Recent Developments in Physician-Assisted Suicide

June 2001

LITIGATION

1. *Sampson v. Alaska*, No. 3AN-98-11288CI (Alaska Super. Ct.), appeal pending, No. S9338 (Alaska Sup. 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. On 11/14/00, the Alaska Supreme Court heard arguments on the appeal. A draft opinion was circulating as of 6/18/01.

2. *Cooley v. Granholm*, No. 99-CV-75484 (E.D. Mich.), appeal pending, No. 01-1067 (6th Cir.). On 11/12/99, Professor Robert Sedler filed a 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 plaintiffs claimed that Michigan's ban on assisted suicide violates the Fourteenth Amendment right "to be relieved from unbearable pain and suffering." On 12/20/00, Judge Nancy G. Edmunds granted the defendants' motion for summary judgment and dismissed the complaint. On 1/12/01, plaintiffs appealed to the Sixth Circuit Court of Appeals. The final brief on appeal was filed on 6/4/01. Both sides have requested oral argument.

3. *Sanderson v. People*, 12 P.3d 851 (Colo. App. 2000), cert. denied (Colo. Sup. Ct. Oct. 23, 2000). In February 1996, retired state trial court judge Robert Sanderson filed a petition asking the Prowers County District Court for authority to execute a power of attorney authorizing his wife to have a physician end his life by lethal injection, provided that two physicians agree his medical condition is hopeless. Sanderson asserted claims under the First, Fourth, Fifth, Sixth, Ninth, and Fourteenth Amendments to the United States Constitution. In December 1998, Judge Norman Arends dismissed the lawsuit for failure to state a claim. Sanderson appealed, raising only his First Amendment claim that Colorado's statute criminalizing assisted suicide interfered with his religious belief in "free will" and therefore violated his rights under the Free Exercise Clause. On 6/8/00, the Colorado Court of Appeals affirmed the trial court's dismissal, finding that Colorado's assisted suicide statute "is a valid, religiously-neutral, and generally-applicable criminal statute that prohibits conduct a state is free to regulate." On 10/23/00, the Colorado Supreme Court denied certiorari. Sanderson decided not to appeal to the U.S. Supreme Court after the national board of the Hemlock Society decided to withdraw its financial support for the litigation.

LEGISLATION

1. California. California Assemblywoman Helen Thomson announced her intention, as chair of the Assembly Health Committee, to hold a hearing during March 2001 on implementation of Assembly Bill 791, which took effect on 1/1/00. AB 791 requires pain management and end-of-life care to be part of the medical school curriculum for persons entering medical school after 6/1/00 who seek a license as a California physician. In addition, AB 791 requires inpatient health facilities to include pain as a fifth vital sign, which is to be noted in the patient's medical record.

2. Hawaii. On 1/19/01, a bill was introduced in the Hawaii legislature authorizing "death with dignity" (the painless inducement of death by a physician). Senate Bill 709 allows death with dignity by the request or advance written

declaration of a patient who has an incurable medical condition that is expected to cause severe distress or render the patient incapable of rational existence.

3. Kansas. A bill introduced in the House would protect the jobs of pharmacists and others if they refuse to take part in medical procedures or treatments that violate their religious and moral convictions, including physician-assisted suicide and euthanasia. Violations of the law could lead to civil fines of no less than $5,000, plus attorney fees. Critics say the bill is so broadly written that insurance companies and even employers who help pay for insurance will have new legal protection if they refuse coverage for some medical treatments.

4. Oregon.

    a. Compassion in Dying. According to Compassion in Dying Federation's 2000 Annual Report, the organization now has six affiliate organizations (in Oregon, Washington, Alaska, Northern California, Southern California, and New York). During 2000, 100,000 people contacted Compassion in Dying seeking information about pain care and choice at the end of life, and the organization managed 450 patient cases (including 325 new patients) nationwide. Comparable figures for 1999 were 60,000 contacts and 225 cases. Compassion in Dying of Oregon managed 99 patient cases during 2000; of the 68 competent, terminally ill clients who died, 21 hastened their death through physician-assisted suicide.

    b. Carolyn Lund. On 3/5/01, 66-year-old Yachats resident Carolyn Lund died 37 1/2 hours after taking lethal medication under the Oregon Death with Dignity Act. Lund, who was a newspaper reporter in Santa Rosa, California, for nearly 30 years before moving to Oregon, fell asleep within five minutes after taking the medication and died peacefully.

