction Act of 1997" (H.R. 1003), which would ban use of federal tax dollars to pay for physician-assisted suicide under such programs as Medicaid, Medicare, federal employee health benefits plans, medical services for federal prisoners, and military health care. On 4/16/97, the Senate passed the Act by a vote of 99 to 0. On 4/30/97, the Act was signed by President Clinton. The Act also authorizes the Secretary of Health and Human Services to fund research into pain treatment and suicide prevention and requires a federal study of how health care professionals are trained in end-of-life care.

OTHER NATIONAL DEVELOPMENTS

1. Michigan

a. Dr. Kevorkian's recent assisted suicides (since 3/1/97). These individuals were all found dead in motel rooms with a note to contact Dr. Kevorkian's attorney, but no evidence of cause of death was discovered and Dr. Kevorkian has not claimed responsibility:

(1) 48th suicide 3/6/97 = Helen Livengood (59-year-old woman with crippling arthritis and extreme weight loss).

(2) 49th suicide 3/18/97 = Albert Miley (42-year-old quadriplegic man).

(3) 50th suicide 3/25/97 = Janette Knowles (75-year-old woman w/ Lou Gehrig's disease).

(4) 51st suicide 4/8/97 = Heidi Aseltine (27-year-old woman w/ AIDS).

(5) 52nd suicide 5/7/97 = Delouise Bacher (63-year-old woman with multiple sclerosis).

b. Criminal prosecutions of Dr. Kevorkian

(1) Mistrial declared in Ionia County case. Dr. Kevorkian and Janet Good were indicted in Ionia County for the common law crime of assisting in a suicide, practicing medicine without a license, and conspiring to commit each act in connection with the 8/30/96 death of Loretta Peabody, which was reported as being from natural causes. Following a hearing on 5/16/97, the charges against Good (who is terminally ill) were dismissed; Good, Peabody's family members, and funeral workers were granted immunity from prosecution based on their testimony in the case; and portions of a seized videotape showing Peabody with Dr. Kevorkian were held to be admissible evidence. On 6/6/97, the Michigan Court of Appeals ruled that the prosecution could introduce evidence linking Dr. Kevorkian to the deaths of three other patients shown on the Peabody videotape. On 6/12/97, after the jury was impaneled, Judge Miel granted Voet's motion for a mistrial on the ground that defense attorney Geoffrey Fieger opening statement was "improper and prejudicial in several respects" and there was a "high likelihood" that some jurors would be so affected that they could not render a fair verdict. Voet has not indicated whether he will seek a retrial, a move that would provoke a lengthy appeals process.

(2) Cease and desist order. On 4/4/97, Dr. Kevorkian was served with an order from the Michigan Department of Consumer and Industry Services to cease and desist from practicing medicine by assisting in suicides without a medical license (Kevorkian's license was suspended on 8/21/92, although the suspension technically is still under appeal). The order applies to future suicides only. Violation of the order would constitute a felony

punishable by 4 years in prison and a $2,000 fine; charges could be brought by the Attorney General's Office either in the county circuit court where the act occurred or in Ingham County (where Lansing is located). Dr. Kevorkian has 30 days to appeal the order to the state Board of Medicine.

c. Dr. Kevorkian's civil action against the American Medical Association. On 5/27/97, Wayne County Circuit Judge Sharon Finch denied the AMA's request to dismiss a $10 million libel suit filed against the AMA and the Michigan State Medical Society by Dr. Kevorkian, who claims the AMA defamed him by calling him a "killer" and his behavior criminal. The AMA announced it will appeal the ruling.

d. Patient's civil action. On 5/26/97, Cheryl Fink filed a lawsuit against the Oakland County Prosecutor, two deputies, and St. Joseph Mercy Hospital. Fink, who suffers from a rare brain disorder, alleged that she was taken to the psychiatric ward of the hospital after going to the Oakland County Prosecutor's office in 1995 to get Dr. Kevorkian's telephone number.

e. Survey of Michigan voters. A telephone survey of 600 Michigan voters was conducted during January 1997 by EPIC/MRA. The poll showed that 63% favored allowing physician-assisted suicide and about half would consider physician-assisted suicide for themselves. The percentage who would consider physician-assisted suicide due to various conditions was as follows: need for life-support machines = 89%, chronic pain = 60%, loss of mobility = 50%, becoming a burden = 49%, loss of independence = 48%, less than 6 months to live = 43%, incontinence = 27%, prospect of nursing home = 25%.

2. Oregon. A complaint was filed by the State Board of Medical Examiners against Dr. James Gallant of Corvallis for engaging in active euthanasia with respect to his patient, Clarietta Day, who died 3/22/96, allegedly as a result of a lethal injection administered by a nurse. The Board held a second closed hearing on 3/13/97.

3. Florida. On 10/22/96, the state Agency for Health Care Administration suspended the license of Dr. Ernesto Pinzon after investigators charged him with intentionally giving deadly drugs on 10/6/96 to a man dying of cancer, Rosario Gurrieri of Sebring, Florida. On 11/21/96, Pinzon was indicted for first-degree murder. Pinzon is charged with administering six shots of morphine and two of Valium during a half-hour period, then injecting potassium chloride. Gurrieri's relatives did not know about or approve of Dr. Pinzon's actions. Trial of the case began 5/27/97. On 6/23/97, the trial judge blocked key testimony from a nurse based on state law protecting details of internal peer-review investigations; the prosecutor plans to appeal the ruling.

