



Recent Developments in Physician-Assisted Suicide

June 1999

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LITIGATION

1. *Kevorkian v. Thompson*, 947 F.Supp. 1152 (E.D. Mich. 1997), appeal dismissed (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 12/15/98, the pending appeal to the Sixth Circuit Court of Appeals was voluntarily dismissed.
 2. *Sampson v. Alaska*, No. 3AN-98-11288CIV(Alaska Super. Ct.). On 12/15/98, Kevin Sampson (a 43-year-old man who is HIV-positive) and "Jane Doe" (a female cancer patient in her 60's who is a physician) filed suit in Alaska Superior Court in Anchorage challenging Alaska's ban on physician-assisted suicide based on state constitutional claims of privacy, liberty, and equal protection. The suit is sponsored by the Compassion in Dying Federation. An answer to the complaint was filed on 1/22/99, and a hearing is set for 8/9/99.
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LEGISLATION

1. California
 - a. Assisted suicide bill. On 4/20/99, by a vote of 8-7, the California Assembly Judiciary Committee approved Assembly Bill 1592, a bill patterned after the Oregon Death with Dignity Act that was introduced by Assemblywoman Dion Aroner. On 5/27/99, the bill was narrowly approved by the Assembly Appropriations Committee. However, Aroner announced that she would not ask for further action on the measure because she lacked the votes needed to send the bill to the Senate. A Field poll released in April 1999 showed that more than 70% of all Californians and 68% of Roman Catholics favored legalizing physician-assisted suicide.
 - b. Pain relief bill. On 5/25/99, the California Assembly passed Assembly Bill 1226, which would require health insurance plans to make decisions within 72 hours authorizing the use of pain management medications for patients who suffer from intractable pain. On 6/2/99, the bill was referred to the Senate Committee on Insurance. The California Medical Association supports the bill, but the California Department of Health Services opposes it.
2. Florida. On 1/31/99, the Florida Panel for the Study of End of Life Care, a study group created by the 1998 legislature, issued its first report following a series of hearings around the state. The report recommended eliminating the requirement that a person be "terminally ill" before life-sustaining treatment can be withheld or withdrawn. On 5/28/99, a bill that would implement the panel's recommendations (Senate Bill 2228) was sent to Florida's governor for signature.
3. Hawaii. Governor Ben Cayetano's Blue Ribbon Panel on Living and Dying with Dignity issued a 101-page report in June 1998, recommending by a vote of 11-7 that the state legislature legalize physician-assisted suicide and "physician-assisted death" (active euthanasia) for "mentally-alert patients who either are terminally ill or suffer intractable and unbearable illness that cannot be cured or successfully palliated." On 2/6/99, members of the House Health Committee voted unanimously to hold a physician-assisted suicide bill (House Bill 1155) in

committee, effectively killing the bill; on 2/19/99, members of the Senate Health and Human Services Committee voted to hold a similar bill (Senate Bill 1037) in committee. However, Governor Cayetano has indicated that he will introduce the same legislation next year.

4. Louisiana. On 2/25/99, Senator Lynn Dean introduced Senate Bill 128, a bill patterned after the Oregon Death with Dignity Act. On 4/16/99, the bill was withdrawn from further consideration. The Louisiana legislature passed a law banning assisted suicide in 1995.

5. Maine

a. PRO 916. Following the Maine legislature's rejection in February 1998 of a bill that would have legalized physician-assisted suicide, assisted suicide supporters launched the PRO 916 campaign to collect petition signatures to put the proposal on the ballot in 1999 or 2000. Supporters must collect about 42,000 voter signatures.

b. Assisted suicide bill defeated. On 2/11/99, the Maine House refused by a vote of 99-42 to refer to the voters a proposal approving physician-assisted suicide, despite a Strategic Marketing Services poll of 450 voters during January 1999 that showed that 71% of respondents believed that terminally ill, mentally competent patients should have the right to have a physician help them die. The Maine legislature has rejected physician-assisted suicide three times before, most recently in 1995.

6. Maryland. On 3/23/99, the Maryland House voted 28-19 in favor of House Bill 496, which makes assisting or attempting to assist a suicide a felony punishable by up to one year in prison, a fine of up to \$10,000, or both. On 4/7/99, the bill passed the Senate by a vote of 27-20 after days of emotional debate. Governor Glendening signed the bill on 5/27/99.

