Recent Developments in Physician-Assisted Suicide

October 1997

LITIGATION

1. *Lee v. Harcleroad*, 107 F.3d 1382 (9th Cir. 1997), cert. denied (Oct. 14, 1997, 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. Plaintiffs' petition to the U.S. Supreme Court for writ of certiorari and motion to defer consideration were denied on 10/14/97. However, the final judgment in the case is not expected to be entered for 1-2 weeks, and opponents of the Act have vowed to prevent its implementation prior to the November 4 election.

2. *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 the right to privacy or to equal protection under California's Constitution. Opening briefs were filed in September in the pending appeal to the Ninth Circuit.

3. *Kevorkian v. Thompson*, 947 F.Supp. 1152 (E.D. Mich. 1997), appeal pending (6th Cir. No. 97-1094). Dr. Kevorkian and Janet Good filed suit asking for an injunction forbidding prosecutors in three counties from using Michigan's temporary criminal statute to prosecute various assisted suicides that occurred during 1992 and 1993. On 1/6/97, U.S. District Judge Gerald Rosen 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 9/8/97, a motion to remand was filed in the pending appeal to the Sixth Circuit. The parties filed a status report on 9/30/97; the next report is due 10/29/97.

4. *Krischer v. McIver*, 697 So.2d 97 (Fla. Jul. 17, 1997), reversing *McIver v. Krischer*, No. CL-96-1504-AF (Fla. 15th Cir. Ct. Jan. 31, 1997). 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. 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 applied only to Dr. McIver and Charles Hall. On 7/17/97, the Florida Supreme Court reversed in a 5-1 vote, holding that the federal constitutional claims were governed by *Washington v. Glucksberg* and *Vacco v. Quill* and that Florida's statute did not violate the Privacy Amendment to Florida's Constitution.

LEGISLATION

1. Intractable pain legislation. At least 16 states now have legislation intended to make physicians more willing to take steps to control patients' intractable pain. In every state except Wisconsin, the legislation was enacted in 1995 or later. Iowa and California are among the states that are expected to consider pain management legislation in their next

legislative sessions.

2. Florida. The Hemlock Society of Florida has abandoned its efforts to push a law allowing physician-assisted suicide after it could not find a legislator to sponsor the bill. Instead, Hemlock has joined forces with the Florida Commission for Aging with Dignity (which opposes physician-assisted suicide) to seek passage of legislation to improve end-of-life care.

3. Maine. Maine lawmakers will consider a physician-assisted suicide bill later this year.

4. Michigan

a. Voter initiative. The group Merian's Friends, which supports physician-assisted suicide for the terminally ill, intends to gather 270,000 voter signatures in an attempt to put the issue to a vote of the people in November 1998. A poll of 600 Michigan voters conducted by EPIC/MRA in late July found that 56% would vote for or were leaning in favor of the initiative.

b. Legislature. Senator William Van Regenmorter, chairman of the Senate Judiciary Committee and sponsor of a bill that would outlaw physician-assisted suicide, is conducting public hearings on the question. Another bill has been proposed that would refer the question to Michigan voters in November 1998.

5. New York. The Hemlock Society of New York has embarked on a campaign to contact state legislators, urging them to consider legislation authorizing physician-assisted suicide.

6. Oregon. The Oregon legislature passed HB 2954, which asks voters to repeal the Oregon Death with Dignity Act. Ballots on the referendum (known as Measure 51) were mailed to voters on 10/15/97. The election will be on 11/4/97.

a. Contents of ballot. Oregon's governor vetoed HB 3502, which would have changed the usual ballot measure procedure, having the legislature (rather than the attorney general) write the measure's title and precluding review by the state supreme court. Both supporters and opponents of Measure 51 challenged the attorney general's proposed title, but the Oregon Supreme Court upheld the language.

b. Statewide public opinion poll. A statewide poll conducted in early September by the Oregonian newspaper showed that 65% thought the legislature should have allowed the Oregon Death with Dignity Act to go into effect and 64% planned to vote against repeal.

