



Recent Developments in Physician-Assisted Suicide

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LITIGATION

1. Sampson v. Alaska, No. 3AN-98-11288CI (Alaska Super. Ct.). On 12/15/98, Kevin Sampson (a 43-year-old HIV-positive man) and "Jane Doe" (a female physician in her 60s with cancer) 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. On 9/9/99, Judge Eric T. Sanders issued a written opinion rejecting the plaintiffs' claims and granting summary judgment to the defendant. The plaintiffs are expected to appeal the ruling.
2. Reding v. Granholm. In March 1999, Dr. Georges Reding filed a lawsuit in U.S. District Court in Ann Arbor, Michigan, against Attorney General Jennifer Granholm, asking for an injunction that would prevent him from being prosecuted for assisting in the suicides of two terminally ill patients. On 9/10/99, Judge Barbara K. Hackett issued a ruling denying a motion to dismiss the lawsuit.

LEGISLATION

1. Florida. On 8/1/99, the Florida Panel for the Study of End of Life Care, a study group created by the 1998 legislature, issued its final report based on more than a year of meetings and public hearings. Recommendations in the report include more training of medical professionals in the importance of pain control and in the latest pain control methods and more public education campaigns on advance medical directives. The only reference to aid-in-dying was a statement that the emphasis on pain management "should [not] be taken to promote or condone physician-assisted suicide or euthanasia." Copies of the report are available from the Pepper Institute on Aging and Public Policy in Tallahassee, Florida, (850) 644-2831, or on-line at www.pepperinstitute.org.
2. Maine. In September 1999, the group Mainers for Death With Dignity filed petitions with state election officials supporting a November 2000 ballot measure on legalizing physician-assisted suicide. The group said that it submitted 50,000 voters' signatures to the Secretary of State's office, well over the 42,101 needed.
3. Oregon
 - a. Amendments to Oregon Death with Dignity Act. As expected, Governor John Kitzhaber signed Senate Bill 491 (1999 Or. Laws ch. 423), a compromise bill supported by supporters and most opponents of the Oregon Death with Dignity Act.

- b. 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. Although the legislature passed a bill (HB 5029) that would have prohibited payments from the Oregon Health Plan for medical assistance that gets no federal funding (including abortion and physician-assisted suicide), Governor Kitzhaber vetoed the bill.
- c. 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. Several bills were introduced in the legislature as a result of the Task Force's recommendations, but the only ones that passed were SJR 28 (directs health-related state agencies and encourages health care professionals to support rights of persons with pain), SB 1140 (creates Pain Management Demonstration Projects in one rural area and one urban area), 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).
- d. Compassion in Dying

(1) Booklet. Compassion in Dying of Oregon has prepared a booklet on Frequently Asked Questions about the Oregon Death with Dignity Act. The booklet indicates that 11 of the 15 deaths that occurred under the Act during 1998 involved assistance from Compassion in Dying, all 11 patients had a loved one or close friend with them when they took the medication, all 11 patients died in their home or a home-like environment, and the Act prevented at least two homicides and six violent suicides. A Complete Patient Packet of information can be obtained for \$5 from Compassion in Dying of Oregon, PMB 410, 6312 SW Capitol Highway, Portland, OR 97201.

(2) Patient histories. In an article published in the Oregon State Bar Elder Law Section Newsletter (Fall 1999), Barbara Coombs Lee reported on the experiences of Compassion in Dying of Oregon during its first year (ending 10/28/98) of counseling patients, families, and physicians about end-of-life care options. The organization fielded over 350 requests for information, including 56 from individuals qualified to use the Oregon Death with Dignity Act and wishing to do so. Thirty-four died during the year, but only 10 due to ingesting lethal medication. In 12 of the 34 deaths, palliative care improved dramatically after the patient's request for assisted suicide; 70% of the 34 patients were receiving hospice care when they died. In 11 cases, the patient felt that the choice of assisted suicide was unreasonably foreclosed and the care provided was not entirely successful in relieving the patient's anguish. Patients contacted Compassion in Dying an average of 36 days prior to death, with 11 dying before the 15-day waiting period was completed (four by stopping eating and drinking, five by "double effect," and one by "terminal sedation"). The 10 patients who ingested lethal medication under the Act contacted Compassion in Dying much earlier, with an average of 62 days from initial contact to death. Before contacting Compassion in Dying, eight of the 34 patients had planned to die by suicide or being killed by their spouses.