7. Michigan

a. Merian's Friends. Merian's Friends, the organization that campaigned for Proposal B (an initiative measure that would have legalized physician-assisted suicide) has disbanded following the measure's rejection by Michigan voters.

b. Organ harvesting. On 6/2/99, the Michigan legislature approved three bills (Senate Bill 381 and House Bills 4025 and 4466) that regulate organ harvesting. The Senate bill requires that organ harvests take place in a licensed facility. The two House bills provide that only licensed physicians or their delegates may remove human organs for any medical or scientific purpose; unauthorized removal would be a felony punishable by up to four years in prison and a \$1,000 fine. The bills were proposed in response to an incident in which Dr. Jack Kevorkian harvested the organs of an assisted suicide patient.

8. Nebraska. On 3/30/99, Nebraska's governor signed Legislative Bill 226, which permits physicians to prescribe controlled substances exceeding the regular dosage, if needed to help suffering patients. Nebraska Right to Life supported the proposal, which contains safeguards to prevent physician-assisted suicide and euthanasia.

9. Oregon

a. Deaths by assisted suicide. On 2/18/99, the Oregon Health Division issued a report on deaths during 1998 under the Oregon Death with Dignity Act. The complete report is available on-line at www.ohd.hr.state.or.us/cdpe/chs/pas/ar-index.html. A published version of the report is found in Arthur Eugene Chin et al., *Legalizing Physician-Assisted Suicide in Oregon-The First Year's Experience*, 340 *New Eng. J. Med.* 577 (1999). The report included the following information:

(1) 23 persons had received prescriptions for lethal medications, of whom 15 died after taking the medication, six died from their underlying illness, and two were alive as of 1/1/99.

(2) Median age of the 21 patients who died was 69, all were white, 52% were male, 52% lived in the Portland metropolitan area, and 86% had cancer.

(3) All of the 21 had been Oregon residents for more than six months, except for one patient who moved to Oregon four months before death to be cared for by family members.

(4) Four of the 21 received a psychiatric or psychological consultation.

- (5) All but one of the 21 patients received prescriptions for nine grams of a fast-acting barbiturate, either secobarbital or pentobarbital.
- (6) Median time from taking the medication to unconsciousness was five minutes (range = 3-20 minutes).
- (7) Median time from taking the medication to death was 26 minutes (range = 15 minutes to 11.5 hours). Four patients died more than three hours after taking the medication. The patient who took 11.5 hours to die fell asleep five minutes after taking the medication.
- (8) No complications (such as vomiting or seizures) were reported by any physician.
- (9) No patient who chose physician-assisted suicide voiced concern to their physician about the financial impact of their illness, and only one expressed concern about end-of-life pain.
- (10) A total of 14 physicians wrote prescriptions for the 15 patients who died by physician-assisted suicide. These physicians represented a wide range of specialties, ages, and years in practice.
- (11) Six patients who chose physician-assisted suicide had requested lethal medications from one or more providers before finding a physician who would participate.
- (12) All physician reports were in full compliance with the law.

Comparison studies with two control groups showed that age, race, sex, and Portland metropolitan residence status did not predict participation in physician-assisted suicide. Patients who chose physician-assisted suicide were not disproportionately poor, lacking in insurance coverage, or lacking in access to hospice care. However, persons who were divorced and persons who had never married were more likely to choose physician-assisted suicide than persons who were married. In addition, patients who chose physician-assisted suicide were much more likely than controls to express concerns about loss of autonomy and loss of control of bodily functions. Physicians for 67% of control patients would have refused to write a prescription for lethal medications had the patients asked; physicians for 21% of control patients would have agreed; and physicians for 12% of control patients were unsure.

- b. Patrick Matheny. On 3/10/99, Patrick Matheny, a 43-year-old man from Coos Bay suffering from Lou Gehrig's disease, died after taking legally-prescribed lethal medication. Matheny's brother-in-law, Joe Hayes, helped Matheny die but refused to discuss his actions with reporters. An investigation requested by Coos Bay District Attorney Paul Burgett was closed without any charges being filed after the investigator concluded that Matheny intended to die and that Hayes merely held a glass so that Matheny could drink a lethal mixture from a straw.
- c. Oregon Health Plan. Based on an earlier decision of the Oregon Health Services Commission to include physician-assisted suicide as part of comfort care services, the Oregon Health Plan began covering physician-assisted suicide for low-income Oregonians on 12/1/98.
 - (1) Federal investigation. On 2/12/99, Representative Thomas Bliley, chairman of the Congressional House Commerce Committee, and three other Republicans wrote to Health and Human Services Secretary Donna Shalala asking for a review of whether the Oregon Health Plan was using federal funds for physician-assisted suicide in violation of the federal Assisted Suicide Funding Restriction Act of 1997. The Health Care Financing Administration (HCFA) concluded that Oregon had instituted an adequate system to segregate claims related to assisted suicide from all other claims, but in March 1999 Oregon health officials refunded \$60 of federal Medicaid funds that might have been used to pay physicians or pharmacists before the system was in place. On 6/4/99, following a report by HCFA to the congressional committee, Oregon was directed to refund an additional \$1,167 in federal Medicaid funds.
 - (2) State legislature. The Senate Ways and Means Subcommittee on Human Resources

