



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 60's 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 have appealed the ruling.
 2. Michigan lawsuits.
 - a. Reding v. Granholm, No. 99-CV-60170 (E.D. Mich.). In March 1999, Dr. Georges Reding filed a lawsuit in U.S. District Court against Attorney General Jennifer Granholm and the Michigan Board of Medicine, asking for an injunction that would prevent him from being prosecuted for assisting in the suicides of two terminally ill patients. Reding was represented by Wayne State University law professor Robert Sedler. On 10/7/99, Judge Barbara K. Hackett dismissed the case without prejudice.
 - b. Cooley v. Granholm, No. 99-CV-75484 (E.D. Mich.). On 11/12/99, Professor Robert Sedler filed a new federal lawsuit against Attorney General Jennifer Granholm and the Michigan Board of Medicine on behalf of two Michigan physicians, Roy Cooley and M.W. El-Nachef. The suit claims that Michigan's ban on assisted suicide violates the Fourteenth Amendment right "to be relieved from unbearable pain and suffering." On 1/31/00, Judge Nancy G. Edmunds entered a pretrial scheduling order and set the case for trial on 12/1/00.
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LEGISLATION

1. Maine. In November 1999, Maine's Secretary of State ruled that the group Mainers for Death With Dignity had submitted sufficient voters' signatures to permit the proposed Maine Death with Dignity Act to appear on the November 2000 ballot. The initiative measure generally is patterned after the Oregon Death with Dignity Act but mandates mental health counseling and referral to a palliative care specialist. Under Maine's constitution, an initiated bill must first go to the Maine legislature for possible passage and then is referred to the voters if the legislature refuses to pass the bill. On 2/23/00, after conducting hearings on the initiative, the legislature's Judiciary Committee voted unanimously to send the bill to the voters, making it likely that the full legislature would accept that recommendation without further debate or votes. The Maine Medical Association, the Roman Catholic Diocese of Portland, the head of Maine's Bureau of Health, and the executive director of the Maine Hospice Council all have spoken out against the bill.
2. Oregon
 - a. Confidentiality of Oregon Health Division records. In November 1999, officials with the Oregon Health Division said that, based on advice from Oregon's Attorney General, federal Drug Enforcement Administration officials would not be given access to reports filed by physicians under the Oregon Death with Dignity Act. The statement was issued in response to Senator Don Nickles' statement that the DEA would be able to enforce any federal legislation simply by looking at Oregon Health Division records.

- b. 1999 deaths by assisted suicide. On 2/23/00, the Oregon Health Division issued a report on deaths during 1999 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.htm. A published version of the report is found in Amy D. Sullivan et al., *Legalized Physician-Assisted Suicide in Oregon—The Second Year*, 342 *New Eng. J. Med.* 598 (2000). The report included the following information:

(1) 33 persons received prescriptions under the Act; 27 died after taking lethal medication (one of whom obtained the prescription in 1998), five died from their underlying illness, and two were alive as of 1/1/00.

(2) Median age of the 27 patients who died was 71, 96% were white, 59% were male, 33% lived in the Portland metropolitan area, and 48% were college graduates.

(3) 17 of the 27 patients who died had cancer, four had amyotrophic lateral sclerosis, and four had chronic obstructive pulmonary disease; 78% of the patients were enrolled in a hospice program, and all had health insurance.

(4) Ten of the 27 patients received a psychiatric or psychological consultation.

(5) The most common reasons for choosing assisted suicide expressed by patients to their physicians were loss of autonomy (81%), an inability to participate in activities that make life enjoyable (81%), and loss of control of bodily functions (59%). Twenty-six percent cited being a burden on others and 26% inadequate pain control; none voiced concern about the financial impact of their illness.

(6) According to family members who were interviewed, the most common reasons patients chose assisted suicide were loss of control of bodily functions (68%), loss of autonomy (63%), physical suffering (53%), an inability to participate in activities that make life enjoyable (47%), and concern about being a burden on others (47%). Fourteen of 19 family members stated that the patient was determined to control the circumstances of his or her death, and 14 mentioned the patient's wish to avoid a prolonged death.