- 4. Federal legislation. On 6/17/99, Senator Don Nickles and Representative Henry Hyde introduced the Pain Relief Promotion Act of 1999 (HR 2260/SB 1272), which would amend the federal Controlled Substances Act to prohibit the prescribing of medication for purposes of assisted suicide or euthanasia. Under the Act, the Attorney General could "give no force and effect to State law authorizing or permitting assisted suicide or euthanasia." The Act also would authorize prescribing medication to relieve a patient's pain, even if the medication would hasten the patient's death, and would establish research, educational, and training programs on pain management and palliative care. On 9/14/99, the House Judiciary Committee approved the bill on a vote of 16-8, with all the Republican members voting in favor of the bill and all the Democratic members voting against it. Oregon Senator Ron Wyden has declared that he will filibuster the legislation if it reaches the Senate floor. The Pain Relief Promotion Act is supported by a number of organizations that opposed the Lethal Drug Abuse Prevention Act during the previous congressional session, including the National Hospice Organization and the American Medical Association. Opponents include the Oregon Medical Association, the Oregon Hospice Association,

OTHER NATIONAL DEVELOPMENTS

1. California. In February 1999, Dr. Frank Fisher was charged with murder in the deaths of several patients treated at his clinic in Redding. Fisher said that he treated a large number of patients, many of them poor, who had chronic intractable pain and had been unable to obtain treatment. Fisher was jailed when he was unable to post the \$15 million bail but was released from jail on 7/16/99 after a Shasta County judge reduced three murder charges to involuntary manslaughter because of insufficient evidence of an intent to kill.

2. Michigan
 - a. Dr. Kevorkian's conviction in death of Thomas Youk. On 3/26/99, Dr. Jack Kevorkian was convicted by a jury of second-degree murder and illegal delivery of a controlled substance in connection with the death of Thomas Youk by lethal injection.
 - (1) Incarceration. Kevorkian, who was held originally at the maximum-security Oaks Correctional Facility in western Michigan but was transferred in August 1999 to the medium-security Kinross Correctional Facility in the Upper Peninsula, will not be eligible for parole until May 2007. Michigan's state treasurer sued Kevorkian in July 1999 to recover the costs of his imprisonment (estimated at \$93 per day). However, a settlement reached in August 1999 limited the state's recovery to approximately \$28,000 from Kevorkian's personal bank account and \$364.50 per month (90%) of his monthly pension from St. John Health System; Kevorkian will keep his original artwork and more than \$77,000 in a legal defense fund.
 - (2) 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. On 7/15/99, Judge Jessica Cooper issued a ruling denying the motion.
 - (3) Appeal. On 8/23/99, Kevorkian's lawyer Mayer Morganroth filed a notice with the Michigan Court of Appeals to overturn his conviction and order a new trial. Grounds for appeal (which must be filed within 56 days) 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. Dr. Kevorkian's defamation suit. On 8/6/99, the Michigan Court of Appeals issued a 2-1 opinion entering summary judgment for the defendants in Dr. Kevorkian's defamation action against the American Medical Association and the Michigan State Medical Society. *Kevorkian v. American Medical Association*, ___ N.W.2d ___, 1999 WL 607917 (Mich.App. 1999). The majority found that Kevorkian was virtually "libel-proof" because of his public role in the debate over assisted suicide.
 - c. Dr. Reding. On 8/19/99, Dr. Kevorkian's associate Dr. Georges Reding was indicted in New Mexico for first-degree murder, practicing medicine without a license, trafficking in a controlled substance, and evidence tampering in connection with the 8/30/98 death of Donna Brennan, a 54-year-old woman with multiple sclerosis, by a lethal dose of pentobarbital. A search of Reding's home reportedly yielded information about other possible assisted suicides in the United States and Canada. After neither Reding nor any lawyer representing him appeared for his scheduled arraignment on 9/3/99, a judge issued a

warrant for Reding's arrest without possibility of bail. Authorities have not been able to determine the whereabouts of Reding, who is now represented by attorneys Geoffrey Fieger and Michael Schwartz. Brennan's relatives have contested her 8/21/98 will in favor of her neighbor and caregiver, Bernadette Griego, who was present when Reding met with Brennan. On 9/3/99, Brennan's family filed a wrongful death and medical malpractice action against Reding.