4. New York

a. State commission. On 4/17/97, New York Attorney General Dennis Vacco announced a new statewide commission to examine ways of improving the quality of care for the dying. The commission, chaired by Dr. Thomas Fahy, includes 19 health professionals from hospitals, medical schools, and hospices around the state, all of whom are opposed to physician-assisted suicide.

b. Sharon LaDuke. After carrying out a physician's orders to give a narcotic to dying patient Willis Dobisky to ease her death in 1993, nurse Sharon LaDuke was fired by Hepburn Medical Center, which also asked a district attorney to prosecute her as a killer. LaDuke, who was cleared of any wrongdoing by the prosecutor and found blameless by the state Department of Health and a peer panel, has sued the hospital to regain her job and be paid damages for slander. The hospital also faces a $4 million medical malpractice suit filed by the Dobisky family, which intends to use the money to open a hospice center for the terminally ill.

5. Washington. On 6/5/97, Betty Drumheller, a 64-year-old woman undergoing treatment for an aggressive form of leukemia, asked the West Spokane Unitarian Universalist Church to provide her sanctuary for physician-assisted suicide if her treatment fails. The church's interim minister, Rev. David Parke, turned down the request on 6/13/97 on the ground that the church first needed to develop a mechanism for making congregation-wide decisions.

6. American Bar Association. The Beverly Hills Bar Association has submitted a resolution supporting legalization of physician-assisted suicide to the ABA House of Delegates for a vote at the ABA annual meeting in August 1997.

7. AMA nationwide survey. A telephone survey of 1,000 adults nationwide sponsored by the AMA revealed that 76% were concerned about issues related to care at the end of life, including physician-assisted suicide and adherence to advance directives.

8. Rx Remedy nationwide poll. On 6/23/97, Rx Remedy, Inc. released the results of a comprehensive survey of Americans age 55 and over regarding right-to-die issues. The 5-year-old firm has invested $20 million in building a data warehouse about the health practices, attitudes, and behavior of American consumers in more than 1.2 million 55+ households. Over 100,000 households returned the completed 44-question survey, with 30,000 surveys selected and tabulated to create a demographically balanced national sample. Median age of sample respondents is 71. Results included the following:

a. 63% agreed that the terminally ill should have a legal right to commit suicide with a physician's assistance.

b. 64% favored enacting legislation authorizing physician-assisted suicide.

c. Support by religious affiliation: atheists 96%, Jews 88%, Protestants 68%, Catholics 50%.

d. Support remained constant as individuals aged: 64.7% for ages 55-65, 64.8% for ages 66-80, 65.9% for those over age 80.

e. Support was weakest in the Midwest and Deep South, but 46 states had 50% or more respondents who supported the right to physician-assisted suicide.

f. 57% agreed that more attention to pain control could virtually eliminate the need for euthanasia.

g. 78% agreed that it is acceptable to give patients high doses of pain-control drugs even if it hastens death.

h. 53% agreed that physicians should be allowed to give people instructions on how to end their own lives.

MEDICAL DEVELOPMENTS

1. Medicare reimbursement for palliative care. The Health Care Financing Administration (HCFA) has begun to reimburse physicians for palliative (comfort) care under a new code included on forms used to request reimbursement for Medicare patients. The new code clarifies that Medicare will pay for palliative care in a hospital setting.

2. AMA 100th anniversary conference. A two-day conference, "Ethics and American Medicine--History, Change and Challenge," was held 3/14-15/97 in Philadelphia in celebration of the 150th anniversary of the AMA and its code of ethics. Sponsors included the AMA and the University of Pennsylvania's Center for Bioethics. The conference brought together some of America's most noted medical ethicists and professional leaders.

3. AMA Institute for Ethics. On 3/14/97, the AMA launched a new Institute for Ethics that will focus on professionalism, managed care, genetic medicine, and end-of-life care. The institute will be housed at the AMA's Chicago headquarters with a core staff of nine medical ethicists, headed by director Dr. Linda Emanuel (AMA vice president for ethical standards). In addition to a $1 million annual budget from the AMA, the institute will use a $1.5 million, two-year grant from the Robert Wood Johnson Foundation to train physicians on improving care to the dying. The physician education program, which is designed to reach every physician in the United States over the next few years, intends to make advance care planning a routine part of patient care and to integrate palliative medicine into accepted care options.

4. AMA media symposium. In April 1997, the AMA and its partners in the Coalition for Quality End-of-Life Care hosted a media symposium in New York on end-of-life issues that drew about 50 journalists. The AMA indicated that outreach to the news media was viewed as essential "to counter the misguided--and highly vocal-- proselytizers for assisted suicide." At the symposium, the formation of a commission to improve the quality of end-of-life care in New York state was announced.