(7) 26 patients received prescriptions for nine grams or more of secobarbital, and one patient received a prescription for six grams of pentobarbital.

(8) Median time from taking the medication to unconsciousness was 10 minutes (range = 1-30 minutes).

(9) Median time from taking the medication to death was 30 minutes (range = 4 minutes to 26 hours). Twenty-four patients died within 4 hours; three patients died after 11 hours or more, one of whom ingested only two-thirds of the dose, became unconscious after 13 minutes, and died 26 hours later.

(10) No complications (such as vomiting or seizures) were reported by any physician.

(11) A total of 22 physicians prescribed lethal medications to 33 persons; six of the physicians also prescribed such medications in 1998. These physicians represented a wide range of specialties, ages, and years in practice.

(12) Eighteen patients who chose physician-assisted suicide had requested lethal medications from one or more providers before finding a physician who would participate.

Oregon Health Division statistics for 1999 generally were consistent with statistics for 1998. The number of deaths increased from 16 in 1998 (including one death not reported until 1999) to 27, but the difference was largely due to the low number of deaths during the first few months of 1998. More patients who died in 1999 were married (44% as compared to 12% in 1998), and the median interval between the first request for assistance and death was 83 days, as compared with 22 days in 1998.

- c. Oregon physicians' experiences. Researchers mailed a questionnaire during February-August 1999 to 4,053 Oregon physicians practicing in the fields of internal medicine, family practice, general practice, gynecology, surgery, therapeutic radiology, and neurology to determine their experiences with the Oregon Death with Dignity Act since October 1997. The responses are reported in Linda Ganzini et al., *Physicians' Experiences with the Oregon Death with Dignity Act*, 342 *New Eng. J. Med.* 557 (2000). Of the 2,649 physicians who returned the survey, 144 (5%) had received a total of 221 requests for prescriptions. The responses from those physicians revealed the following information:

(1) Physician attitudes. Fifty-five percent of the physicians supported the Oregon Death with Dignity Act, and 51% were willing to prescribe a lethal medication for a terminally ill patient. However, physicians in small towns were very unlikely to prescribe lethal medication even though 59% supported the Act. Thirty-five percent of patients who requested a prescription for a lethal medication had to consult

more than one physician.

(2) Physician education. During the prior four years, 88% of the physicians had sought to improve their knowledge of the use of pain medications "somewhat" or "a great deal," 76% had sought to improve their ability to recognize psychiatric illnesses such as depression in the terminally ill "somewhat" or "a great deal" and 86% reported that their confidence in the use of pain medications in the terminally ill had improved "somewhat" or "a great deal."

(3) Patient characteristics. The mean age of patients who requested assistance was 68 years, 97% were white, 52% were men, 46% were married, 5% had not completed high school, and 2% had no medical insurance. Four patients had lived in Oregon for less than six months, but only one had moved to Oregon specifically because of the availability of assisted suicide. Cancer was the most common diagnosis. Patient demographics were almost identical to those of members of the general population of Oregon who died during the same period.

(4) Reasons for requests. Important factors in patient requests were loss of independence (57% of patients), poor quality of life (55%), readiness to die (54%), and a desire to control the circumstances of death (53%). Uncommon reasons were a perception of being a financial burden to others (11%) and lack of social support (6%).

(5) Physicians' interventions. Physicians provided information about interventions they recommended or implemented in the case of 142 patients. The most commonly recommended interventions were pain control (for 30%), control of other physical symptoms (for 30%), seeking the advice of a colleague (for 28%), referral to a hospice program (for 27%), a mental health consultation (for 20%), and a trial of antidepressant or anti-anxiety medication (for 18%). Physicians implemented at least one substantive intervention or sought the advice of a colleague in the case of 68 patients. Forty-six percent of the patients for whom substantive interventions were made changed their minds about assisted suicide, as compared with 15% of those for whom no substantive interventions were made.