c. Election campaign

(1) Supporters of repeal. The Yes on 51 committee has hired Chuck Cavalier (an expert political consultant who helped defeat physician-assisted suicide laws in Washington, California, and Australia) and has launched a costly and highly visible campaign claiming that the Oregon Death with Dignity Act is "fatally flawed." One of their chief claims is that Dutch studies show that 25% of all suicide attempts fail, resulting in extreme patient suffering; substantial questions have been raised about the accuracy of this claim, but supporters of Measure 51 refuse to retract it. The major Oregon television stations have refused to air one of four television ads produced by Yes on 51, on the ground it is misleading. Physicians for Compassionate Care, a group that supports Measure 51, is taking a visible role and has published 100,000 pamphlets for use by physicians who want to urge their patients to vote for Measure 51. Campaign funds raised as of 9/24/97 amounted to $2.25 million, including $800,000 from Catholic archdioceses around the country, $250,000 from the U.S. Catholic Conference, and $100,000 from Oregon Right to Life.

(2) Opponents of repeal. Opponents of Measure 51 include Governor Kitzhaber (an emergency room physician) and a group of physicians known as Physicians for Death with Dignity. Campaign funds raised as of 9/24/97 amounted to $370,000, including $150,000 each from a local millionaire and international philanthropist George Soros (who is also funding the Project on Death in America, which has launched a variety of programs to encourage research on and training in end-of-life issues).

7. National Right to Life Committee. The National Right to Life Committee sponsored a weekend retreat for legislators which included discussion of potential anti-assisted suicide bills, including a bill that would allow patients' relatives to sue anyone who helped in an assisted suicide and another bill that would protect physicians who prescribe large amounts of pain medication from civil, criminal, or professional charges of improper conduct.

8. Federal legislation. Choice in Dying is promoting a federal bipartisan bill for the next Congressional session, known as the Compassionate Care Act. The Act would require that advance medical directives be placed in a patient's medical file and their existence clearly noted; require that states honor directives validly executed under the law of other states; and ask the federal government to study the creation of uniform advance directives.

OTHER NATIONAL DEVELOPMENTS

1. Michigan

a. Dr. Kevorkian's recent assisted suicides (since 6/1/97). On 8/13/97, Dr. Kevorkian's attorney acknowledged Kevorkian's responsibility for over 100 assisted suicides, including 8 recent deaths. Deaths identified since 6/1/97 include the following:

(1) 53rd suicide 6/26/97 = Janis Murphy (40-year-old woman with chronic fatigue syndrome and fibromyalgia.

(2) 54th suicide 7/2/97 = Dorinda Scheipsmeier (51-year-old woman with multiple sclerosis).

(3) 55th suicide 7/2/97 = Lynne Dawn Lennox (54-year-old woman with multiple sclerosis).

(4) 56th suicide 8/13/97 = Karen Shoffstall (34-year-old woman with multiple sclerosis).

(5) 57th suicide 8/29/97 = Thomas Summerlee (55-year-old man with multiple sclerosis).

(6) 58th suicide 9/3/97 = Carol Fox (54-year-old woman with ovarian cancer).

(7) 59th suicide 9/7/97 = Deborah Sickels (43-year-old woman with multiple sclerosis).

(8) 60th suicide 9/20/97 = Natverlal Thakore (78-year-old man with Parkinson's disease).

(9) 61st suicide 9/29/97 = Kari Miller (54-year-old woman with multiple sclerosis).

(10) 62nd suicide 10/3/97 = John Zdanowicz (50-year-old man with Lou Gehrig's disease).

(11) 63rd suicide 10/8/97 = Lois Caswell (65-year-old woman with chronic pain syndrome).

(12) 64th suicide 10/13/97 = Annette Blackman (34-year-old woman with multiple sclerosis).

b. Nonmedical panel to establish guidelines. On 7/2/97, Dr. Kevorkian announced that a nonmedical panel, headed by Janet Good, would establish "reasonable and sensible" guidelines for physician-assisted suicide because the medical profession has failed to do so.

c. Janet Good dies. On 8/26/97, Janet Good, one of Dr. Kevorkian's closest allies and founder of the Michigan chapter of the Hemlock Society, died after a long battle with pancreatic cancer. Her death was thought to be a suicide with the assistance of Dr. Kevorkian.