3. New York. In July 1999, a Manhattan grand jury refused to indict veterinarian Dr. Marco Zancope, who had admitted injecting Cara Beigel, a 33-year-old woman who was terminally ill with cancer, with a fatal dose of phenobarbital at her request on 8/28/97. Beigel's family supported Zancope's actions.
4. Oregon. On 9/1/99, the Oregon Board of Medical Examiners approved a disciplinary plan for Dr. Paul Bilder, a 54-year-old pulmonary disease specialist from Roseburg, who agreed to a stipulated order acknowledging that his treatment of six patients between 1993 and 1998 constituted unprofessional or dishonorable conduct and gross or repeated acts of negligence. The board, which announced in 1998 that it would investigate physicians for the undertreatment as well as the overtreatment of pain, had charged Bilder with failing to give adequate pain medication to seriously ill or dying patients. Bilder must complete a one-year peer program in which another physician will work with Bilder to assess his practice and make improvements, complete a course on physician-patient communication, and continue meeting with a psychiatrist who will give regular reports to the board for at least a year. According to the Federation of State Medical Boards, no other state has taken action against a physician primarily for undertreating pain.
5. Washington. On 7/21/99, the state Medical Quality Assurance Commission voted to censure 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 found that Turner acted in an incompetent and unprofessional manner but should be allowed to continue practicing medicine. 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.
6. Conference on assisted dying. A three-day world conference on "Assisted Dying in the New Millennium—An International Perspective" will be held September 1-3, 2000, in Boston, Massachusetts. The conference is sponsored by the World Federation of Right to Die Societies and the Hemlock Society.

MEDICAL DEVELOPMENTS

1. HCFA ruling on pain treatment. On 12/16/98, Compassion in Dying Federation, Americans for Better Care of the Dying, the American Academy of Pain Management, the American Pain Foundation, the Medicare Rights Center, and Choice in Dying sent a letter to the Health Care Financing Administration (HCFA) asking that California medical providers be investigated for not complying with the Patient Self-Determination Act. In June 1999, HCFA issued a letter confirming that California health care facilities must inform patients of their right to adequate pain treatment under California's Pain Patient's Bill of Rights, enacted in 1997. Richard Chambers, acting deputy regional administrator for HCFA's San Francisco regional office, indicated that action would be taken to implement the letter.
2. End-of-life care in Oregon. In June 1999, the Oregon Health Sciences University Center for Ethics in Health Care issued a report on end-of-life care in Oregon, *The Oregon Report Card: Improving Care of the Dying*, presenting data from two of the Center's projects, "Barriers to Improving Care of the Dying" and "Improving Care of the Dying: Overcoming Barriers and Advancing Gains in End-of-Life Care." While confirming that Oregon continues to be a national leader in end-of-life care, the new publication noted a number of areas needing further improvement. For example, 13% of families reported severe pain and 21% reported moderate pain for patients during the last week of life. Many families said that transfers from a health care facility during the final month of life were poorly coordinated by health care providers, causing additional stress. In addition, one-fifth of hospice patients had fewer than three visits from hospice workers before they died. Copies of *The Oregon Report Card*, which was mailed to all Oregon health care providers, may be obtained from the Center by calling (503)