(6) Depression. Twenty percent of patients requesting a prescription had symptoms of depression. A total of 28 patients received medications for depression or anxiety or were evaluated by a mental health practitioner, but only three of the 28 changed their minds about obtaining a prescription.

(7) Patients' experiences. Physicians reported the outcomes for 165 patients. Twenty-nine patients (18%) received prescriptions and 17 (10%) died from taking the prescribed medication. Of the 136 patients who did not receive prescriptions, 20% died before all the provisions of the Oregon Death with Dignity Act had been met, 15% did not meet the legal criteria for receiving a prescription, and 15% changed their minds.

(8) Patients who died by assisted suicide. Among the 44 patients who died before the physician completed the questionnaire, who were eligible to receive a prescription, who lived through the waiting period, and who requested a prescription from a physician willing to prescribe it, 17 (39%) died by taking a prescribed lethal medication. Thirteen of the 17 were enrolled in a hospice program; one patient refused hospice care and another was denied care by a hospice unwilling to participate in assisted suicide. In nine cases, the physician was present when the patient took the medication. The time to death was noted in the case of 10 patients, with three having died more than five hours after taking the medication. No adverse events were reported, although one patient who was still conscious 30 minutes after taking the lethal medication was given more of the medication to take.

3. Federal legislation

- a. Pain Relief Promotion Act introduced. 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 (1) amend the federal Controlled Substances Act to prohibit the "intentional dispensing, distributing, or administering of a controlled substance" for purposes of assisted suicide or euthanasia, (2) instruct the Attorney General to "give no force and effect to State law authorizing or permitting assisted suicide or euthanasia," and (3) establish research, educational, and training programs on pain management and palliative care.
- b. House of Representatives. On 10/27/99, the House of Representatives passed HR 2260 by a vote of 271 to 156.

- c. American Medical Association. The AMA's board of trustees gave early support to the Pain Relief Promotion Act. However, the Oregon Medical Association voted in November 1999 to ask the AMA House of Delegates to reconsider the AMA's position. In December 1999, the AMA House of Delegates voted to reaffirm AMA policy but also adopted resolutions that the AMA (1) "work with interested state and national specialty societies" to delete objectionable provisions that "establish federal protocols and/or regulations for pain management and palliative care" and (2) oppose any future legislation that "gives the federal government the responsibility to define appropriate medical practice and regulate such practice through the use of criminal penalties." However, subsequent discussions produced relatively minor suggested changes.
- d. Other organizations. The National Hospice Organization also gave early support to the proposed federal legislation. However, opposition has grown. At present, the bill is opposed by at least 12 state medical societies and many other organizations, including the American Academy of Pain Medicine, the American Academy of Family Physicians, the American Nurses Association, Americans for Better Care of the Dying, and the American Geriatrics Society. In Oregon, the bill is opposed by Governor Kitzhaber, the Task Force to Improve Care of Terminally Ill Oregonians, the Oregon Hospice Association, and most of Oregon's Congressional delegation.
- e. Senate. On arrival in the Senate, the Senate parliamentarian referred HR 2260 "by mistake" to the Senate Judiciary Committee (chaired by Senator Orrin Hatch, who opposes assisted suicide). Senate Jim Jeffords, a moderate Republican from Vermont, objected unsuccessfully to the departure from normal Senate procedure, which would have assigned the bill to the Health, Education, Labor and Pensions Committee which he chairs. Senator Hatch has made the bill one of his top six priorities before the Senate recesses March 13-17. The bill is now co-sponsored by 38 Senators, but Oregon Senator Ron Wyden has declared that he will filibuster the legislation if it reaches the Senate floor. Ending a filibuster requires the votes of at least 60 Senators.
- f. Potential for veto. President Clinton's position is not clear. Although the President does not favor assisted suicide, an Attorney General's opinion issued by the Department of Justice in October 1999 opposed the bill on two grounds: (1) physician-assisted suicide would become a federal crime that could potentially subject a physician to a mandatory 20-year criminal sentence and (2) the federal government would be deciding policy questions more appropriately left to the individual states. Overriding a Presidential veto requires a 2/3 vote in Congress (which is more than the House vote in October).
- g. Likely court challenges. If the Pain Relief Promotion Act passes, Oregon's Attorney General will file an action for declaratory judgment in federal court. Private lawsuits are also expected to be filed in federal court in both New York and Oregon.