    c. Possible federal action. Supporters of the Oregon Death with Dignity Act have speculated that President Bush may take administrative action to overturn Oregon's law. Possible actions might include instructing the U.S. Attorney's office to prosecute Oregon physicians, a letter from Attorney General John Ashcroft affirming an earlier opinion of the Drug Enforcement Administration's head that prescribing lethal medication is not a "legitimate medical purpose" under the Controlled Substances Act, holding public hearings that might lead to adoption of new administrative rules under the Controlled Substances Act, and an executive order from President Bush. Some commentators have suggested that President Bush may be reluctant to act because of concerns that Oregon voters might retaliate against Republican Senator Gordon Smith, who will run for reelection in 2002.

    d. Attitudes of Oregon psychologists. Researchers collected responses of 423 Oregon psychologists during 1996 to a questionnaire regarding physician-assisted suicide and the Oregon Death with Dignity Act. The responses are reported in Darien S. Fenn & Linda Ganzini, Attitudes of Oregon Psychologists Toward Physician-Assisted Suicide and the Oregon Death with Dignity Act, 30 Professional Psychiatry: Research & Practice 235 (1999). The responses revealed the following information:

        (1) Acceptability of assisted suicide. Eighty-five percent said that physician-assisted suicide was morally acceptable under some circumstances, 9% said it was never morally acceptable, and 6% said that it was up to the individual involved. Twenty-nine percent believed that a physician should always be allowed to prescribe lethal medication if requested by a competent terminally ill patient, 56% that it should be allowed under some circumstances, and 15% that it should never be allowed. Seventy-eight percent favored the enactment of the Oregon Death with Dignity Act, but 56% said that organizations representing psychologists should take no official public position on the Act.

        (2) Willingness to perform mental health evaluation. Of the 275 psychologists for whom making a mental health evaluation under the Act would be within their practice area, 60% would perform the evaluation, 33% would refuse to perform the evaluation but would make a referral to a colleague, and 7% would refuse to perform the evaluation and take no further action.

        (3) Confidence in ability to evaluate patient. Half of the respondents were "not at all confident" that they could evaluate a patient accurately in the context of a single evaluation. In the context of a long-term relationship, however, 64% reported that they would feel "very confident."

        (4) Safeguards. Sixty-seven percent believed that the safeguards contained in the Act are adequate, although 66% thought that patients should be required to inform their families of their decision. Only 52% believed that the Act's two-week waiting period is adequate to prevent transitory desire to end life.

e. Oregon physicians' experiences. Researchers mailed a questionnaire during February-May 1999 to 3,981 Oregon physicians practicing in the fields of internal medicine, family practice, general practice, gynecology, surgery, radiation oncology, 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., Oregon Physicians' Attitudes About and Experiences with End-of-Life Care Since Passage of the Oregon Death with Dignity Act, 285 JAMA 2363 (2001). The responses from the 2,641 physicians who returned the survey by August 1999 revealed the following information:

(1) Hospice referrals. Thirty percent of the physicians reported that they had increased the number of patients they referred to hospice since 1994. (Between 1994 and 1997, the percentage of all deaths in Oregon involving hospice enrollment rose from 22% to 35%.)

(2) Knowledge of palliative care. Among the physicians who cared for at least one terminally ill patient in the previous year, 76% reported that they had made efforts to improve their knowledge of the use of pain medications in the terminally ill "somewhat" or "a great deal." Sixty-nine percent reported that they sought to improve their recognition of psychiatric disorders such as depression. Seventy-nine percent reported that their confidence in the prescribing of pain medications had improved.

(3) Physician attitudes. Thirty percent of the physicians agreed that prescribing lethal medication under the Act was immoral and/or unethical, 59% disagreed, and 11% neither agreed nor disagreed. Fifty-one percent supported the Act, 32% opposed it, and 17% neither supported nor opposed it. Four out of five said they had not changed their views on the law since it passed in 1994; for those who did change their view, almost twice as many had become more supportive (13%) than more opposed (7%). One-third of the physicians were willing to write a lethal prescription, 20% were uncertain, and 46% were unwilling. However, fifty-three percent would consider obtaining a physician's assistance to end their own lives if terminally ill.