d. Ionia County criminal prosecution dropped. On 8/1/97, Ionia County prosecutor Raymond Voet announced that he would not refile criminal charges against Dr. Kevorkian in connection with the 8/30/96 death of Loretta Peabody, which was reported as being from natural causes. Voet's motion for a mistrial was granted in June, after the jury was impaneled, on the ground that defense attorney Geoffrey Fieger's opening statement was improper and prejudicial.

e. Dr. Kevorkian's civil actions against Oakland County officials. A $50 million civil lawsuit brought by Dr. Kevorkian and Janet Good is pending against two Oakland County prosecutors and five Bloomfield Township police officers in connection with the 9/6/96 raid against Isabel Correa's motel room, in which a suicide machine and other evidence was seized. In August 1997, Dr. Kevorkian also sued the Bloomfield Township police and Ionia County Sheriff's Department for $10,000, claiming they had damaged his suicide machine, video recorder, and videotape and failed to return seized drugs to him.

2. Arizona. Arizona governor Fife Symington has created a 10-member panel, the Arizona Commission on Aging and End of Life, to deal with aging and end-of-life care. The governor's charge to the commission includes making recommendations for "preservation of Arizona's legal and cultural disfavor of assisted suicide." The commission's first meeting was scheduled during August 1997.

3. Florida. On 10/22/96, the medical license of Dr. Ernesto Pinzon was suspended after investigators charged him with intentionally giving deadly drugs on 10/6/96 to a man dying of cancer. Dr. Pinzon was indicted for first-degree murder but was acquitted by a jury on 6/26/97. Dr. Pinzon is now seeking to regain his license: a hearing before an administrative law judge was held in September, but the Florida Board of Medicine will make the final decision.

4. Mississippi. Dr. John McFadden, who operates a pain clinic in Tupelo, Mississippi, has been forbidden to prescribe most narcotics to his chronic pain patients after the state medical licensing board found that he was overprescribing pain medication.

5. Oregon. On 7/17/97, the State Board of Medical Examiners voted 7-2 to reprimand Dr. James Gallant for unprofessional and dishonorable conduct and suspend his medical license for 60 days (from September 1 to November 1) 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. A number of health insurance companies have informed Dr. Gallant's patients that they will no longer contract with him. The case is being reviewed by the Lane County district attorney's office for possible criminal prosecution.

6. Virginia. On 8/5/97, the Virginia Board of Medicine suspended the revocation of Dr. William Hurwitz's medical license. Dr. Hurwitz's license was suspended in 1996 for overprescribing controlled pain medications, despite the pleas of his patients. A class action suit by patients of Dr. Hurwitz for violation of their civil rights was rejected by a federal judge but is being appealed.

7. American Bar Association. Prior to the ABA annual meeting in August 1997, the Beverly Hills Bar Association submitted Resolution 10B supporting legalization of physician-assisted suicide, and the ABA Commission on Legal Problems of the Elderly and the ABA Commission on Mental and Disability Law submitted Resolution 102A urging states to refrain from considering adoption of physician-assisted suicide. The House of Delegates did not adopt either proposal but instead approved by voice vote the ABA Commission's compromise resolution that physician-assisted suicide should be "left to be resolved by state and territorial legislatures and their electorates after extensive and informed public discussion" and that, if physician-assisted suicide is implemented, states should "ensure that information and reporting systems are established to achieve close monitoring of the impact of such practices, especially with respect to vulnerable populations."

8. Compassion in Dying. On 6/27/97, Barbara Coombs Lee, executive director of Compassion in Dying, announced the formation of the Compassion Center for End of Life Law and Policy, which will work on bringing laws on assisted dying in line with public opinion. Kathryn Tucker, the Seattle lawyer who argued *Washington v. Glucksberg* before the U.S. Supreme Court, will be the center's director. Compassion in Dying also has opened two new offices, one in Oregon and another in Northern California.

9. Hemlock Society patient advocacy program. In July 1997, the Hemlock Society USA announced a new nationwide patient advocacy program, initially limited to its members, to intervene if an advance directive is not being honored or a member is dying with pain that should be treated. The new program calls for mediation by a Hemlock advocate or intervention by a Hemlock local chapter, members of its medical advisory board, or the local hospital ombudsman. If these methods fail, Hemlock will instigate lawsuits on behalf of its members.