OTHER NATIONAL DEVELOPMENTS

1. Dr. Jack Kevorkian. 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. Kevorkian is being held in the medium-security Kinross Correctional Facility and will not be eligible for parole until May 2007. On 11/12/99, Kevorkian's lawyer Mayer Morganroth filed an appeal with the Michigan Court of Appeals to reverse Kevorkian's conviction and dismiss the case or order a new trial. Grounds for appeal 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 of ineffective assistance of counsel.
2. Dr. Georges Reding. On 8/19/99, Dr. Jack Kevorkian's associate Dr. Georges Reding was indicted 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. 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 believed to have fled the country. 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 11/8/99, Sandoval County Judge Louis McDonald granted a default judgment against Reding in a civil suit filed by Brennan's family, finding Reding responsible for wrongful death, battery, breach of contract, infliction of emotional distress, and medical malpractice.
3. Conference on "self-deliverance" technology. An invitation-only "Self-Deliverance New Technology Conference," sponsored by Derek Humphry's Euthanasia Research & Guidance Organization (ERGO!), was held November 13-15, 1999, in Seattle, Washington. About 30 participants attended from countries that included Australia, France, Germany, the Netherlands, and the United States. The group discussed various methods being

developed for use by a layperson, including Dr. Philip Nitschke's "suicide pill" and several devices that would involve breathing deadly gas.

4. Video guide to suicide. Derek Humphry has produced a 34-minute videotape guide to suicide based on his book *Final Exit*. Hundreds of copies of the videotape have been sold by Humphry's Euthanasia Research & Guidance Organization to its members, and the videotape is also for sale to the public through Amazon.com. The videotape was aired twice on public access cable television in Lane County, Oregon, in February 2000 to raise public awareness of the bill pending in Congress that would nullify the Oregon Death with Dignity Act.

MEDICAL DEVELOPMENTS

1. Oregon conference on improving care of the dying. On 10/15/99, over 180 health care leaders from Oregon hospitals, hospices, and nursing homes attended a conference in Portland presented by the Oregon Health Science University Center for Ethics in Health Care, called "Improving Care of the Dying: A Workshop for Change Agents." The purpose of the conference was to discuss problems identified in the Center's June 1999 publication, *The Oregon Report Card: Improving Care of the Dying*, and to brainstorm solutions. The Center will hold a second conference solely for long-term care facilities in Eugene in April and then reconvene the Portland group to discuss any progress that has been made.
2. Michigan Commission on End of Life Care. On 1/24/00, Governor John Engler appointed a new Commission on End of Life Care to coordinate efforts to improve end-of-life care in Michigan. The Robert Wood Johnson Foundation has awarded a \$450,000 grant to the Michigan Partnership for the Advancement of End of Life Care, which will fund construction of two walk-in consumer education centers on death and dying, creation of model pain-management guidelines for nursing homes, and the design of a teaching curriculum on end-of-life care for medical, nursing, pharmacy, and other health care schools.
3. Medical groups adopt core principles for end-of-life care. Fourteen medical associations and the Joint Commission on Accreditation of Healthcare Organizations have signed on to a set of 11 core principles for end-of-life care contained in a report co-authored by Christine K. Cassel and Kathleen M. Foley and published in 1999 by the Milbank Memorial Fund, *Principles for Care of Patients at the End of Life: An Emerging Consensus Among the Specialties of Medicine*.
4. Shortage of painkillers in poor nations. In a report published on 2/23/00, the International Narcotics Control Board, a United Nations agency based in Vienna, found that the ten largest consumer countries accounted for as much as 80% of analgesic morphine consumption, while those painkillers were used infrequently or not at all in 120 poor countries. The board recommends making more painkillers accessible in developing countries.