5. New York's Hospital Palliative Care Initiative. The United Hospital Fund has awarded $1.1 million to five hospitals in New York City (Beth Israel Medical Center, the Brooklyn Hospital Center, Montefiore Medical Center, the Mount Sinai Medical Center, and St. Vincent's Hospital and Medical Center) to improve emotional and physical care at the end of life. Each hospital has created a specific and different program intended to meet the needs of its patients and staff members. Strategies include creating a new staff position for a palliative care expert, focusing on pain relief rather than curing disease, monitoring how physicians deal with dying patients, and creating palliative care consultation teams. The United Hospital Fund also has given a grant to the New York Academy of Medicine to develop a curriculum to educate medical professionals about pain relief and another grant to a medical ethnographer to define patterns of decisionmaking and treatment for dying patients in several New York City hospitals. A major conference in palliative care is scheduled for June 1997, at which an analysis of end-of-life care in several New York City hospitals will be released.

6. Institute of Medicine report. On 6/4/97, a 12-member panel of experts in medicine, nursing, law, economics, and other fields, chaired by Dr. Christine Cassel, issued *Approaching Death: Improving Care at the End of Life*. The report, issued under the auspices of the National Academy of Sciences' Institute of Medicine, found that studies show that 40% to 80% of Americans die in preventable pain. The report recommended better training of health care professionals, reform of federal and state laws that inhibit the use of pain-relieving drugs, research on how people view and adjust to dying, and testing new insurance and other payment options for chronic illness.

7. Catholic plan to improve care of dying. At a meeting of the Catholic Health Association of the United States held in Chicago on 6/9/97, a coalition of Roman Catholic health care organizations (known as the Supportive Care for Dying Coalition) unveiled a plan to reform care of the dying in all of the nation's 1,200 Catholic hospitals by the year 2000. The coalition developed the plan after interviewing 407 people in 55 focus groups throughout the United States. The new approach will begin at five health care systems and expand to other Catholic hospitals within 3 years.

8. AMA initiatives. On 6/22/97, the AMA at its annual meeting introduced two initiatives intended to head off calls for physician-assisted suicide: (1) a bill of rights for dying patients and (2) a way for patients with Medic Alert bracelets to leave instructions for their final care. The bill of rights will be incorporated into the AMA's new physician education

program.

9. Maryland initiative. The Johns Hopkins University Bioethics Institute and the Maryland Attorney General's office have joined forces on a 4-year project to reduce barriers that cause patients to die in pain. In addition to pain management, the initiative will focus on advance directives and financial incentives to improve patient care in hospitals and nursing homes. Jack Schwartz, chief counsel for opinions and advice to Maryland's Attorney General, and Johns Hopkins researchers will travel the state to meet with patients, relatives, physicians, social workers, and hospital and nursing home administrators. A public conference will be held by the end of 1997, and a state advisory board will be appointed to decide which recommendations to pursue. Ultimately, potential solutions will be tested in pilot projects.

10. Pain management

a. NIH pain consortium. The National Institutes of Health has convened a pain consortium to coordinate research by the various scientific disciplines into pain and pain management, and to shepherd basic science findings into commercial development.

b. Hospital charting of patient pain. At the urging of the American Pain Society, some hospitals have begun to include a description of the patient's pain on the medical chart recording other vital signs.

c. Hospital guidelines. The Department of Health and Human Services has issued guidelines (co-authored by Dr. Daniel Carr) instructing hospitals to treat both chronic and acute pain aggressively with strong opioids.

11. Government audit of hospice programs. As part of the government's Operation Restore Trust, a dozen hospice programs have been notified by the inspector general's office of the Department of Health and Human Services that they improperly spent $83 million caring for people who lived more than 210 days after enrolling for hospice care. Program officials fear that they may be forced to repay Medicare funds spent to care for dying patients. Operation Restore Trust is working in five states (California, Florida, Illinois, New York, and Texas), but the government has announced that it will be expanded to all 50 states.

12. Booklet for Oregon physicians. Oregon's Task Force to Improve the Care of Terminally Ill Oregonians, which was formed by Oregon Health Sciences University after Measure 16 was passed, is made up of a broad range of health experts for and against assisted suicide. The Task Force has prepared a 54-page booklet, *The Final Months of Life*, giving a county-by-county listing of resources for dying patients. The booklet has been mailed to 4,000 Oregon physicians who treat the dying.

13. Michigan State Medical Society. On 5/4/97 at its annual meeting, the Michigan State Medical Society changed its policy toward physician-assisted suicide from one of neutrality, calling physician-assisted suicide "fundamentally incompatible with the physician's role as healer." However, the group still opposes bills that would outlaw physician-assisted suicide because of concern such bills would cause physicians to give insufficient pain medication to patients. The group also adopted four resolutions calling for better pain management and depression treatments and better education for physicians on using hospice care.

14. American Psychological Association. The APA has not taken a stance on assisted suicide, but its Board for the Advancement of Psychology in the Public Interest has established a working group to look at the issue.