held hearings during May 1999 about the Oregon Health Plan's coverage of expenses related to physician-assisted suicide. Subcommittee chair Senator Eileen Qutub is seeking to overturn the decision of the Oregon Health Services Commission to include physician-assisted suicide as part of comfort care services.

- d. Task Force on Pain and Symptom Management. On 12/17/98, the 30-member Task Force on Pain and Symptom Management, which was appointed pursuant to 1997 legislation, issued a report making recommendations to Oregon's governor and the 1999 legislature on treatment of chronic pain. The following legislation has been introduced in the 1999 legislature as a result of the Task Force's recommendations: SJR 28 (directs health-related state agencies and encourages health care professionals to support rights of persons with pain), SB 1027 (creates Uninsured Access to Hospice Program), SB 1140 (creates Pain Management Demonstration Projects in one rural area and one urban area), SB 1141 (establishes Pain Management Advocate within Oregon Department of Human Resources), and HJR 62 (declares support for persons suffering from chronic pain, encourages medical teaching facilities to increase training in chronic pain management, and encourages Board of Medical Examiners to ensure that its rules do not inhibit chronic pain management).
 - e. Amendments to Oregon Death with Dignity Act. Senate Bill 491 was passed by the Oregon Senate on 4/26/99 by a vote of 22-6 and by the House on 5/24/99 by a vote of 42-17; Governor John Kitzhaber was expected to sign the bill. The original version of SB 491 would have made substantial changes to the Oregon Death with Dignity Act, but the final compromise version was supported by both supporters and opponents of the Act. The bill would make the following changes to the Act: (1) allow a health care facility that prohibits assisted suicide on its premises to penalize a physician who violates the policy with loss of privileges or staff membership at a hospital, termination of the physician's office lease, or other nonmonetary remedies; (2) allow patients to contract separately with the physician; (3) allow the physician to respond to patients' questions about assisted suicide and refer patients to other physicians to help them; (4) require physicians to recommend that patients not take lethal medication alone or in a public place; (5) permit a state agency to charge a person's estate for any costs that might arise if the patient commits suicide on public property; (6) require patients to demonstrate Oregon residence by showing an Oregon driver's license, Oregon tax return, or other proof; (7) explicitly extend the Act's protection to pharmacists; (8) require health care providers to file a copy of the dispensing record for lethal medication with the Oregon Health Division; and (9) require physicians to give pharmacists the ability to opt out of filling a lethal prescription. During earlier hearings, supporters of the Oregon Death with Dignity Act pointed out that Oregon's Attorney General had issued a written opinion (No. 8264) on 2/22/99 that hospitals and other health care facilities already have the ability to enforce a prohibition that is contained in a contract or lease.
 - f. Oregon Medical Association. On 4/25/99, the Oregon Medical Association's House of Delegates voted 51-33 against a resolution opposing continued coverage of physician-assisted suicide under the Oregon Health Plan. The resolution was proposed by Physicians for Compassionate Care, a group that opposes the Oregon Death with Dignity Act.
10. Wisconsin. In April 1999, State Senate President Fred Risser and Representative Frank Boyle introduced bills (Senate Bill 124 and Assembly Bill 297) that would legalize physician-assisted suicide. The bills are patterned after the Oregon Death with Dignity Act but require three witnesses to the written request, rather than only two. A similar bill was the subject of a Senate committee hearing during the 1997-98 legislative session, but was never voted on by the committee.
 11. Federal legislation
 - a. Lethal Drug Abuse Prevention Act. The Lethal Drug Abuse Prevention Act of 1998 (H.R. 4006 and S. 2151) died in both houses of Congress upon adjournment but may be renewed in 1999. The Act would have amended the Controlled Substances Act to revoke the prescribing privileges of a physician who prescribes medication to assist in suicide or euthanasia.
 - b. Advance Planning and Compassionate Care Act of 1999. On 3/16/99, Senators Jay Rockefeller and Susan Collins and Representatives Darlene Hooley and Sander Levin, among others, introduced the Advance Planning and Compassionate Care Act of 1999 (S. 628 and H.R. 1149), aimed at improving end-of-life care and ensuring that physician-assisted suicide remains rare. The Act would require that living wills be placed prominently in patients' medical records and continue to be valid if patients move to other states. Other provisions include assessing care of persons with chronic debilitating diseases, establishing a consumer hotline to provide information about end-of-life issues, extending Medicare coverage to self-administered pain medications, and ensuring that Medicare patients can discuss end-of-life care decisions with a trained professional.
 - c. Conquering Pain Act of 1999. On 5/3/99, Oregon Senators Ron Wyden and Gordon Smith introduced the Conquering Pain Act of 1999, which is intended to improve pain management nationwide. The Act would authorize \$18 million to create six regional centers to provide information to patients and their families 24