10. National Public Radio. NPR is planning 25 pieces on death and dying to air during 1997 and 1998 in a special project headed by producer Sean Collins, called "The End of Life: Exploring Death in America." The project will begin with a week-long series beginning November 3, 1997, on All Things Considered that will include a roundtable led by Linda Wertheimer, an hour-long piece following a close-knit family as the 82-year-old mother dies of leukemia, a report by Howard Berkes on the Missoula Demonstration Project in which Dr. Ira Byock is seeking to change a community's attitudes towards death and dying, and two literary essays.

11. AMA survey. The AMA End of Life Survey, conducted during December 1996, showed that 52% of respondents approved and 35% disapproved of intentionally ending the life of a terminally ill patient in cases of unrelievable suffering or expected suffering; 56% believed that physician-assisted suicide should be legal, 22% that it should be illegal and physicians prosecuted, and 12% that it should be illegal but physicians should not be prosecuted if done according to set guidelines and openly reported.

12. USA Today/CNN/Gallup poll. In a poll conducted during late June 1997, 58% of those polled favored the option of physician-assisted suicide for patients with an incurable disease and living in severe pain; 53% favored it even in the absence of severe pain. However, only 40% personally would consider the option if living in severe pain, and only 27% personally would consider it in the absence of severe pain.

13. Harris poll. According to the 9/24/97 issue of USA Today, a Harris poll shows that 68% of adults say the law should let physicians aid dying patients who want to end their lives.

MEDICAL DEVELOPMENTS

1. Robert Wood Johnson Foundation grants. The Robert Wood Johnson Foundation has announced a new grant program, called Promoting Excellence in End-of-Life Decisions, that will make awards totaling $12 million over three years to fund innovative projects to improve care for the dying. Letters of intent are due by 9/1/97 and full proposals by 12/15/97.

2. California Medical Association. Although the California Medical Association remains opposed to assisted suicide, its House of Delegates has instructed the organization to more actively seek input and dialogue on all sides of the issue. Over the next two years, the CMA will sponsor a series of symposia on state-of-the-art pain management. The CMA also is participating with the AMA's Coalition on End-of-Life Care, and has received a $1.54 million grant from the Robert Wood Johnson Foundation to train physicians in the care of the terminally ill.

3. Colorado Collective for Medical Decisions. A Denver-based nonprofit organization, the Colorado Collective for Medical Decisions, has developed nine medical recommendations to improve end-of-life care. CCMD is seeking community input

through discussion groups and forums, after which the guidelines will be presented to health care providers and hospitals, along with a report on community reactions. Susan Fox Buchanan is executive director of CCMD.

4. Florida Pain Management Commission. The Florida Pain Management Commission, formed three years ago and consisting of legal and medical experts, has documented problems of pain management and is now working on solutions. Florida no longer automatically investigates any physician who is reported for prescribing large quantities of narcotics. The commission is proposing a law that would include recognition of certain types of physicians and centers as pain treatment specialists. Florida also has produced pain guidelines that recognize the need for broad flexibility in prescribing drugs for intractable pain and require physicians to document individual need and failed attempts at alternative treatment.

5. Morphine use and comfort care in Oregon. Federal data from the first half of 1996 show that Oregon's increased focus on care of the dying has made the state the nation's leader in the medical use of morphine, with per-capita wholesale distribution more than 50% higher than the national average. Since 1994, the Oregon Board of Medical Examiners has emphasized that physicians should treat end-of-life pain aggressively. A number of hospitals have established patient comfort care teams, and utilization of hospice care has risen dramatically.

6. Oregon physicians release guidelines for physician-assisted suicide. A group of 24 Salem-area physicians, known as the Mid-Valley Physician Assisted Suicide Interest Group, has released a 6-page document containing guidelines for physicians wishing to participate in physician-assisted suicide. Guidelines for the day of the suicide include the following:

a. Completing a checklist to ensure compliance with the law's requirements.

b. Waiting to write the prescription until the day the patient plans to take it, making it valid for only one day, promptly filling the prescription, and noting on the prescription the purpose for which it is being written.

c. Dispensing the prescription directly to the attending or consulting physician.

d. Handing the drugs to the patient only after confirming that the patient is competent and wishes to proceed.

e. Using medical judgment to relieve distressing symptoms during or after taking the drugs (e.g., by administering antiemetics, antianxiety agents, oxygen, and/or antiseizure medications).

f. Remaining near the patient at least until unconsciousness occurs, and leaving only if another physician or an RN remains.

g. If the patient changes his mind, making every reasonable effort to recover him but nonetheless honoring any CNR request.

h. Allowing the patient to recover naturally if the attempt at suicide fails, and making another attempt only if the patient regains consciousness and still requests assisted suicide within the allowable time period.