15. Recent surveys and articles

a. Observations of terminally ill patients who choose suicide. The experiences of terminally ill patients who voluntarily elected suicide to hasten death and who met the guidelines of Compassion in Dying were reported in 1996. Thomas A. Preston & Ralph Mero, *Observations Concerning Terminally Ill Patients Who Choose Suicide*, 4 Journal of Pharmaceutical Care in Pain & Symptom Control 183 (1996), and Drug Use in Assisted Suicide and Euthanasia, at 183 (M. Battin & A. Lipman eds., 1996). During its first 13 months of operation, Compassion in Dying received 300 serious requests from patients, most of whom did not meet the guidelines because they did not have an incurable medical condition or were not in the terminal stage of dying. Members of Compassion in Dying had extensive working contact with 46 patients who met the guidelines and died during this period. Nine patients were in institutions and unable to obtain medicines necessary to hasten death. Of the remaining 37 patients, 8 asked their physicians for medication but were refused, 5 obtained medication but died naturally, and 24 hastened death at home with prescription drugs. Death ensued at an average of three hours after ingesting lethal drugs, with all falling deeply asleep within five minutes and then peacefully dying within 25 minutes to 10 hours. The authors describe the typical dosages of antinausea medication and lethal drugs found to be effective. Patients who chose to hasten death had good pain management and comfort care but chose to terminate life because of what they characterized as unbearable suffering.

b. "Terminal sedation." Dr. Paul Rousseau of the Geriatrics and Extended Care Veterans Affairs Medical Center in Phoenix, Arizona, has suggested that "terminal sedation" (based on the principle of double effect) is a means to provide compassionate care while relieving inordinate suffering. Paul Rousseau, *Terminal Sedation in the Care of Dying Patients*, 156 Archives of Internal Medicine 1785 (1996). Questions raised by Dr. Rousseau include the level of symptoms that warrants terminal sedation, steps to

be taken before deciding on terminal sedation, drug choice and means of delivery, and the level sedation desired by the patient.

c. Defining the "terminally ill." A research team at George Washington University's Center to Improve Care of the Dying has reviewed data from the SUPPORT study and concluded that deciding who should be counted as "terminally ill" will pose such severe difficulties that it may be untenable as a criterion for permitting physician-assisted suicide. Joanne Lynn et al., *Defining the "Terminally Ill": Insights from SUPPORT*, 35 Duquesne L. Rev. 311 (1996). Physicians in the five participating hospitals were asked to rate the study patients' chances for surviving for another 6 months. Of those rated as having a 50% chance of survival, almost half lived well beyond 6 months--some up to 3 years. Of those rated as having a 20% chance of survival, 10% lived beyond 3 years. Inability to predict survival was especially difficult for patients with congestive heart failure: of those rated as having a 20% chance of survival, actual survival was more than double the 6-month limit and was 7 times the rate expected by physicians. Similar conclusions were reached when analyzing data from both the SUPPORT study and the Acute Physiology and Chronic Health Evaluation (APACHE) study of patients admitted to the ICUs of 40 hospitals. Joanne Lynn et al., *Prognoses of Seriously Ill Hospitalized Patients on the Days Before Death: Implications for Patient Care and Public Policy*, 5 New Horizons 56 (1997).

d. Physician-patient communication. A report published in January 1997 analyzed audiotapes of physician-patient discussions and questionnaires, at 11 sites in the United States and Canada in 1985 and 1986, to determine communication patterns and patient and physician satisfaction. Debra L. Roter et al., *The Patient-Physician Relationship: Communication Patterns of Primary Care Physicians*, 277 JAMA 350 (1997). Analysis revealed five distinct communication patterns: (1) "narrowly biomedical," characterized by closed-ended medical questions and biomedical talk; (2) "expanded biomedical," with moderate levels of psychosocial discussion; (3) "biopsychosocial," with a balance of psychosocial and biomedical topics; (4) "psychosocial," characterized by psychosocial exchange; and (5) "consumerist," characterized primarily by patient questions and physician information giving. The two most common patterns, narrowly biomedical and expanded biomedical, each accounted for one-third of visits and were used at least once by more than 60% of physicians; the biopsychosocial pattern was evident in 20% of visits and was used by 42% of physicians; the psychosocial and consumerist patterns were much less common (7% and 8% of visits) and were used by fewer than a quarter of physicians. Patient satisfaction was highest with the psychosocial pattern, while physician satisfaction was highest with the consumerist pattern; both patients and physicians were least satisfied with the narrowly biomedical pattern. The length of visits remained about the same regardless of the pattern of communication.

e. Practical issues. An article published 1/15/97 discusses some of the practical issues that need to be addressed if physician-assisted suicide is legalized. Margaret A. Drickamer et al., *Practical Issues in Physician-Assisted Suicide*, 126 Annals of Internal Medicine 146 (1997). These issues include determining patients' motivations for requesting physician-assisted suicide, assessing mental status, diagnosing and treating depression, maximizing palliative interventions, evaluating external pressures on the patient, predicting life expectancy, determining effective medications and dosages, and discussing the physician's position on physician-assisted suicide with the patient.

f. Advance directives. Three articles published 1/15/97 have concluded that advance directives alone do not substantially enhance physician-patient communication or decisionmaking about resuscitation, typically do not contain specific instructions to guide medical decisionmaking (and such instructions, when present, often are not followed), and do not lead to a reduction in hospital resource use by dying patients. Joan M. Teno et al., *Advance Directives for Seriously Ill Hospitalized Patients: Effectiveness with the Patient Self-Determination Act and the SUPPORT Intervention*, 45 J. American Geriatrics Society 500 (1997); Joan M. Teno et al., *Do Advance Directives Provide Instructions That Direct Care?*, 45 J. American Geriatrics Society 508 (1997); Joan M. Teno et al., *The Illusion of End-of-Life Resource Savings with Advance Directives*, 45 J. American Geriatrics Society 513 (1997).