3. Supportive Care of the Dying. Supportive Care of the Dying (a coalition of 13 Catholic health care organizations and the Catholic Health Association) conducted 55 focus groups including 407 persons at 11 sites around the country during March-June 1996 to determine the needs and experiences of patients with life-threatening illnesses, family members, caregivers, and community members. The purpose of the research was to determine what information, services, and support these groups need. An executive summary of the study appears on-line at www.careofdying.org. A portion of the group's work was published in the 6/17/99 issue of the Journal of Palliative Medicine.
4. American Medical Association. At its annual meeting in June 1999, the American Medical Association's House of Delegates directed the AMA to seek a number of changes in the Medicare program, including extending the prognosis necessary to approve a patient's placement in hospice from six months to 12 months.
5. Joint Commission on Accreditation of Healthcare Organizations. In August 1999, the Joint Commission on Accreditation of Healthcare Organizations adopted standards under which hospitals, nursing homes, and home-care agencies must "recognize the right of patients to appropriate assessment and management of pain."
6. Brown University study. On 9/2/99, Dr. Joan Teno and other researchers at Brown University launched a five-year study of the quality of life and circumstances of people facing imminent death. The study, to be funded by a \$2.3 million grant from the Robert Wood Johnson Foundation, will include interviews with more than 2,000 people about the dying experiences of family members, as well as in-depth interviews with 120 families. The study will also attempt to describe the dying process in Medicare-certified nursing homes.
7. Recent articles
 - a. David P. Phillips et al., *The Influence of Medical and Legal Authorities on Deaths Facilitated by Physicians*, 29 *Suicide & Life-Threatening Behavior* 48 (Spring 1999) [mortality data show a peak in similar deaths within one-month period following publication of Dr. Quill's article in *New England Journal of Medicine* in 1991 and one-month period following *Cruzan* decision of U.S. Supreme Court in 1990].
 - b. Daniel P. Sulmasy & Edmund D. Pellegrino, *The Rule of Double Effect: Clearing Up the Double Talk*, 159 *Archives Internal Med.* 545 (1999) [authors seek to clarify the nature and use of the rule of double effect].
 - c. Joanne Wolfe et al., *Stability of Attitudes Regarding Physician-Assisted Suicide and Euthanasia Among Oncology Patients, Physicians, and the General Public*, 17 *J. Clinical Oncology* 1274 (1999) [researchers conducted follow-up interviews of 111 oncology patients, 158 members of the general public, and 324 oncologists who had participated in 1996 survey regarding four patient vignettes; results showed that attitudes of patients and the public remained relatively stable regarding physician-assisted suicide and euthanasia; by contrast, opposition of oncologists to these practices had increased significantly over time].
 - d. Bregje D. Onwuteaka-Philipsen et al., *Consultants in Cases of Intended Euthanasia or Assisted Suicide in the Netherlands*, 170 *Med. J. Australia* 360 (1999), and Herbert Hendin, *Euthanasia Consultants or Facilitators?*, 170 *Med. J. Australia* 351 (1999) [interviews of 405 Dutch physicians from November 1995 to February 1996 showed that 42% had at some time served as a consultant in intended physician-assisted suicide or euthanasia; in about 60% of cases, the consultant was a general practitioner].
 - e. Laura C. Hanson et al., *Community Physicians Who Provide Terminal Care*, 159 *Archives Internal Med.* 1133 (1999) [researchers interviewed physicians and family members of North Carolina patients over age

65 who died of cancer, congestive heart failure, chronic lung disease, cirrhosis, or stroke between September 1994 and December 1995 in a community setting rather than in an academic hospital; results showed a low incidence of aggressive end-of-life treatment, relatively long-term physician-patient relationships, and early discussion of end-of-life treatment options].