7. Tennessee Medical Association. The issue of physician-assisted suicide was raised at a board meeting of the Tennessee Medical Association in July 1997. The TMA's president-elect, Dr. David Gerkin, reported that the TMA will oppose physician-assisted suicide when the issue is brought before state legislators in the coming year.

8. Recent surveys and articles

a. Physicians attitudes about PVS patients. A mailed questionnaire survey of physicians from the American Academy of Neurology and the American Medical Directors Association revealed that 89% believed it was ethical to withdraw artificial nutrition and hydration from patients in a persistent vegetative state (PVS), and 20% believed that it would be ethical to hasten the patient's death by lethal injection. About 94% thought that PVS patients would be better off dead. Kirk Payne et al., *Physicians' Attitudes About the Care of Patients in the Persistent Vegetative State: A National Survey*, 125 Annals of Internal Medicine 104 (1996).

b. Terminal sedation and slow euthanasia. An article by Dr. J. Andrew Billings suggests that "slow euthanasia" is regularly employed and tacitly accepted by the medical profession in the last few days of a dying patient's life, either in the form of "hanging a morphine drip" where dosage is maintained or adjusted upward gradually or in the form of providing terminal sedation in the context of hospice palliative care. J. Andrew Billings, *Slow Euthanasia*, 12:4 J. Palliative Care 21 (1996). The journal also includes four separate responses to the article.

c. Current developments. An article in the May 1997 issue of Scientific American reports on recent efforts to improve the care of dying patients. John Horgan, *Seeking a Better Way to Die*, 276 Scientific American 100 (May 1997).

d. Screening for depression. A study of patients receiving palliative care for advanced cancer showed that brief screening measures for depression were not as effective as a single-item interview that asked, in

effect, "Are you depressed?" Harvey Max Chochinov et al., *"Are You Depressed?" Screening for Depression in the Terminally Ill*, 154 American J. Psychiatry 674 (1997).

e. Guidelines for aid-in-dying. The June 1997 issue of The Western Journal of Medicine contains a number of articles on physician-assisted suicide, including an article outlining advisory guidelines developed for the San Francisco Bay area by the Bay Area Network of Ethics Committees and a report of a consensus conference held in September 1996 at the Stanford University Center for Biomedical Ethics. Steve Heilig et al., *Physician-Hastened Death--Advisory Guidelines for the San Francisco Bay Area from the Bay Area Network of Ethics Committees*, 166 The Western Journal of Medicine 370 (1997); Ernlé W.D. Young et al., *Report of the Northern California Conference for Guidelines on Aid-in-Dying: Definitions, Differences, Convergences, Conclusions*, 166 Western J. Med. 381 (1997).

f. Patient preferences for communication with physicians. On 7/1/97, researchers reported the preferences of selected SUPPORT study patients for communication with their physicians about cardiopulmonary resuscitation and prolonged mechanical ventilation. Jan C. Hoffman et al., *Patient Preferences for Communication with Physicians About End-of-Life Decisions*, 127 Annals of Internal Medicine 1 (1997). Only 23% of patients had discussed CPR preferences with their physicians, and only 12% had discussed ventilation preferences. The most surprising finding was that most patients who had not discussed their preferences did not wish to do so (58% as to CPR, 80% as to ventilation), despite the fact that 25% of patients did not want CPR and 87% did not want prolonged ventilation.

g. Patient preferences for living permanently in a nursing home. On 7/1/97, researchers reported the willingness of selected SUPPORT study patients to live permanently in a nursing home, as well as surrogate and physician understanding of patient preferences. Thomas J. Mattimore et al., *Surrogate and Physician Understanding of Patients' Preferences for Living Permanently in a Nursing Home*, 45 J. American Geriatrics Society 818 (1997). Patients were asked, "Would you be very willing, somewhat willing, somewhat unwilling, very unwilling, or would you rather die, than put up with living in a nursing home all the time?" Twenty-six percent were very willing or somewhat willing to live permanently in a nursing home, 37% were somewhat or very unwilling, 30% said they would rather die, and 6% were undecided. Surrogates understood 61% of patients' preferences but identified only 35% of patients who were willing to live permanently in a nursing home. Physicians identified only 18% of patients willing to live permanently in a nursing home.