g. Older adults' attitudes about end-of-life decisions. A report published in March 1997 analyzed the responses of 388 relatively healthy adults ages 60-100 to 17 decision situations depicting terminal and nonterminal conditions with a very low quality of life and correlated the results with demographic, health, and psychosocial characteristics. Victor G. Cicirelli, *Relationship of Psychosocial and Background Variables to Older Adults' End-of-Life Decisions*, 12 Psychology and Aging 12 (1997). The average percentage endorsing each of 7 decision options was as follows: 51% try to continue living, 49% refuse or withdraw treatment, 36% let someone close decide what was best, 20% let their physician or someone else make a decision about ending their life, 12% ask someone else to end their life for them, 12% ask someone else to help them take their own life, 7% take their own life. Those who favored maintaining life no matter how dire the circumstances tended to be black, have less education and lower occupational status, have a greater subjective religiosity, place a lower value on quality of life, and have less fear of the dying process but more fear of destruction of the body. Those who favored ending their lives tended to be white, have more education and higher occupational status, have less subjective religiosity, place a higher value on quality of life, and have more fear of the dying process and the unknown but less fear of destruction of the body.

h. Equating terminally ill patients who require life-sustaining treatment with those who do not. In a "Special

Communication" published 6/4/97, two physicians argue that court decisions equating terminally ill patients who require life-sustaining treatment with those who do not (i.e., decisions under the Equal Protection Clause) are based on a faulty clinical view of the care of terminally ill patients and might undermine the care of such patients. Ann Alpers & Bernard Lo, *Does It Make Clinical Sense to Equate Terminally Ill Patients Who Require Life-Sustaining Interventions with Those Who Do Not?*, 277 JAMA 1705 (1997).

i. Data from the Netherlands. In a "Commentary" published 6/4/97, three authors reanalyze data from the 1990 and 1995 studies of Dutch medical practices and reach opposite conclusions from those of the original researchers (as reported in the New England Journal of Medicine in November 1996). Herbert Hendin, Chris Rutenfrans & Zbigniew Zylicz, *Physician-Assisted Suicide and Euthanasia in the Netherlands: Lessons from the Dutch*, 277 JAMA 1720 (1997). The authors conclude that "there has been an erosion of medical standards in the care of terminally ill patients in the Netherlands" and that "the Dutch experience indicates that these practices defy adequate regulation." The Dutch researchers and the editor of the New England Journal of Medicine claim that the JAMA attack is biased and that portions of the article are misleading or irrelevant.

j. Psychiatric practice in the Netherlands. An article published on 6/19/97 reports the results of an anonymous questionnaire sent to Dutch psychiatrists in 1996 by the Dutch Department of Public Health. Johanna H. Groenewoud et al., *Physician-Assisted Death in Psychiatric Practice in the Netherlands*, 336 New England J. Medicine 1795 (1997). Based on the results of 552 questionnaires, the researchers concluded that explicit requests for physician-assisted suicide or active euthanasia are not uncommon in psychiatric practice in the Netherlands, but these requests are rarely granted. In addition, psychiatric consultation for medical patients who request physician-assisted death is relatively rare. Specific findings (which covered 1994 and 1995) included the following:

(1) Patients requesting assistance. The predominant psychiatric diagnosis of patients requesting assistance was a mood disorder; 64% of patients were under age 50. The most frequent reasons for requesting assistance were the absence of any hope of improvement (68%), unbearable mental suffering (58%), being a burden to others (29%), pain or other physical suffering (18%), and the loss of dignity (14%).

(2) Response to actual patient requests. 37% of psychiatrists had received an explicit, persistent request for physician-assisted death, but only 2% of psychiatrists had granted a request (for a total of 12 cases). Most of the patients for whom a request was granted had both a mental disorder and a serious physical illness. The most frequent reasons for refusing a request were the belief that a patient had a treatable mental disorder, opposition in principle to assisting in a suicide, and doubt that the patient's suffering was unbearable or hopeless.

(3) Psychiatrists' acceptance of physician-assisted death. Of those who had not actually granted a request, 64% thought granting a request for a psychiatric patient could be acceptable and 44% could conceive of a situation in which they would be willing to assist.

(4) Psychiatric consultation. 30% of psychiatrists had been consulted at least once by a physician in another specialty about a patient's request, but consultation is estimated to occur in only about 3% of all cases. Psychiatrists agreed strongly (96%) that a psychiatrist should be consulted when a request is made due to mental suffering; when a request is made due to physical suffering, however, 78% thought a psychiatrist should be consulted only if the attending physician judged it necessary.