(4) Discussion with patients. Ninety-one percent of the physicians were "somewhat" or "a great deal" comfortable about discussing the Act with a patient who would ask. Thirty-six percent had been asked by a patient if they would potentially be willing to prescribe a lethal medication.

(5) Physician concerns. Among the 1,841 physicians who were not morally opposed to writing a lethal prescription, 58% were at least "a little" concerned about being labeled a "Kevorkian," 82% were concerned that writing a lethal prescription might violate federal Drug Enforcement Administration law, and 65% were concerned that their hospital might sanction them. Eighteen percent of respondents practiced in a hospital system with a policy forbidding prescription of lethal medications.

(6) Information available to physicians. Among the 886 physicians who were willing to prescribe lethal medication, 23% had received information from The Oregon Death with Dignity Act: A Guidebook for Health Care Providers, 21% from other physicians, 9% from a patient advocacy group, and 8% from experts or resource persons in their health care system. Fifty-five percent of willing physicians (including 15% of the 73 willing physicians who had actually received a patient request) had not sought information from any source. Twenty-seven percent of willing physicians (including 16% of those who had received a patient request) were "not at all" or "only a little" confident about finding reliable information about what to prescribe for a lethal medication. Thirty-eight percent of willing physicians (including 27% of those who had received a patient request) were "not at all" or "only a little" confident about their ability to determine when a patient has less than six months to live.

f. Likely court challenges. Oregon's Attorney General, as well as private parties such as physicians and patients, are expected to file suit in federal court if either Congress or the Bush administration seek to overturn the Oregon Death with Dignity Act. The plaintiffs' claims are likely to include violation of states' rights under the Tenth Amendment.

5. Federal legislation

a. Pain Relief Promotion Act. The likelihood that the Pain Relief Promotion Act will be reintroduced in Congress during 2001 has been greatly diminished by the Democrats' taking control of the Senate following Senator James Jeffords' defection from the Republican party.

b. Conquering Pain Act. On 6/13/01, Senators Ron Wyden and Gordon Smith and Representative Darlene Hooley of Oregon reintroduced the Conquering Pain Act in Congress. The bill, which is similar to legislation introduced in 1999, 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, direct the surgeon general to report on the state of pain management in the United States, create an advisory committee on pain and symptom management at the U.S. Department of Health and Human Services, and convene a national conference on the delivery of health services under the auspices of the National Institutes of Health.

OTHER NATIONAL DEVELOPMENTS

1. Dr. Jack Kevorkian

   a. Appeal of criminal conviction. 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 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.

   b. Request for release pending appeal. On 12/27/00, Jack Kevorkian's attorney Mayer Morganroth filed a petition for writ of habeas corpus in U.S. District Court contending that Kevorkian should be released from prison while his murder conviction is appealed, because he is at risk of a stroke, he poses no threat to the public, and the issues on appeal have strong merit. Kevorkian v. Ludwick, No. 00-CV-75557 (E.D. Mich.). Morganroth claimed that Kevorkian's rights were violated by a 12/12/00 Michigan Supreme Court decision that refused to overturn lower court rulings keeping him in prison. On 6/14/01, U.S. District Judge Paul Borman held a hearing on Kevorkian's request.

   c. ABC suit against Department of Corrections. On 7/19/00, Genesee County Circuit Court Judge Robert Ransom ordered Michigan Department of Corrections director Bill Martin and deputy director Dan Bolden to permit ABC's Barbara Walters to conduct a face-to-face interview with Dr. Kevorkian for the television program "20/20." ABC claimed that the defendants had arbitrarily and unconstitutionally applied a new policy barring cameras and recording devices in the state's 39 prisons. On 6/4/01, the Michigan Court of Appeals issued a ruling in favor of the Department of Corrections.

   d. 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. The majority found that Kevorkian was virtually "libel-proof" because of his public role in the debate over assisted suicide. The Michigan Supreme Court denied Kevorkian's appeal on 5/23/00, and the U.S. Supreme Court denied certiorari on 4/23/01. *Kevorkian v. American Medical Association*, 237 Mich.App. 1, 602 N.W.2d 233 (1999), appeal denied, 462 Mich. 862, 613 N.W.2d 720 (2000), cert. denied, 121 S.Ct. 1655 (2001).