hours a day, require federal health programs to make pain treatment a priority, direct the surgeon general to report by October 2000 on the state of pain management in the United States, create an 11-member advisory committee on pain and symptom management, and convene a national conference under the auspices of the National Institutes of Health. Oregon Representative Darlene Hooley was expected to introduce companion legislation in the House.

OTHER NATIONAL DEVELOPMENTS

1. Michigan

a. Dr. Kevorkian's conviction in death of Thomas Youk

(1) Criminal charges. On 9/17/98, Dr. Kevorkian assisted in the death of Thomas Youk, a 52-year-old man with advanced Lou Gehrig's disease, by giving him a lethal injection. As a result of his actions, Oakland County Prosecutor David Gorcyca charged Kevorkian with first-degree murder, assisted suicide, and illegal delivery of a controlled substance.

(2) Pretrial rulings. On 3/9/99, Judge Jessica Cooper ruled that Kevorkian could be tried on both murder and assisted suicide charges, because his actions started as a planned assisted suicide but graduated to active euthanasia. Judge Cooper also ruled that evidence about Youk's pain and suffering was admissible on the assisted suicide charge but not on the murder charge and that Youk's consent was not a defense to the murder charge. Following Judge Cooper's rulings, prosecutors elected to drop the assisted suicide charge.

(3) Trial and conviction. During a trial that began on 3/22/99, Kevorkian (who chose to represent himself) offered no evidence after Judge Cooper refused to allow Youk's wife and brother to testify. On 3/26/99, following more than 12 hours of deliberation, the jury convicted Kevorkian of second-degree murder and illegal delivery of a controlled substance.

(4) Sentence. On 4/14/99, Judge Cooper sentenced Kevorkian to 10 to 25 years in prison on the second-degree murder conviction and three to seven years for delivery of a controlled substance. The sentences will be served concurrently. Judge Cooper had Kevorkian taken into custody after denying bond.

(5) Motion for new trial. On 5/21/99, Kevorkian attorney Mayer Morganroth filed a motion for a new trial, claiming that Kevorkian's conviction was caused by ineffective counsel from trial lawyer David Gorosh. Argument was heard on the motion by Judge Cooper on 6/3/99.

(6) Appeal. Kevorkian is expected to appeal his conviction. Grounds may include a Fifth Amendment claim that a prosecutor improperly referred to Kevorkian's failure to testify, a Ninth Amendment claim of a patient's right to physician assistance in dying, and a claim that the judge should have permitted Youk's relatives to testify because their testimony would have been relevant to Kevorkian's intent.

b. 60 Minutes. Following criticism of the November 1998 "60 Minutes" program on Dr. Kevorkian and Thomas Youk's death, a follow-up story was aired on 2/28/99, featuring additional interviews with Youk's relatives and profiles of five terminally ill Lou Gehrig's disease patients who have chosen hospice or other options over euthanasia.

c. Dr. Reding. New Mexico authorities are investigating Kevorkian's associate Dr. Georges Reding in connection with the 8/30/99 death of Donna Brennan, a 54-year-old woman with multiple sclerosis, by a lethal dose of pentobarbital. Assisted suicide is a fourth-degree felony in New Mexico, punishable by up to 18 months in prison. Brennan's relatives have indicated that they will contest her 8/21/99 will in favor of her neighbor and caregiver, Bernadette Griego, who was present when Reding met with Brennan. A search of Reding's home reportedly yielded information about other possible assisted suicides in the United States and Canada.

d. Public opinion poll. The Grand Rapids Press's Opinion 2000 survey of 800 people in 10 West Michigan counties, which was conducted by Wirthlin Worldwide, revealed that 59% opposed legalizing assisted

suicide. A second poll of 200 blacks and 100 Hispanics in Kent and Ottawa Counties showed that 68% of blacks, 63% of Hispanics, and 59% of whites were opposed to assisted suicide.