INTERNATIONAL DEVELOPMENTS

1. Australia

a. Northern Territory legislation. The Rights of the Terminally Ill Act (which authorized both physician-assisted suicide and active euthanasia) has been repealed by legislation enacted in the national parliament. However, deputy opposition leader John Bailey introduced a private member's bill in the Northern Territory parliament on 4/23/97 (known as the Criminal Code (Euthanasia) Amendment Bill of 1997) that would circumvent the Euthanasia Laws Bill 1996 by providing that euthanasia is illegal, but allowing physicians to engage in euthanasia subject to only a $50 fine if they abide by regulatory guidelines. The bill is expected to be debated in the Northern Territory parliament around 8/20/97.

b. Federal legislation

(1) Euthanasia Laws Bill 1996. The Euthanasia Laws Bill 1996, which strips the Australian territories of the power to make laws permitting active euthanasia or assisted suicide, was signed into law on 3/27/97. The bill (which passed in the House of Representatives by a vote of 88 to 35 last December) was passed in the Senate on 3/25/97 by a vote of 38 to 33

following four days of intense debate. Before being passed, the bill was amended by voice vote to commit the government to greater focus on palliative care. Northern Territory Chief Minister Shane Stone has indicated that a High Court challenge against the federal legislation is being considered.

c. Other proposed legislation

(1) South Australia. A private member's bill that would legalize euthanasia, known as the Voluntary Euthanasia Bill 1996, was introduced in the South Australia parliament on 11/8/96 by Labor MP Anne Levy. The bill goes farther than the Northern Territory legislation in that it allows execution of an advance request naming a trustee to act on behalf of a patient who is no longer able to speak to communicate a wish for euthanasia. The Upper House is expected to vote on the bill by the end of June; the legislation is believed to face almost certain defeat in the Lower House, which defeated a prior bill on voluntary euthanasia in July 1995 by a vote of 30 to 12.

(2) Tasmania. The state parliament has announced its intention to begin a Select Committee inquiry into the need for euthanasia legislation.

(3) Referendum. The Australian Democratic Party has announced it will push for a referendum in the states where it has members in the state parliament (South Australia, Western Australia, and New South Wales).

d. Esther Wild. Esther Wild, who had qualified for euthanasia under the Northern Territory legislation before its repeal, died on 4/16/97, nearly 4 days after Dr. Philip Nitschke began terminal sedation or "slow euthanasia." South Australia's Director of Public Prosecutions says that he will not urge that Dr. Nitschke be charged with a crime, even though he technically has confessed to murder in describing the circumstances of Wild's death. However, the coroner is conducting an inquiry into discrepancies between Wild's death certificate and Dr. Nitschke's public comments after her death.

e. Dr. Nitschke's "coma machine." Dr. Philip Nitschke is building a "coma machine" that would link a terminally ill patient's brain activity to a constant drug infusion of morphine for pain relief and Midazolam as a sedative, aimed at keeping the patient permanently unconscious until death.

f. Medical surveys

(1) Attitudes of Australian physicians. A national survey of Australian physicians released 11/18/96 correlated responses to four clinical scenarios with physicians' sex, religion, medical training, and country of medical degree. A major finding of the study was that physicians did not make consistent decisions on the treatment of severely and terminally ill patients at the end of life, suggesting that no uniform criteria exist to guide physicians. In the scenario involving a patient request for aid in dying, approximately 86% of physicians were unwilling to provide more than palliative care; 9% were willing to participate in physician-assisted suicide and 5% in active euthanasia. Charles Waddell et al., *Treatment Decision-Making at the End of Life: A Survey of Australian Doctors' Attitudes Towards Patients' Wishes and Euthanasia*, 165 Medical Journal of Australia 540 (1996).

(2) Comparison of attitudes of physician and community attitudes in Queensland. A survey of physicians and community members in Queensland published on 2/3/97 revealed that community members support greater choice and control over end-of-life decisions than do physicians. Margaret A. Steinberg et al., *End-of-Life Decision-Making: Community and Medical Practitioners' Perspectives*, 166 Medical Journal of Australia 131 (1997). Questions asked and percentage of affirmative responses by each group were as follows:

(a) Question 1. If good palliative care were freely available to everyone who needed it, do you think anyone would ever ask for assistance to end their lives? Yes = 79% physicians, 75% community.

(b) Question 2. If it were always possible to control a person's pain, in a terminal care situation, do you think anyone would ever ask for euthanasia? Yes = 68% physicians, 54% community.

(c) Question 3. If a terminally ill patient has decided that his/her life is of such poor quality that he/she would rather not continue living, do you think a doctor should be allowed by law to assist a terminally ill person to die? Yes = 36% physicians, 65% community.

(d) Question 4. If a person is being kept alive by a life-support system (such as a respirator) and that person asks for the machine to be turned off, do you think the doctor should comply with that request? Yes = 54%

physicians, 78% community.

(e) Question 5. Do you think the law should be changed to allow active voluntary euthanasia for terminally ill people who decide that they no longer wish to life? Yes = 33% physicians, 70% community.

In addition, 53% of physicians said they had been asked by patients for assistance to end their life, 43% had been asked by patients to administer something to end their life, and 62% had been asked to administer something to end their suffering. Nineteen percent had been asked by a patient's family to terminate the patient's life, and 62% had been asked to terminate the patient's suffering.

(3) Practices of Australian physicians. A survey of Australian physicians published on 2/17/97 revealed that an estimated 36.5% of all deaths result from a physician intentionally accelerating the patient's death. In almost half of these deaths, the patient made no explicit request, there was no discussion of ending the patient's life, and the physician did not believe that the patient had expressed a wish for death to be hastened. The euthanasia rate in Australia was double that of the Netherlands, and Australian physicians were far less likely to discuss their decision to hasten a patient's death with the patient or even to seek the patient's consent. Helga Kuhse et al., *End-of-Life Decisions in Australian Medical Practice*, 166 Medical Journal of Australia 191 (1997).