2. New trial ordered for Utah physician. On 1/9/01, Utah Second District Judge Thomas L. Kay granted a new trial to Dr. Robert Weitzel, a psychiatrist who was convicted by a jury in July 2000 of two counts of second-degree felony manslaughter and three counts of misdemeanor negligent homicide in connection with the deaths of five elderly patients at the geriatric psychiatric unit of the Davis Hospital and Medical Center in Layton, Utah, during a 16-day period from late 1995 to early 1996. Prosecutors had contended that all five patients were admitted for dementia, not for life-threatening diseases, and that Weitzel killed them with lethal doses of morphine, while the defense had contended that Weitzel merely provided comfort care. Weitzel's motion for a new trial was granted on the ground that prosecutors failed to disclose pretrial statements from Dr. Perry Fine, a University of Utah Medical Center physician and expert in pain management and end-of-life care, that could have aided Weitzel's defense. Prosecutors are expected to appeal Judge Kay's decision. Family members of one of the patients have filed a civil lawsuit against Weitzel, and his Utah medical license has been suspended. In May 2001, Jane Orient, executive director of the Association of American Physicians and Surgeons, wrote to Davis County Attorney Melvin Wilson and to state officials, urging them not to prosecute Weitzel a second time because doing so would have a chilling effect on physicians' willingness to provide adequate pain relief.

3. Conference on "self-deliverance" technology. During May 2001, an invitation-only conference was held in Vancouver, B.C., to discuss methods of hastening death without the assistance of a physician. Approximately 40 people attended from seven countries.

MEDICAL DEVELOPMENTS

1. Palliative medicine. Grants from the Robert Wood Johnson Foundation and the Soros Foundation's Project on Death in America will assist several projects of the American Board of Hospice and Palliative Medicine, including developing and standardizing requirements for hospice and palliative medicine fellowship programs, improving the existing certification examination, creating a re-certification process, and developing physician consensus on the appropriate organizational base for a palliative medicine specialty.

2. World Medical Association. On 5/10/01, at its annual meeting in Geneva, the World Medical Association called on physicians in the Netherlands and elsewhere not to participate in euthanasia, which violates the ethical principles of the medical profession. It has been reported that the Holland Medical Association may withdraw from the WMA as a result of its stand.

3. Lawsuit for undertreatment of pain. On 6/13/01, a jury in Alameda County Superior Court awarded $1.5 million in damages to the family of William Bergman, who claimed that Dr. Wing Chin violated California's Elder Abuse and Dependent Adult Civil Protection Act by failing to prescribe adequate pain medication for Bergman as he battled lung cancer. The jury decided by a vote of 9 to 3 that Chin's conduct constituted reckless abuse of a senior citizen but deadlocked 8 to 4 on whether Chin was also liable for punitive damages for malice or oppression or for intentionally causing emotional distress. The complaint also named Eden Medical Center, but the hospital settled with the family out of court in April 2001 for an undisclosed sum of money and a promise to educate the medical staff in a new approach to pain management. In 1998, the Medical Board of California found that pain management for Bergman "was indeed inadequate" but declined to take any disciplinary action against Chin.

4. Palliative care guidelines. On 4/3/01, the National Comprehensive Cancer Network and the American Cancer Society introduced the new "Cancer Pain Treatment Guidelines for Patients," which integrate palliative care into routine cancer therapy. The guidelines are intended to empower patients and their families by providing them with information about pain and its treatment. The guidelines apply when a patient meets any of three criteria: advanced or progressive disease with no effective curative therapy, life expectancy of one year or less, or patient request for palliative care. Recommended palliative care interventions are tailored to the patient's life expectancy. The section of the guidelines on physician-assisted suicide and euthanasia states: "The most appropriate response to a request for assistance in suicide is to intensify palliative care." Caregivers are told to explore the reasons for the request, reassess symptom control, provide information about the natural history of the disease, and discuss alternatives to physician-assisted suicide such as treatment withdrawal, stopping eating or drinking, and sedation. Guidelines will be issued in the same format for the ten most common types of cancer.