Recent articles

- a. Ellen Fox et al., *Evaluation of Prognostic Criteria for Determining Hospice Eligibility in Patients with Advanced Lung, Heart, or Liver Disease*, 282 JAMA 1638 (1999) [review of SUPPORT study data showed that recommended clinical prediction criteria for seriously ill hospitalized patients with advanced chronic obstructive pulmonary disease, congestive heart failure, or end-stage liver disease are not effective in identifying patients with a survival prognosis of 6 months or less].
- b. Howard Wineberg, *Oregon's Death with Dignity Act: Fourteen Months and Counting*, 160 Archives Internal Med. 21 (2000) [examining characteristics of patients who used the Oregon Death with Dignity Act during 1998].
- c. Dick L. Willems et al., *Attitudes and Practices Concerning the End of Life: A Comparison Between Physicians from the United States and from the Netherlands*, 160 Archives Internal Med. 63 (2000) [interviewers who asked identical questions of 152 Oregon physicians and 67 Dutch internists during 1995-96 regarding attitudes and practices found two significant differences: American physicians more often found increasing morphine and physician-assisted suicide acceptable in cases where patients were concerned about becoming a burden to their family, and Dutch physicians were much more likely to support and participate in active euthanasia].
- d. David Orentlicher & Arthur Caplan, *The Pain Relief Promotion Act of 1999: A Serious Threat to Palliative Care*, 283 JAMA 255 (2000) [authors express concern that enactment of the Pain Relief Promotion Act would compromise the quality of palliative care by causing physicians to fear criminal prosecution, put Drug Enforcement Administration officials in the position of regulating medical decisions, and interfere with state authority to regulate medical practice].

- e. Muriel R. Gillick, *Rethinking the Role of Tube Feeding in Patients with Advanced Dementia*, 342 New Eng. J. Med. 206 (2000) [author concludes that gastrostomy tubes are not effective and may cause suffering in patients with advanced dementia and suggests that physicians, nursing homes, and hospitals adopt a policy recommending against their use].
- f. Youlian Liao et al., *Quality of the Last Year of Life of Older Adults: 1986 vs 1993*, 283 JAMA 512 (2000) [researchers used National Mortality Followback Surveys for 1986 and 1993 to compare overall quality of life during the last year of life for persons aged 65 years and older, based on reports by next of kin as to days of hospital or nursing home stays, ability to engage in activities of daily living, cognitive function, and overall sickness; most measures for men and women age 65-84 improved or did not change, and men and women at least 85 years old experienced a better overall quality of life in the last year of life in 1993 than in 1986].
- g. Ilinka Haverkate et al., *Prevalence and Content Analysis of Guidelines on Handling Requests for Euthanasia or Assisted Suicide in Dutch Nursing Homes*, 160 Archives Internal Med. 317 (2000) [survey of Dutch nursing homes showed an increase in the number having written institutional guidelines on euthanasia or assisted suicide from 36% at the beginning of 1995 to 58% by 1997; however, the guidelines varied considerably, and only 65% contained all official requirements].
- h. Johanna H. Groenewoud et al., *A Nationwide Study of Decisions to Forego Life-Prolonging Treatment in Dutch Medical Practice*, 160 Archives Internal Med. 357 (2000) [researchers who compared data from deaths nationwide in 1990 and 1995 found that the incidence of decisions to withhold or withdraw life-sustaining treatments had increased from 28% to 30% of all deaths, that artificial nutrition and hydration were the treatments most often foregone, and that life was shortened by an estimated 24 hours or less in 42% of patients and one month or more in 8% of patients].
- i. Nicholas A. Christakis & Elizabeth B. Lamont, *Extent and Determinants of Error in Doctors' Prognoses in Terminally Ill Patients: Prospective Cohort Study*, 320 British Med. J. 469 (2000) [survival estimates provided by 343 physicians for 468 terminally ill patients referred to five outpatient hospice programs in Chicago over 130 days in 1996 were accurate (within 33% of actual survival) in only 28% of cases, with 63% overly optimistic and 17% overly pessimistic; overall, physicians overestimated survival by a factor of 5.3, which may adversely affect the quality of care given to patients near the end of life].
- j. Johanna H. Groenewoud et al., *Clinical Problems with the Performance of Euthanasia and Physician-Assisted Suicide in the Netherlands*, 342 New Eng. J. Med. 551 (2000) [studies of euthanasia and physician-assisted suicide in 1990 and 1995 showed that problems were more common with assisted suicide; complications such as vomiting occurred in 7% of assisted suicide cases and problems with completion (a longer-than-expected time to death, failure to induce coma, or induction of coma followed by awakening of the patient) in 16% of cases; the physician decided to administer a lethal medication in 18% of assisted suicide cases because of problems with completion or inability of the patient to take all the medications].
- k. Linda Ganzini et al., *Physicians' Experiences with the Oregon Death with Dignity Act*, 342 New Eng. J. Med. 557 (2000) [SEE SUMMARY ABOVE UNDER "LEGISLATION"].
- l. Amy D. Sullivan et al., *Legalized Physician-Assisted Suicide in Oregon—The Second Year*, 342 New Eng. J. Med. 598 (2000) [SEE SUMMARY ABOVE UNDER "LEGISLATION"].