(4) Attitudes of Australian nurses. A survey releasing by the nursing journal Nursing Review in March 1997 showed that nearly 70% of Australian nurses supported the introduction of voluntary euthanasia.

(5) Survey of Royal Australian College of General Practitioners. In a survey released on 4/10/97, 68% of members of the Royal Australian College of General Practitioners believed that euthanasia is a caring act, 56% supported euthanasia but believed it should be limited to the terminal stage of a terminal illness, and 45% said they would wish to have the option themselves if they were dying.

(6) Survey of physicians in Victoria. On 4/13/97, the Melbourne *Sunday AGE* published the results of a survey of 54 Victorian physicians who treat terminally ill patients. Thirty-four indicated they disagreed with the actions of the national parliament in overturning the Northern Territory euthanasia law; 26 said that Victoria should legalize euthanasia, although only 9 definitely were willing to appear on a national register of physicians willing to assist patients with euthanasia. Twelve physicians admitted killing terminally ill patients in violation of the law; one AIDS physician publicly announced that he had assisted three AIDS patients to die.

(7) AMA survey of physicians. On April 1997, the Australian Medical Association issued a survey of 3,000 physicians showing that many already are helping patients to die by administering potentially lethal doses of pain relief regardless of the law.

(8) Palliative care study of cancer patients. The first palliative care study of cancer patients and how they live over time is currently under way. The study examines 180 cancer patients' quality of life, their pain symptoms, and the information given between patient, family, and physician. The study is due to be completed by the end of 1997.

g. Public opinion polls

(1) Survey of attitudes in the Northern Territory. Survey results published on 2/22/97 revealed that the Northern Territory legislation was approved of by 79.3% of community members, 65.4% of nurses, and 34.9% of physicians in the Northern Territory. M. Steinberg et al., 349 *The Lancet* 577 (1997).

(2) Public opinion poll. In a Morgan poll released 3/16/97 by the Voluntary Euthanasia Society of Victoria, 77.3% of voters opposed the federal bill that would overturn the Northern Territory's legislation authorizing euthanasia; 79.9% supported the right of a terminally ill patient to receive a lethal injection from a physician.

2. Canada

a. Prosecution of physicians

(1) Dr. Genereux. Dr. Maurice Genereux, who has been charged with assisting the suicide of an HIV-positive patient, Aaron McGinn, in Toronto in April 1996, could face up to 14 years in prison. At a preliminary hearing that began 5/1/97 and will resume in October, the prosecutor sought to add four more charges: counseling suicide and criminal negligence causing death in relation to McGinn's death and aiding suicide and criminal negligence

causing bodily harm in connection with an attempted suicide by another patient in July 1996.

(2) Dr. Morrison. Dr. Nancy Morrison was charged in May 1997 with first-degree murder in connection with the death on 11/10/96 of patient Paul Mills, reportedly from a lethal injection, in the intensive care unit at the Queen Elizabeth II Health Sciences Centre in Halifax. Conviction would carry an automatic life sentence with no possibility of parole for 25 years. Mills' death was reported as being from natural causes following the family's consent to withdrawal of life support. Dr. Morrison has been released from jail on $10,000 bail and is free to practice medicine outside the hospital's intensive care unit until her preliminary hearing scheduled to begin 2/9/98. Colleagues have expressed support for Dr. Morrison, a respected physician and medical school professor. The hospital has appointed an independent panel to review Mills' death. Halifax police are now investigating other cases of sudden or unexpected death in the hospital (none of which involve Dr. Morrison).

b. Legislation. Svend Robinson's proposed bill to decriminalize physician-assisted suicide (Private Members' Bill C-304) died 3/6/97 in the House of Commons without a vote.

c. Latimer prosecution. Robert Latimer was convicted of second-degree murder in 1994 for the mercy killing of his disabled 12-year-old daughter. On 2/6/97, the Supreme Court of Canada issued a 9-0 decision granting Latimer a new trial because the government prosecutor had ordered police to question prospective jurors (including five who ended up on the jury) concerning their views on religion and euthanasia; however, the court rejected Latimer's request that his confession be suppressed. Latimer had been sentenced to life in prison without possibility of parole for 10 years, but spent only one day in jail before being released on $10,000 pending the appeal. Latimer's new trial is set for 10/27/97.

3. Colombia

a. Court decriminalizes active euthanasia. On 5/20/97, Colombia's Constitutional Court issued a 6-3 decision decriminalizing active euthanasia of terminally ill patients who consent; the court subsequently reaffirmed its ruling on 6/12/97. The Catholic church has petitioned to overturn the ruling, and the matter will be debated again in 4 weeks. Four of the 9 judges reportedly support overturning the ruling. The ruling came in a case brought by a Bogota lawyer, José Parra, who had sought to invalidate existing criminal laws that impose a lesser penalty for mercy killing than for murder. If the court's ruling becomes final, Colombia's congress is expected to consider legislation regulating euthanasia.

b. Public opinion poll. A poll carried out by the National Consulting Center and published in the 5/15/97 edition of Bogota's El Espectador newspaper showed that 53% of Colombians agreed that no penalty should be imposed for the act of putting someone who is incurably ill and suffering intensely out of their misery.