5. Recent articles

    a. Darien S. Fenn & Linda Ganzini, *Attitudes of Oregon Psychologists Toward Physician-Assisted Suicide and the Oregon Death with Dignity Act*, 30 Professional Psychiatry: Research & Practice 235 (1999) [SEE SUMMARY ABOVE UNDER "LEGISLATION"].

    b. Linda Ganzini et al., *Oregon Physicians' Attitudes About and Experiences with End-of-Life Care Since Passage of the Oregon Death with Dignity Act*, 285 JAMA 2363 (2001) [SEE SUMMARY ABOVE UNDER "LEGISLATION"].

    c. Joanne Lynn, *Serving Patients Who May Die Soon and Their Families: The Role of Hospice and Other Services*, 285 JAMA 925 (2001) [in the context of a specific patient's history, discusses issues raised as a patient nears death].

    d. Vincent Perron & Ronald Schonwetter, *Assessment and Management of Pain in Palliative Care Patients*, 8 Cancer Control 15 (2001) [discusses pain management in palliative care and reviews management strategies].

    e. Robert M. Walker, *Physician-Assisted Suicide: The Legal Slippery Slope*, 8 Cancer Control 25 (2001) [author examines several recent right-to-die court cases and concludes that euthanasia for incapacitated patients is possible, and perhaps likely, if physician-assisted suicide is accepted].

f. R. Jeffery Kohlwes et al., *Physicians' Responses to Patients' Requests for Physician-Assisted Suicide*, 161 Archives Internal Med. 657 (2001) [study during July 1997-January 1998 in Seattle and San Francisco of practices of 11 AIDS physicians, eight oncologists, and one hospice physician who had received requests for assisted suicide showed that physicians responded similarly to such requests: they addressed physical suffering aggressively and treated depression empirically, but struggled with requests arising from existential suffering; physicians rarely talked to colleagues about requests for assisted suicide; 50% of the physicians had prescribed lethal medication for at least one patient; of 50 requests received, 16 patients (32%) were given a lethal prescription; 11 (69%) of these 16 patients were experiencing primarily existential suffering problems].

g. Symone B. Detmar et al., *Patient-Physician Communication During Outpatient Palliative Treatment Visits*, 285 JAMA 1351 (2001) [study conducted between June 1996 and January 1998 of communications between 10 oncologists and 240 of their patients with incurable cancer who were being treated in the outpatient palliative chemotherapy clinics of the Netherlands Cancer Institute; physicians devoted 64% of their communications to medical/technical issues and 23% to health-related quality of life (HRQL) issues, while patients devoted 41% to medical/technical issues and 48% to HRQL issues; in 20% to 54% of the consultations in which patients were experiencing serious HRQL problems, no time was devoted to discussion of those problems; emotional functioning of these patients remained unaddressed 54% of the time, and fatigue remained unaddressed 48% of the time].

h. Tom Stooker et al., *Costs of Care in the Last Year of Life*, 38 Inquiry ____ (Apr. 1, 2001) [study of 84,734 members of a Dutch sickness fund during 1990-93 showed that, although health care expenditures rise sharply in the last months of life, only about 10% of expenditures for acute care during the last year of life are the result of end-of-life care].

i. Joan M. Teno et al., *Research Letter: Persistent Pain in Nursing Home Residents*, 285 JAMA 2081 (2001) [analysis of Minimum Data Set (MDS) data collected at all nursing homes nationwide during 1999 showed that 14.7% of residents were in persistent pain; 41.2% of residents in pain at first assessment were in severe pain 60 to 180 days later, with statewide rates varying from 37.7% to 49.5%]. Individual state reports are available at http://www.chcr.brown.edu/dying/severepain.htm.

j. Stefan C. Weiss et al., *Understanding the Experience of Pain in Terminally Ill Patients*, 357 The Lancet 1311 (2001) [interviews of 988 terminally ill patients from six randomly-selected sites in the United States during 1996 and 1997 showed that 50% reported moderate or severe pain; 52% had seen a primary care physician for treatment of pain in the previous four weeks and 20% saw a pain specialist; of those who had been treated by their primary care physician, 73% were still experiencing moderate to severe pain but only 29% wanted more therapy; reasons for not wanting additional therapy included fear of addiction, dislike of mental or physical side effects, and not wanting to take more pills or injections].