2. Oregon

- a. Dr. Gallant. On 3/17/99, the Oregon Court of Appeals affirmed the decision of the Oregon Board of Medical Examiners to reprimand Dr. James Gallant for unprofessional and dishonorable conduct and suspend his license for 60 days for engaging in active euthanasia with respect to his patient, Clarietta Day, who died in 1996 as a result of a lethal injection administered by a nurse. *Gallant v. Board of Medical Examiners*, 159 Or.App. 175, 974 P.2d 814 (1999). The court found that the board correctly applied the preponderance of the evidence standard of proof and did not improperly permit a disqualified board member to participate in deliberations. The Lane County district attorney announced in 1997 that no criminal charges would be filed in connection with the patient's death.
 - b. Dr. Bilder. On 3/19/99, the Oregon Board of Medical Examiners charged Dr. Paul Bilder, a 54-year-old pulmonary disease specialist from Roseburg, with unprofessional or dishonorable conduct and gross or repeated acts of negligence between 1993 and 1998. The board's order charged that Bilder failed to give six seriously ill or dying patients adequate pain medication. The board gave Bilder 21 days from receipt of the order to decide whether he wants a hearings officer to review the case. Disciplinary action could range from a reprimand to revocation of his medical license.
3. Washington. The state Medical Quality Assurance Commission held a hearing May 26-28 on a staff proposal to revoke the medical license of Dr. Eugene Turner, who was charged with suffocating 3-day-old Conor McInerney on 1/12/98, when the infant began to revive after being declared dead. The Commission is expected to announce its decision within 90 days. Prosecutors earlier dismissed without prejudice a second-degree murder charge against Turner. The infant's parents have filed civil suits against both Turner and Olympic Memorial Hospital in Port Angeles.
 4. Americans for Integrity in Palliative Care. In late 1998, nine physicians and two lawyers founded a group called Americans for Integrity in Palliative Care, which opposes legalization of physician-assisted suicide. Members of the group include Dr. Herbert Hendin and former Surgeon General C. Everett Koop. The group criticized the Oregon Health Division's report on physician-assisted suicide under the Oregon Death with Dignity Act, contending that insufficient evidence existed to establish that patients received adequate pain relief and were not motivated by financial concerns.
 5. Educational Broadcasting Corporation series. In January 1999, the Robert Wood Johnson Foundation announced a \$2.75 million grant to the Educational Broadcasting Corporation for a four-part series by Bill and Judith Moyers on the cultural, medical, ethical, and spiritual aspects of death and dying in America. Euthanasia and physician-assisted suicide are among the themes of the series.
 6. Last Acts public opinion poll. A telephone poll of 1,007 people conducted on behalf of Last Acts 3/5-3/7/99 revealed a significant percentage of fair to poor marks for various aspects of end-of-life care: 46% for pain management, 48% for including patients and relatives in care decisions, 54% for helping patients maintain their dignity, and 79% for preserving the savings of the dying. Sixty-five percent said that the best way to deal with end-of-life pain and suffering is better care, while 23% favored physician-assisted suicide.

MEDICAL DEVELOPMENTS

1. Robert Wood Johnson grants. On 1/15/99, the Robert Wood Johnson Foundation and the Midwest Bioethics Center announced the award of 17 first-round grants to state coalitions under a national program known as Community-State Partnerships to Improve End-of-Life Care. Coalitions were selected from a pool of 51 applicants representing 43 states and the District of Columbia. The RWJ Foundation will award a total of \$11.25 million over three years to up to 25 coalitions, each of which will receive either a three-year project grant or a one-year planning grant.
2. Oregon Health Sciences University. During February 1999, researchers at Oregon Health Sciences University sent a survey to 4,600 Oregon physicians to determine how many have had requests for assisted suicide, how often depression was suspected, and what caused patients to abandon efforts to get lethal medications. A second study involves interviews with family members after the deaths of loved ones from assisted suicide or other causes.
3. Survey shows inadequate relief of chronic pain. On 2/17/99, the American Pain Society, the American Academy of Pain Medicine, and Janssen Pharmaceutica released the results of a survey of 805 individuals suffering from moderate to severe chronic pain as a result of arthritis, back disorders, and other non-cancer medical problems. Although 56% of those surveyed reported suffering from pain for more than five years, only 22% had been referred to a specialized pain treatment program or clinic, 47% had changed physicians at least once, and 29% of those with very severe pain had switched physicians three or more times. The most common reasons for