- f. Sylvia McSkimming et al., *The Experience of Life-Threatening Illness: Patients' and Their Loved Ones' Perspectives*, 2 J. Palliative Med. 173 (1999) [six Catholic healthcare organizations conducted focus groups of patients with life-threatening illnesses, personal/family caregivers, and bereaved individuals at 11 Catholic healthcare sites around the country between December 1995 and June 1996; study revealed many sources of dissatisfaction with care that are interpersonal in nature].
- g. Antonio Vigan˜ et al., *The Relative Accuracy of the Clinical Estimation of the Duration of Life for Patients with End of Life Cancer*, 86 Cancer 170 (1999) [Canadian researchers studied accuracy of estimated period of survival of 233 patients as of onset of cancer's terminal phase; oncologists' estimates were accurate to within one month only 25% of the time; period of survival was overestimated 52% of the time, particularly for patients who died within one month of onset].
- h. George E. Dickinson et al., *Twenty Years Beyond Medical School—Physicians' Attitudes Toward Death and Terminally Ill Patients*, 159 Archives Internal Med. 1741 (1999) [1996 survey of physicians who had been surveyed in 1976 shortly after graduation from medical school revealed that physicians had become more willing to inform terminally ill patients of their prognosis and more confident in dealing with dying patients].
- i. Harvey Max Chochinov et al., *Will to Live in the Terminally Ill*, 354 The Lancet 816 (1999) [twice-daily surveys of 168 terminal cancer patients at a palliative care unit in Winnipeg, Canada, showed wide variations in a patient's will to live within a period of 30 days or less; as a patient's physical symptoms worsened over time, the factor having the greatest influence on will to live changed from anxiety to depression and then to shortness of breath].
- j. Dwenda K. Gjerdingen et al., *Older Persons' Opinions About Life-Sustaining Procedures in the Face of Dementia*, 8 Archives Fam. Med. 421 (1999) [interviews of 84 cognitively normal persons age 65 and older revealed that about three-fourths would not want CPR, a respirator, or artificial nutrition with mild dementia; in the case of severe dementia, 95% or more would not want these procedures and only one-third would want to be hospitalized or given antibiotics].
- k. Ezekiel J. Emanuel et al., *Assistance from Family Members, Friends, Paid Care Givers, and Volunteers in the Care of Terminally Ill Patients*, 341 New Eng. J. Med. 956 (1999) [988 terminally ill patients and 893 primary caregivers in six randomly selected areas of the United States were interviewed to determine how nonmedical needs for assistance were met; interviews revealed that 86.8% of patients needed assistance, 62% with transportation, 55.2% with homemaking services, 28.7% with nursing care, and 26% with personal care; family members were primary caregivers in 96% of cases, and 72.1% of caregivers were women; 15.5% of patients relied primarily on paid assistance; unpaid volunteers who were not family members or friends provided less than 3% of all care].

INTERNATIONAL DEVELOPMENTS

1. Australia

- a. Euthanasia clinics. Dr. Philip Nitschke continues to conduct information clinics on euthanasia in various

Australian cities. In August 1999, he reported that two of 13 people who attended clinics in Melbourne during April had since committed suicide.

- b. Dr. Syme. Authorities are investigating a death reported to the coroner by Dr. Rodney Syme, president of the Voluntary Euthanasia Society of Victoria, who seeks to reopen the euthanasia debate in Australia. His patient "Jane," a 52-year-old Melbourne woman with advanced multiple sclerosis, died in April 1999 after she stopped eating and drinking and then received increasing levels of sedation. The coroner is still investigating Syme's report that he helped a 60-year-old cancer patient to die in August 1997 through terminal sedation.

2. Canada

- a. Physician survey. In July 1999, Dr. Douglas Kinsella and Marja Verhoef of the University of Calgary published results of a 1995 survey of Canadian physicians in *Annals RCPSC*, the peer-reviewed journal of the Royal College of Physicians and Surgeons of Canada. Of 1,855 practicing physicians who responded to the survey, 57% said they would not practice physician-assisted suicide if it were legalized. When asked whether they would want physician-assisted suicide for themselves or a close relative, 40% said they would want it for themselves if terminally ill, and 38% said they would want it for a relative. Even among the 40% of physicians who would want physician-assisted suicide for themselves, only 45% said they would be willing to practice it, 25% said they would not be willing, and 30% were uncertain.
- b. Jim Wakeford. On 9/7/99, AIDS activist Jim Wakeford announced at a news conference in Ottawa that he was filing a constitutional case in the provincial court, seeking the right to die with the help of a physician. Wakeford had written to Prime Minister Chrétien in January 1999 asking that he be granted the right to physician-assisted suicide, but Chrétien's office replied in March that no consensus existed and further debate was necessary before the government could take action.
- c. Marilynne Seguin. On 9/9/99, Marilynne Seguin, a 61-year-old Toronto nurse who founded the Canadian organization Dying with Dignity, died by taking lethal medication with a physician present. Seguin had counseled several hundred dying patients over a 20-year period. She left an unpublished manuscript, *Managing Your Death*, to be edited and published posthumously.