k. Simon N. Whitney et al., *Views of United States Physicians and Members of the American Medical Association House of Delegates on Physician-Assisted Suicide*, 16 J. Gen. Internal Med. 290 (2001) [during 1997, researchers conducted the first national survey of physician attitudes toward physician-assisted suicide, using a questionnaire completed by 658 physicians nationwide and by 315 members of the AMA House of Delegates; members of the AMA House of Delegates strongly opposed physician-assisted suicide (61.6% opposed legalization, 23.5% favored it, and 14.9% were unsure), but rank-and-file physicians showed no national consensus (44.5% favored legalization, 33.9% opposed it, and 21.6% were unsure); attitudes were most strongly influenced by political orientation and religious beliefs; 55% of physicians and 58% of members of the AMA House of Delegates preferred having no law at all, instead leaving end-of-life decisions to the physician and patient].

INTERNATIONAL DEVELOPMENTS

1. Australia

   a. Dr. Nitschke. Dr. Philip Nitschke has continued to hold information clinics on euthanasia in various locations for healthy individuals who want to learn about their options when facing death. In April 2001, Dutch Health Minister Els Borst said that the government would do whatever it could to prevent Nitschke

from setting up a floating euthanasia ship off the Dutch coast.

b. West Australia. MP Norm Kelly, who favored adoption of a Voluntary Euthanasia Bill, lost his bid for re-election to the West Australian parliament. However, a coalition of the Labor party and the Greens may introduce legislation.

c. South Australia. Democratic MP Sandra Kanck has introduced a private member's "Dignity in Dying" bill in the upper house of the South Australian parliament that would legalize voluntary euthanasia. Independent Bob Such introduced the legislation in the lower house. The proposed legislation is patterned after recent legislation in the Netherlands.

2. Belgium

a. Draft euthanasia bill. On 12/22/99, the ruling six-party coalition 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. In January 2001, senators from two parliamentary working groups voted 17-10 to adopt the compromise draft text of controversial Article Three of the bill, which sets out the conditions under which patients may ask for a physician's assistance in dying. Under the draft text, the opinion of a second physician would be required for a terminally ill patient. In the case of a patient who is not terminally ill, the opinion of a third physician (either a psychiatrist or a specialist in the patient's illness) would be required, and at least one month would have to elapse between the patient's request and the act of euthanasia. On 3/20/01, senators from two parliamentary working groups approved the final text of the draft bill by a vote of 17-12, with one abstention. The draft legislation will be presented to both houses of parliament, which is expected to pass it.

b. Survey of end-of-life decisions in medical practice. A survey of physicians regarding 1,925 deaths in Flanders during January-April 1998, using the same questionnaire employed in earlier surveys in the Netherlands and Australia, revealed that 4.4% of deaths involved euthanasia or physician-assisted suicide. Overall results generally were similar to those in the Netherlands, except for a significantly higher incidence in Flanders of physicians intentionally ending the lives of patients without their explicit request. Luc Deliens et al., End-of-Life Decisions in Medical Practice in Flanders, Belgium: A Nationwide Survey, 356 The Lancet 1806 (2000).

3. Canada

a. Robert Latimer. Supporters of Robert Latimer continue to protest his life sentence, without possibility of parole for 10 years, for the mercy killing of his disabled 12-year-old daughter. More than 100 Canadians have each offered to serve one month of Latimer's jail sentence, and over 10,000 copies of a clemency petition have been downloaded from a website, http://www.robertlatimer.com. A poll of 1,000 Canadians conducted during April 2001 by Ipsos-Reid for the Globe and Mail and CTV revealed that 71% believed that Latimer's sentence should be reduced and 59% believed that the Supreme Court should not have upheld the mandatory minimum sentence.

b. Palliative care. In March 2001, Montreal physician Balfour Mount, who is considered Canada's "father of palliative care," published an article in the Annals (the journal of the Royal College of Physicians and Surgeons of Canada) saying that Canada must dramatically improve its palliative care system for the dying to provide an alternative to euthanasia or assisted suicide. Mount indicated that palliative care is available in Canada to only five percent of dying patients. The article, titled End-of-Life Care: Recent Developments in the Netherlands and Canada, discusses the safeguards included in recent legislation in the Netherlands.

c. Patient Pain Manifesto. The Canadian Pain Society, which includes over 500 physicians, nurses, and scientists, launched The Patient Pain Manifesto at its annual conference in Montreal in May 2001. The group said that more than half of patients in Canadian hospitals suffer pain ranging from moderate to severe, in part because patients are not aware of their right to adequate pain treatment. The society hopes to raise public awareness about pain by including a small bookmark about pain treatment in patients' hospital admission packages and placing posters in hospital units and other clinics. In addition, the society hopes to put pressure on the medical field to include pain as a fifth vital sign.