changing physicians were "too much pain" (42%), physician's lack of knowledge about pain treatment (31%), physician's failure to take patient's pain seriously enough (29%), and physician's unwillingness to treat pain aggressively (27%). Despite the effectiveness of opioids in relieving pain, only 26% of patients with severe pain were taking opioid medications at the time of the survey.

4. Last Acts campaign. On 3/17/99, Last Acts (a 320-member coalition) announced a national initiative to improve end-of-life care. The group released a national survey of 1,000 Americans that gave low marks to health care professionals for failing to relieve pain, preserve dignity, and involve families in end-of-life decisions.
5. Recent articles
 - a. Annette T. Carron, Joanne Lynn & Patrick Keane, *End-of-Life Care in Medical Textbooks*, 130 *Annals Internal Med.* 82 (1999) [examination of four widely-used medical textbooks revealed inadequate coverage of end-of-life care for 12 illnesses that often cause death].
 - b. Mary Beth Hamel et al., *Patient Age and Decisions to Withhold Life-Sustaining Treatments from Seriously Ill, Hospitalized Adults*, 130 *Annals Internal Med.* 116 (1999) [data from SUPPORT study revealed that older age was associated with higher rates of withholding life-sustaining treatments (15% for each added decade of age for ventilator support, 19% for surgery, and 12% for dialysis) and that physicians underestimated older patients' preferences for life-extending care].
 - c. Raanan Gillon, *Editorial: Euthanasia in the Netherlands-Down the Slippery Slope?*, 25 *J. Med. Ethics* 3 (1999); Jacqueline M. Cuperus-Bosma et al., *Assessment of Physician-Assisted Suicide by Members of the Public Prosecution in the Netherlands*, 25 *J. Med. Ethics* 8 (1999); Henk Jochemsen & John Keown, *Voluntary Euthanasia Under Control? Further Empirical Evidence from the Netherlands*, 25 *J. Med. Ethics* 16 (1999); Johannes J.M. van Delden, *Slippery Slopes in Flat Countries-A Response to Jochemsen and Keown*, 25 *J. Med. Ethics* 22 (1999) [analysis of data regarding physician-assisted suicide and active euthanasia in the Netherlands].
 - d. Arthur Eugene Chin et al., *Legalizing Physician-Assisted Suicide in Oregon-The First Year's Experience*, 340 *New Eng. J. Med.* 577 (1999) [report on deaths during 1998 under the Oregon Death with Dignity Act].
 - e. Nancy P. Gordon & Starley B. Shade, *Advance Directives Are More Likely Among Seniors Asked About End-of-Life Care Preferences*, 159 *Archives Internal Med.* 701 (1999) [survey of 5,117 HMO patients over 65 revealed that one-third had an advance directive, but only 15% had talked with a clinician about end-of-life care preferences; patients who were asked by a physician or nurse about end-of-life care preferences were three times more likely to report having a written advance directive on file with the HMO].
 - f. Susan W. Tolle et al., *Oregon's Low In-Hospital Death Rates: What Determines Where People Die and Satisfaction with Decisions on Place of Death?*, 130 *Annals Internal Med.* 681 (1999) [reporting on two Oregon studies exploring the experiences of dying patients in Oregon, the views of their families about the dying process, and factors influencing whether patients die in their preferred location].

(1) POLST study. For one year, researchers prospectively followed a statewide sample of 316 Oregon nursing home residents, all of whom had requested a do-not-resuscitate (DNR) order and 180 of whom had a POLST (Physician Orders for Life-Sustaining Treatment) form with the specific order: "Transfer only if comfort measures fail." Of the 91 residents who died during the year, 86 died in nursing homes in accordance with their wishes, and only five in the hospital. Researchers, who also found that 91% of nursing home residents had DNR orders in 1996, concluded that advance care planning reduces the rate of in-hospital deaths.