h. Physician knowledge about cancer pain management. A survey of 81 physicians in training at the Washington University Medical Center revealed deficiencies in their knowledge about the use of opioid drugs and palliative radiation therapy in the management of cancer pain. For example, when asked to convert a parenteral dose of morphine to an equivalent dose of a controlled-release preparation, 75% calculated a dose that was less than one-third the correct amount. Joanne E. Mortimer & Nancy L. Bartlett, *Assessment of Knowledge About Cancer Pain Management by Physicians in Training*, 14 J. Pain & Symptom Management 21 (1997).

i. End-of-life decisions for institutionalized mentally disabled individuals in the Netherlands. On 7/12/97, researchers published the results of a nationwide retrospective study of end-of-life decisions made for institutionalized mentally disabled individuals in the Netherlands during 1995. G.J.M.W. van Thiel et al., *Retrospective Study of Doctors' "End of Life Decisions" in Caring for Mentally Handicapped People in Institutions in the Netherlands*, 315 British Medical J. (1997). Physicians who reported a patient death within the previous 5 years had participated in an end-of-life decision in 350 of 859 cases (41%). The 41% figure included 30% (254 cases) for withdrawing or withholding treatment, 11% (92 cases) for relieving pain and symptoms with opiates that may have shortened life, and 0.5% (4 cases) for ending life with a lethal injection. Sixty-seven physicians were interviewed regarding the most recent end-of-life decision in which they had participated: they reported 3 cases of euthanasia by lethal injection, each involving a terminally ill patient expected to live no more than one week.

j. End-of-life decisions for neonates and infants in the Netherlands. On 7/26/97, researchers published the results of two studies of end-of-life decisions made for neonates and infants in the Netherlands. Agnes van der Heide, *Medical End-of-Life Decisions Made for Neonates and Infants in the Netherlands*, 349 The Lancet (1997). A questionnaire sent to physicians who had attended 338 consecutive deaths in 1995 revealed that 57% of all deaths had been preceded by a decision to forego life-sustaining treatment, 4% solely by a decision to give drugs to alleviate pain and symptoms in doses that may have shortened life, and 1% solely by a decision to give a drug specifically to hasten death. A separate interview study showed that parents were involved in 79% of decisions, and colleagues were consulted in 88% of decisions.

k. Medical residents' views on assisted death. A study published on 7/28/97 reports the attitudes of 96 residents in internal medicine, psychiatry, and emergency medicine at the University of New Mexico School of Medicine in 1995 towards 6 patient vignettes (5 involving assisted suicide or euthanasia and 1 involving withdrawal of life support). Laura Weiss Roberts et al., *Internal Medicine, Psychiatry, and Emergency Medicine Residents' Views of Assisted Death Practices*, 157 Archives of Internal Medicine 1603 (1997).

l. Oregon's physician-assisted law. An August 1997 issue of the Archives of Internal Medicine includes an editorial on the debate over physician-assisted suicide, as well as an article by Dr. Peter Goodwin (one of the sponsors of Oregon's Death with Dignity Act) responding to criticisms of the Oregon law. Richard M. Sobel & A. Joseph Layon, *Editorial: Physician-Assisted Suicide-- Compassionate Care or Brave New World?*, 157 Archives of Internal Medicine 1638 (1997); Peter Goodwin, *Commentary: Oregon's Physician-Assisted Suicide Law--An Alternative Positive Viewpoint*, 157 Archives of Internal Medicine 1642 (1997).

m. Palliative care in undergraduate medical education. An article published on 9/3/97 concludes that current medical school training in end-of-life care is inadequate, particularly during the clinical years, and offers a number of suggestions for improving palliative care education. J. Andrew Billings & Susan Block, *Palliative Care in Undergraduate Medical Education: Status Report and Future Directions*, 278 JAMA 733 (1997).