3. Great Britain

- a. British Medical Association. On 6/23/99, following an extensive consultation exercise conducted in 1998, the British Medical Association issued new guidance for withholding and withdrawing life-prolonging medical treatment. Where a patient is incompetent to decide whether treatment is beneficial, the decision would be made by the treating physician with the advice of other health care team members and after consulting with relatives. Additional safeguards would apply to withholding or withdrawing artificial nutrition and hydration, including formal clinical review by a senior clinician who is not part of the treating team. Physicians who oppose the proposed guidelines have formed the Medical Ethics Alliance, which claims to represent 2,000 physicians. At the British Medical Association's annual conference held in July 1999, the Alliance failed in its attempts to force an emergency debate or get the delegates to oppose the guidance.
- b. Lorraine Lane. Neil Lane, whose wife Lorraine has been in a coma for six months after a stroke at the age of 42, has launched a legal battle to try to force a hospital to withhold fluids from her. Because Lorraine Lane is in a minimally conscious state with some brain activity, she is not covered by the legal precedent for patients in a persistent vegetative state that was set in the 1992 case of Tony Bland.
- c. Investigation of hospital patients' deaths. Detectives have filed a report with the Crown Prosecution Service after a 22-month inquiry into deaths at the Kingsway Hospital in Derby. Police have examined more than 30 cases in which it was alleged that physicians withdrew food and water, causing the deaths of patients who were not terminally ill. Three nurses have been suspended pending the outcome of the

investigation. Prosecutors are expected to study the police files for several months before making any decision on criminal charges.

4. Netherlands

- a. Proposed legislation. The Dutch government has proposed legislation to legalize physician-assisted suicide and euthanasia, which have been technically illegal in the Netherlands but not prosecuted if physicians followed prescribed guidelines. The bill, which was delivered to the lower house of parliament on 8/9/99, is expected to be approved sometime in 2000. The government dropped a controversial provision that would have allowed terminally ill children age 12 and older to request aid in dying even if their parents objected. 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.

 - b. Government publication. The Dutch Ministry of Foreign Affairs has published a booklet, *Q&A Euthanasia*, explaining its policy on euthanasia. The booklet and other materials are available on-line at www.bz.minbuza.nl/English/c_sumpolicy.html.

 - c. Death of patient with dementia. A physician in the Netherlands has not been prosecuted for helping an elderly patient with vascular dementia to die. A complex protocol was set up by the hospital involved, the Twents Psychiatric Hospital, to consider the patient's request. The hospital's chief psychiatrist, a committee of independent professionals, and an external consultant psychiatrist determined that the patient was sufficiently competent to understand the consequences of his request. The public prosecutor approved the procedure after consultation with the national forum of procurators general. The case was reported in a Dutch medical journal, 143 *Nederlands Tijdschrift Voor Geneeskunde* 17 (1999).
5. 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. In August 1999, the South African Law Commission delivered its *Report on Euthanasia and the Artificial Preservation of Life* to South Africa's Minister of Justice. The report recommended enacting legislation (known as the End of Life Decisions Act 1999) regarding life-sustaining treatment, double effect, advance directives, and surrogate decisionmaking. However, the Commission declined to make a specific recommendation on active voluntary euthanasia, instead merely setting out three different options that might be considered: (1) continuing the existing policy against euthanasia, (2) permitting a medical practitioner to provide a lethal agent in accordance with strict safeguards, or (3) establishing a multidisciplinary panel or committee to consider requests for euthanasia according to set criteria. The report is available on-line at www.law.wits.ac.za/salc/report/euthansum.html.
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* Some information obtained from media reports has not been independently verified.