4. Germany

a. Survey of physicians. The 11/27/96 of the German newsmagazine STERN contained the results of a survey of German physicians conducted by Dr. Karl-Heinz Wehkamp, Director of the Center for Health Ethics in Hannover. A total of 184 hospital chief physicians and 282 general practitioners participated in the written and oral survey during fall 1996. The survey showed that 88.0% of hospital physicians and 74.3% of private physicians approved of administering painkillers having a double effect; 54.4% of hospital physicians and 48.3% of private physicians had been asked by patients to carry out active euthanasia, but only about 1 in 20 had done so; and 32.2% of hospital physicians and 30.2% of private physicians could imagine that they would perform active euthanasia for humanitarian reasons.

b. Nurse convicted. On 5/7/97, a Bavarian nurse was sentenced to 5 years in jail by a court in Ansbach, Bavaria, for having injected an incurable 85-year-old woman with a fatal dose of a sleeping drug. The town council and local residents have donated $580,000 to help the nurse.

5. Great Britain. On 6/12/97, Sir Stephen Brown in the Family Division of the High Court held a preliminary private hearing to consider the request of Annie Lindsell (who suffers from motor neurone disease) to extend the doctrine of double effect and allow her physician to give her drugs that would relieve her distress but also may hasten her death.

6. Japan

a. Dr. Yamanaka. Dr. Yoshihiro Yamanaka administered a muscle relaxant intravenously in April 1996 to hasten the death of an unconscious man who had stomach cancer and was in excruciating pain. Kyoto police, who forwarded the results of their investigation to prosecutors on 4/24/97, said Yamanaka should have known the dose of muscle relaxant would be fatal for the patient.

b. Parliamentary vote on recognizing brain death. On 6/17/97, the Japanese parliament approved a bill that would allow heart and lung transplants for the first time in Japan, but only under strict conditions. The bill accepts the concept of brain death but requires that a donor give consent to be diagnosed as brain

dead and gives the donor's family the right to veto the patient's wish.

7. The Netherlands

a. New reporting procedures. Under recently revealed changes to the reporting procedures, euthanasia cases will no longer be referred to public prosecutors but instead will be submitted to an independent committee made up of legal, medical, and ethical experts. The changes are intended to increase the rate at which physicians report deaths resulting from euthanasia.

b. Physician prosecuted for murder. On 4/8/97, Dr. Sippe Schat, who had been charged with the murder of a 72-year-old patient, Dora Brattinga, in April 1996, was released after a court handed down a 6-month suspended sentence. The court found that Dr. Schat was not guilty of murder because the patient had expressed a wish to die. However, Dr. Schat failed to follow guidelines immunizing physicians who participate in euthanasia, by failing to get a second opinion and falsifying the death certificate to show the patient died of natural causes.

8. Norway. Retired Dr. Christian Sandsdalen has been charged with premeditated murder and had his license revoked for admittedly giving a lethal dose of morphine in June 1996 to a 45-year-old woman suffering from multiple sclerosis. He demanded on national TV that he be charged as a test of Norway's laws against euthanasia. The case is expected to be heard in an Oslo municipal court later in 1997.

9. The Philippines. On 3/25/97, the Philippines' Congress approved for debate the Right to Die Act, which would allow patients dying from terminal diseases to order medical remedies stopped or to ask that artificial means be administered to cause their death. More than 80% of the population is Roman Catholic, and the Catholic church opposes the bill.

10. South Africa

a. South African Law Commission report. The South African Law Commission released a discussion document in April 1997 that is open to public submissions until 6/30/97. The report, which includes draft proposed legislation, recommends legislation permitting the withdrawal and withholding of life-sustaining treatment but takes no position on assisted suicide and active euthanasia.

b. Survey of physicians. A recent survey by the Medical Association of South Africa revealed that 12% of physicians had actively helped terminally ill patients to die and 9% had participated in physician-assisted suicide.

11. Spain

a. Laws amended to reduce criminal penalties. On 11/18/95, the Spanish parliament approved a new penal code scheduled to go into effect 6 months after its publication in the State Official Bulletin. The amended laws reduce criminal penalties for "cooperating" in an assisted death from 6-12 years down to 6-12 months; penalties for "executing" the death (active euthanasia) are reduced from 12-20 years down to 1½-3 years.

b. Ramon Sampedro. Ramon Sampedro, a 53-year-old man from the northwest of Spain who has been paralyzed from the neck down for 28 years, has been campaigning since 1993 for the right to assistance to end his life. After his case was rejected by the Constitutional Court in Barcelona and the European Court of Human Rights, the provincial court of La Coruna agreed to reopen his case in November 1996. Sampedro, who wrote a book called *Letters from Hell* in 1996, has received legal and moral support from a Spanish pro-euthanasia group, Derecho a Morir Dignamente.

c. National poll. A 1992 poll conducted by the Centro de Investigaciones Sociológicas showed that 66% of Spanish adults believed that voluntary euthanasia should not lead to criminal punishment.

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