4. China. Despite increasing demands to make euthanasia available, China's Ministry of Health says that the country is not considering drafting such a law. In Xi'an, capital city of northwest China's Shaanxi province, nine patients with unbearable pain caused by uremia jointly appealed recently to be allowed to die, but no physician was willing to help them. In Hong Kong, a motion calling on the government to study the legalization of euthanasia was voted down during May 2001. A survey of nurses in the city of Wuhan in the central province of Hubei showed that 72% favored mercy killings and 75% opposed legal action against physicians who perform them.

5. France. Health Minister Bernard Kouchner, who is a physician, said in comments published on 4/16/01 that he would press for the legalization of euthanasia after favorable opinion polls in France. A survey of 950 French adults conducted by the Ifop agency during 4/12-4/13/01 showed that 38% were absolutely in favor of euthanasia in cases of unbearable suffering or terminal disease, 50% would allow physicians to end life in certain cases, 10% were opposed, and 2% declined to state an opinion. Kouchner said he would organize a debate at the Health Ministry with health care specialists and ethics experts.

6. Germany. German leaders are unwilling to discuss the subject of euthanasia despite two recent surveys showing that three out of four Germans support euthanasia, at least under some circumstances. A survey by the Forsa polling institute during April 2001 found 73% of West Germans and 83% of East Germans in favor of euthanasia, while a poll by the Allensbach Institute found 64% of West Germans and 80% of East Germans in favor. A 1998 survey by Stern magazine found that nearly 20,000 German physicians (6.4% of hospital physicians and 10.5% of general practitioners) had been present when a physician administered some form of euthanasia.

7. Great Britain

    a. Statement on medical treatment at the end of life. In 1998, the Royal College of General Practitioners and the Royal College of Physicians established a 19-member working group to "identify the kinds of conduct which constitute euthanasia and advise how far they could be justified on moral grounds." Rather than producing a public debate, however, the group was only able to produce a two-page statement affirming its support for the status quo, which was published in the April 2001 Journal of the Royal College of Physicians. The statement was accompanied by a note which read: "This position statement was . . . received but not endorsed by the Royal College of General Practitioners."

    b. Survey of nurses. A survey of 300 nurses by Nursing Times magazine and the Nuffield Trust found that nurses had problems getting physicians to give proper care to dying patients. One-third of nurses thought physicians they worked with were not good at pain management for patients, one-quarter felt they were unable to provide good nursing care in the place where they work, and one-tenth said better pain control is the one thing that would improve the care of the dying. The Nuffield Trust is publishing a report called Care of the Dying.

8. Israel. On 5/21/01, the Knesset's Constitution, Law, and Justice Committee voted 5-2 on the first reading of a bill that would allow terminally ill patients to sign an advance written directive declining to accept life-sustaining treatments. MK Ophir Pines-Paz rejected a request by Health Ministry Director-General Boaz Lev to postpone a decision on the bill for four months. Pines-Paz said he would move the legislation forward for its second and final readings before the Knesset concludes its summer session at the end of July 2001, although he promised to consider more changes in the bill before the second and third readings.

9. Korea. On 5/3/01, an internet survey firm, Vote Korea Co., reported the results of an e-mail survey of 1,067 experts on euthanasia, including lawyers and professors at medical, nursing, and law schools. The results showed that 82.6% supported the practice of euthanasia (including 15.9% who supported active euthanasia by means such as lethal injection). The Korean Medical Association has made a move to include in its ethical guidelines for physicians a clause allowing withdrawal of life-sustaining treatment.

10. Malaysia. On 5/28/01, Deputy Health Minister Datuk Dr. Suleiman Mohamed said in response to a senator's question that the government would never draw up legislation allowing euthanasia to be practiced by medical officers because euthanasia is against the religious beliefs and cultures of Malaysians.