(2) Barriers to Improving Care of the Dying study. Researchers interviewed a sample of family members of 475 adults who died in Oregon over a 14-month period in 1996-97 to determine the timing of and satisfaction with treatment decisions in three settings: home, nursing home, and acute care hospitals. Of the 475 deaths, 184 occurred in hospitals, 180 in nursing homes, and 161 at home. Only 6% of deaths in nursing homes occurred soon after discharge from a hospital; rather, most deaths in nursing homes occurred because of advance planning by patients, a focus on palliative care, and increasing decisions not to transfer many of those near death to an acute care hospital. Patients discharged from a hospital to home near the time of death usually requested the transfer and wanted care to focus on maximizing comfort. Families were very satisfied with treatment decisions: 67% of decedents had executed written advance directives, 93% of families believed that they knew their loved ones' wishes, and 96% of families felt that the patients' wishes had been followed. Decisions not to start a treatment (reported by 79% of family members) were far

more frequent than decisions to withdraw life support (reported by 21%).

(3) Conclusions. Based on these two studies, researchers concluded that Oregon's record of low in-hospital death rates and high patient satisfaction with the location of death was attributable in part to the wide array of end-of-life resources available in Oregon (including hospice and adult foster homes) and to the standard practice of specifically asking about treatment preferences at the time of admission into a long-term care facility or home hospice program.

- g. Alan Meisel, Jan C. Jernigan & Stuart J. Youngner, *Prosecutors and End-of-Life Decision Making*, 159 *Archives Internal Med.* 1089 (1999) [survey of 761 prosecutors nationwide revealed that most would not prosecute in three less-controversial end-of-life scenarios; in fourth scenario involving physician-assisted suicide, only 39.1% would prosecute, 36.3% would not, and 24.6% were undecided; two-thirds believed that physician-assisted suicide would be morally correct in the fourth scenario, and 78.8% would want such assistance if they were in the patient's position; 45.9% favored legislation allowing physician-assisted suicide and 33.4% favored legislation allowing active euthanasia].

INTERNATIONAL DEVELOPMENTS

1. Australia

- a. Northern Territory survey. In February 1999, researchers from Queensland and Northern Territory Universities released the results of a survey of nonaboriginal residents and health care professionals of the Northern Territory that was conducted during 1996 when physician-assisted suicide and euthanasia were legal. The survey showed that:
- (1) Only 48% of physicians supported physician-assisted suicide or euthanasia, while 73% of residents did.
 - (2) The main reason residents opposed euthanasia was religious, but physicians opposed it on the ground that the law should not be involved in end-of-life decisions.
 - (3) 77% of physicians believed they could control the pain of terminally ill patients in all or most cases, but only 34% of residents agreed.
 - (4) Physicians believed that physical pain was the greatest concern of terminally ill patients, but residents' greatest concerns were loss of mental faculties, loss of control, and dependence. More than 60% of residents worried about being a burden to their families, an issue vastly underestimated by physicians.
 - (5) Nurses' attitudes towards euthanasia and pain management were much closer than physicians' to the views of residents.
 - (6) Just over 40% of health professionals had received a request for aid in dying from patients.
 - (7) The leading concerns of health care professionals about the Northern Territory law were inadequate education, lack of a palliative care specialist in the Northern Territory, and lack of a psychiatrist to assess patients.
- b. Television commercials. During March 1999, the Voluntary Euthanasia Society of New South Wales began airing a television commercial in which 59-year-old June Burns, who is suffering from bladder cancer, threatens suicide and pleads for the right to die.
- c. Dr. Nitschke. Dr. Philip Nitschke, who has conducted temporary euthanasia clinics in Brisbane and Sydney, conducted a free clinic at an undisclosed location in Melbourne for three days beginning on 4/27/99. Patients considering euthanasia were offered advice but no prescriptions. The clinic eventually will run for one week every two months and be a base for similar clinics around Australia, including a 3-day clinic planned in Perth during September. On 4/14/99, Nitschke was served a notice by the Victoria's Medical Practitioners Board following a complaint by the Australian Medical Association that he advised patients to obtain lethal drugs illegally. On 4/15/99, Victorian Premier Jeff Kennett warned that Nitschke would be prosecuted if found to be promoting euthanasia illegally. Nitschke claims to have helped about 60 patients from around Australia die since the Northern Territory's euthanasia law was overturned by the federal parliament.