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.

b. 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. On 7/9/97, the Upper House voted 18-3 to refer the bill to a parliamentary select committee that is likely to take at least 6 months to consider evidence and release its findings; it was also agreed that the bill would be amended to require a referendum to be held before becoming law in the event that it is eventually passed by both Upper and Lower Houses. In any event, the bill was expected to lapse and have to be reintroduced following state elections expected to occur during October 1997.

(2) Victoria. Euthanasia supporters believe that Victoria may become the first state to legalize euthanasia. Premier Jeff Kennett is a supporter of euthanasia, and the Liberal Party State Council was expected to vote during October on a motion calling for the state government to conduct a binding plebiscite of Victorian voters on the adoption of legislation similar to the Northern Territory's.

c. Medical articles. An article published on 6/28/97 analyzes the potential adverse effects of euthanasia on Northern Territory aborigines. John J. Collins, *Euthanasia and the Potential Adverse Effects for Northern Territory Aborigines*, 349 The Lancet (1997).

2. Canada

a. Proposed legislation. Liberal Senator Sharon Carstairs has abandoned her plan to introduce a bill in the Senate that would protect physicians from prosecution for withdrawing or withholding life-sustaining treatment upon request or administering pain relief medication that may hasten death; a similar bill previously introduced by Senator Carstairs (S-13) died when the parliament dissolved for elections held in June 1997. After the Kevorkian-assisted suicide of a prominent British Columbian land developer and philanthropist, Natverlal Thakore, MP Svend Robinson announced that he will reintroduce a private member's bill to allow physician-assisted suicide.

b. 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, Mark Anthony Jewitt, 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. 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). Dr. Morrison's preliminary hearing is set for 2/9/98.

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. Latimer's new trial is set for 10/27/97.

d. Recent surveys

(1) National survey of physicians. University of Calgary researchers Marja Verhoef and Douglas Kinsella, both physicians, are expected to publish soon the results of a 1995 national survey of more than 2,000 Canadian physicians, showing that 22% would practice euthanasia if it were legal and 44% would prefer patients to a colleague practicing euthanasia.

(2) Survey of British Columbian social workers. Canadian researcher Russel Ogden will publish in the *British Journal of Social Work* the results of his survey of 527 British Columbian social workers, which caused Ogden to conclude that euthanasia increasingly is being carried out by friends and family of patients and by social workers, rather than by physicians or nurses. Nearly 40% of the social workers assisting medical professionals reported being consulted by a patient about euthanasia or assisted suicide.

3. Colombia. 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 petitioned to overturn the ruling, but the petition was denied on 10/2/97 by a 6-3 vote. Colombia's congress is expected to consider legislation regulating euthanasia.

4. Great Britain

a. British Medical Association. At the annual meeting of the British Medical Association in July 1997, in reaction to a discussion paper seeking for the first time to draw a distinction between euthanasia and physician-assisted suicide, physicians overwhelmingly opposed any attempt to permit either practice. A narrow majority voted to take this position "for the time being." A survey of 1,000 health professionals in 1996 found that 51% of physicians would be willing to help a patient commit suicide; 43% of respondents said physician-assisted suicide was preferable to euthanasia, which was supported by 19%.

b. Physicians admit helping patients die. After the BMA's annual meeting, Dr. Michael Irwin, a prominent British physician and former medical director of the United Nations, announced that he had helped at least 50 patients to die and personally had administered a lethal injection of morphine in over half of the cases. Dr. Irwin indicated that he had decided to speak out to ignite a campaign to amend the British law criminalizing physician-assisted suicide. Following Dr. Irwin's statement, general practitioner Dave Moor announced that he also had assisted well over 100 patients to die. Officials of the British Medical Association called for a criminal investigation of both physicians. On 7/30/97, Dr. Moor was arrested and then released on bail in connection with the death on 7/19/97 of George Liddell, an 85-year-old cancer patient.

c. Liberal Democrats call for royal commission. On 9/25/97, delegates to the Liberal Democrats' annual conference called for establishment of a royal commission to study legalization of voluntary euthanasia. A Downing Street spokesman said the government did not believe there was any need for a commission.

d. Annie Lindsell. Annie Lindsell (who suffers from motor neurone disease) is seeking 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. The case was scheduled to be heard by Sir Stephen Brown in the Family Division of the High Court beginning 10/14/97, but instead was adjourned for several weeks.

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