11. Netherlands

    a. Legislation legalizes physician-assisted suicide and euthanasia. On 4/10/01, following two days of heated debate and public demonstrations by opponents, the upper chamber of the Dutch Parliament voted 46-28

to legalize physician-assisted suicide and euthanasia, which have been technically illegal in the Netherlands but not prosecuted if physicians followed prescribed guidelines. The lower house had approved the legislation on 11/28/00 by a vote of 104-40. In arguing for the bill, government ministers cited public approval ratings of nearly 90%. The new law, called the Termination of Life on Request and Assisted Suicide (Review Procedures) Act, requires that (1) the physician know the patient well, (2) the physician determine that the patient's request is voluntary and well-considered, (3) the patient face unbearable suffering with no prospect of improvement, (4) the patient understand his medical situation and prognosis, (5) the physician and patient agree that there is no reasonable alternative acceptable to the patient, (6) the physician consult at least one other independent physician who has examined the patient, and (7) the physician exercise due medical care and attention in carrying out the termination of life. The physician must report the death to a regional three-member committee consisting of a physician, a lawyer, and an expert on ethical issues. A patient's written advance directive may constitute a valid request for euthanasia. The text of the new law is available at http://www.netherlands-embassy.org.

b. Public opinion poll. On 5/24/01, the Dutch television news program Netwerk announced the results of a public opinion poll about making lethal pills available to Dutch residents (an idea which had been advanced by Dutch Health Minister Els Borst). Almost fifty percent of respondents favored making such pills available to elderly people who no longer want to live, while 46% opposed the idea. Eighty-two percent opposed making lethal pills available to anyone who wanted them.

c. Reported cases of euthanasia. On 5/29/01, the Dutch Ministry of Health announced that 2,123 cases of euthanasia had been reported to regional review committees during 2000, as compared to 2,216 during 1999. The committees found the physician to be negligent in three cases and referred them to the prosecutor's office, but all cases had since been dismissed.

d. Study of euthanasia practices. A new study will be launched in 2001 to evaluate the operation and procedures of the regional euthanasia review committees, examine factors influencing the willingness of physicians to report euthanasia, and gather data allowing comparison with data from prior studies in 1991 and 1996.

e. Prosecution of Dr. Sutorius. On 10/30/00, a court in Haarlem acquitted Dr. Philip Sutorius of charges in connection with the April 1998 assisted suicide of Edward Brongersma, an 86-year-old former politician who had no serious physical or psychiatric illness but was obsessed with his "physical decline" and "hopeless existence." Public prosecutors had called for Sutorius to be given a three-month suspended prison sentence, but the court found that Brongersma was suffering "hopelessly and unbearably," one of four criteria protecting Dutch physicians against prosecution. The public prosecutions office appealed to the High Court, seeking a finding of guilt but no prison sentence. On 5/8/01, the appellate court said that it would hear further expert evidence from a physician and a university professor before handing down its verdict.

f. Prosecution of Dr. van Oijen. In February 2001, an Amsterdam court found Dr. Wilfred van Oijen guilty of murder for injecting a dying 84-year-old woman with alloferine, a muscle-relaxing drug commonly used in euthanasia, without her request or a second medical opinion. The court imposed no prison sentence, finding that van Oijen had made an "error of judgment" but had acted "honourably and according to his conscience" in showing compassion for his patient. Van Oijen received a suspended fine of 5,000 guilders ($2,140) for incorrectly reporting that the patient's death was from natural causes. Van Oijen said he would appeal the verdict.

12. Poland. A poll of 1,036 adult Poles conducted by the Public Opinion Research Center during 4/6-4/9/01 showed that 49% were in favor of allowing euthanasia of terminally ill patients at their request, 37% were opposed, and 12% had no opinion.

13. South Africa. On 5/15/01, at a symposium on euthanasia at the 16th World Congress of Family Doctors in Durban, South African Law Commission member Willem Landman said that euthanasia was being practiced in South Africa, although not on a large scale. He said that draft euthanasia legislation was handed recently to Health Minister Manto Tahabalala-Msimang, but that indications were that the draft legislation would not be tabled before the Cabinet during 2001.

14. Sweden. A poll conducted for Svenska Dagbladet, a Swedish daily newspaper, and reported during February 2001 showed that 70% thought that euthanasia should be available to those who want it, just under 20% were opposed, and 13% were undecided.

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