2. Canada

- a. 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. Although the criminal charge was later dismissed, the College of Physicians and Surgeons of Nova Scotia formally reprimanded Morrison on 3/30/99 for acting outside the accepted standards of medical care. Morrison accepted the reprimand rather than wait several months for a lengthy public hearing and face up to \$175,000 in attorney fees.
- b. Latimer prosecution. On 11/5/97, a jury convicted Robert Latimer of second-degree murder for the mercy killing of his disabled 12-year-old daughter. Latimer faced a mandatory life prison sentence, without a chance for parole for 10 years. However, the jury recommended parole after one year. On 12/1/97, the trial judge granted a special constitutional exemption from the mandatory minimum on the ground that the punishment would be cruel and unusual. Instead, the judge sentenced Latimer to serve one year in a provincial jail (subject to reduction for good behavior) and another year under house arrest on his farm. However, the Saskatchewan Court of Appeal held on 11/23/98 that the sentence was improper and Latimer must serve at least 10 years with no chance for parole. On 5/6/99, the Supreme Court of Canada agreed to consider Latimer's appeal of his conviction and life sentence.
- c. John Hofsess. John Hofsess, founder of the Canadian Right to Die Society, is working to develop a "debreather" mask that would bring about swift and relatively painless death to the user. The mask, which is based on technology taken from scuba diving, would involve breathing air in a closed system until the oxygen is depleted and the person passes out and dies.
- d. Dr. Genereux. On 4/27/99, the Ontario Court of Appeal upheld the sentence imposed by the trial judge on Dr. Maurice Genereux, a physician who entered a guilty plea in December 1997 on two counts of assisting a suicide, and Genereux was taken into custody. Both sides had appealed from the sentence of two years less a day and three years probation.

3. Great Britain

- a. Dr. Moor. In 1997, after prominent physician Dr. Michael Irwin announced that he had helped at least 50 patients to die, general practitioner Dr. David Moor (who has since retired) reported that he had helped 300 patients to die. Subsequently, Dr. Moor was charged with murder in connection with the death on 7/19/97 of George Liddell, an 85-year-old cancer patient who was given a large dose of diamorphine. On 5/12/99, following an 18-day trial, a jury acquitted Moor after deliberating for only 65 minutes. Moor testified that he intended only to relieve Liddell's pain, not to kill him, and the judge ruled that the toxicological evidence was inadmissible.
 - b. Dr. Taylor. On 3/26/99, the General Medical Council found 51-year-old Dr. Ken Taylor guilty of serious professional misconduct and suspended him from practice for six months in connection with the 1995 death of his patient, 85-year-old Mary Ormerod, who died after Taylor instructed nurses to withdraw her food supplement and reduce her fluid intake. Taylor's actions were supported by the patient's family. Police had conducted a murder inquiry in the case, but the Crown Prosecution Service declined to prosecute.
 - c. British Medical Association. The British Medical Association, together with the Royal College of General Practitioners and the Royal College of Nursing, plans to issue new guidance for end-of-life care during summer 1999. The British Medical Association's Medical Ethics Committee conducted a consultation during 1998 that revealed some confusion and variation in practice within Britain.
4. India. Mukundan Pillai and three other elderly men have filed a lawsuit in the southern Indian state of Kerala demanding that assisted suicide be legalized. Experts report that the elderly are increasingly neglected and isolated, especially in Kerala where people live much longer because of the success of primary health care programs.
 5. Netherlands. The Dutch government is backing a private member's bill that would legalize physician-assisted suicide and euthanasia. If passed, the bill would become law in 2001. A recent survey by the University of Rotterdam showed that 92% of respondents supported the current situation in which both practices are technically illegal, but physicians are not prosecuted if they comply with certain guidelines.
 6. South Africa. On 3/5/99, the South African Medical Association said that proposed legislation on active euthanasia should be put on hold and that instead laws should be enacted to protect the rights of terminally ill patients to forgo life-sustaining treatments. A report on the subject of euthanasia is expected from the South African Law Commission.
 7. Switzerland. A 14-member panel known as "Help in Dying" was appointed by Switzerland's minister of justice and police, Arnold Koller, to provide an expert opinion regarding a bill tabled by a parliamentary deputy. The panel members agreed that active euthanasia should remain illegal, but eight members proposed that the law should

not prosecute physicians who perform active euthanasia at the express request of an incurable patient in the terminal stages of illness and suffering intolerable pain.

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