INTERNATIONAL DEVELOPMENTS

1. Australia

- a. State legislation. Every state in Australia has now considered and rejected legalizing euthanasia. The latest was South Australia, where the parliament's Social Development Committee released a report in October 1999, recommending that euthanasia remain a criminal offense and advising against a parliamentary debate on a four-year-old euthanasia bill.

- b. Euthanasia clinics. Dr. Philip Nitschke continues to conduct information clinics on euthanasia in various Australian cities, with clinics currently scheduled in Melbourne, Sydney, Adelaide, Brisbane, and Hobart. Nitschke reported in February 2000 that 105 people (about half of whom were terminally ill) had attended the clinics during 1999 and at least four had taken their lives. A newspaper poll of Tasmanian residents during January 2000 revealed that 64.8% approved of holding euthanasia advisory clinics in Tasmania and 23.3% opposed the clinics.
 2. Belgium. Euthanasia is widely practiced in Belgian hospitals, but physicians who participate are subject to prosecution under the current criminal code. The Belgian Advisory Committee on Bioethics has submitted two reports on alternatives for legally regulating euthanasia: one in 1997 covering competent patients and another in 1999 covering incompetent patients. On 12/22/99, the ruling six-party coalition of French and Flemish Socialists, Liberals, and Greens, which ousted the Christian Democrats from power in mid-1999, introduced a draft euthanasia bill in the Belgian Senate. The draft bill would legalize euthanasia for competent adults with an incurable illness causing unbearable and constant suffering, as well as for patients in a persistent vegetative state who had made a request within the prior five years before two witnesses to have their life ended in such circumstances. A national evaluation committee of physicians and lawyers would be set up to ensure that the law is followed. The bill is expected to pass, despite opposition from Catholics and the national medical association.
 3. Canada. During February 2000, the Subcommittee to Update *Of Life and Death* of the standing Senate Committee on Social Affairs, Science and Technology began conducting hearings intended to culminate with the filing of a report by 6/6/00. The subcommittee is charged with reviewing developments during the five years since the June 1995 report, *Of Life and Death: Report of the Senate Special Committee on Euthanasia and Assisted Suicide*. The subcommittee's charge is limited to the unanimous recommendations made in *Of Life and Death*, which covered palliative care, pain control and sedation practices, withholding and withdrawal of life-sustaining treatment, and advance directives. The subcommittee's charge does not include assisted suicide and euthanasia, as to which the 1995 recommendations were not unanimous.
4. Great Britain
 - a. Government proposals. On 10/27/99, the British government issued the report *Making Decisions*, which was published in response to the Government's 1997 consultation paper *Who Decides?* The Lord Chancellor, Lord Irvine of Lairg, reported that the government will seek creation of a new Court of Protection, which will have London and regional jurisdiction over the health care, personal welfare, and financial affairs of the mentally ill or incapacitated; currently, the High Court hears cases involving the right to die and patients in a persistent vegetative state. The government also proposes to authorize powers of attorney for health care. The Government will introduce a mental health law bill to implement these proposals, but has rejected the Law Commission's argument that living wills should be given statutory authority. Similar reforms are under consideration in Scotland and Northern Ireland.
 - b. Private member's bill. MP Ann Winterton has introduced a private member's bill, the Medical Treatment (Prevention of Euthanasia) Bill, in Parliament. The bill, which was prompted by charges that National Health Service physicians were withholding nutrition and hydration from elderly patients as "involuntary euthanasia," would make physicians guilty of unlawful killing if it is proved that their purpose in withdrawing nutrition, hydration, or medical treatment was to end life. Public Health Minister Yvette Cooper said that the Government is opposed to the bill because of concerns it would prove unworkable in practice. MP Peter Brand, a physician from the Isle of Wight, is being investigated by Hampshire police after revealing during parliamentary debate on 1/28/00 that he participated in withdrawing treatment from a two-year-old leukemia patient in 1973 at the request of the child's parents.
5. Hong Kong. A survey of 1,187 physicians and 618 households, conducted by researchers from City University and the University of Sydney and completed in June 1999, showed a high level of support for euthanasia. Among physicians, 60% said that euthanasia should not be against the law and 28% supported active euthanasia. Among the public, 66% said that euthanasia should not be against the law and 60% supported active euthanasia.
6. Israel. Seven hundred people attended a discussion on "The Right to Die with Dignity" held in Jerusalem on 2/17/00, which was sponsored by the Hadassah-University Hospital and the Hebrew University-Hadassah School of Medicine. Professor Avinoam Reches, who planned the conference, suggested that the Oregon Death with Dignity Act serve as a model for Israel. During the conference, Israeli Health Minister Shlomo Benizri announced that he would establish a committee of physicians, philosophers, ethicists, clergy, and public representatives to study the issue of death with dignity and make recommendations.
7. 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. During January 2000, the Parliamentary Committee of Justice held a public hearing during which strong arguments were made to increase and improve palliative care in the Netherlands.

- b. Suicide website. A how-to guide to suicide methods on an anonymous Dutch-language website called "Thisbe's Self-destruction Site" provoked an outcry in parliament during January 2000 and demands for a change in the government's lax approach to regulating the Internet. The governing Labor Party called on Prime Minister Wim Kok to take action against the site and others containing information that could pose a danger to minors.

8. New Zealand

- a. Fred Robinson. Fred Robinson, who was permanently disabled in a climbing accident and spent 20 years advocating voluntary euthanasia, died on 10/6/99. New Zealand's Parliament considered the question in 1995, defeating MP Michael Laws's euthanasia bill by a vote of 61 to 29.
 - b. Euthanasia survey. The Voluntary Euthanasia Society polled 389 general election candidates in November 1999 seeking their views on the legalization of euthanasia. Of the 49 candidates who responded, 31 said they would support legislation to legalize voluntary euthanasia and 20 said they would be prepared to introduce a private member's bill for that purpose.
9. Switzerland. Elke Baezner, president of the Swiss organization Exit, reported that Exit's "companions in death" helped 120 terminally ill patients commit suicide during 1999 with an overdose of barbiturates. After each death, Exit volunteers notify police and provide a detailed written account with dates, times, and witnesses. Switzerland does not prosecute nonphysicians who assist in suicides unless they act with a selfish motive. No Exit member has ever been prosecuted, but in late 1998 authorities did stop the group from supplying an overdose to a 30-year-old chronically depressed woman.
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* Some information obtained from media reports has not been independently verified.