Recent Developments in Physician-Assisted Suicide

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LITIGATION

1. *Washington v. Glucksberg* (No. 95-1858) and *Vacco v. Quill* (No. 96-110). In these cases, the Second and Ninth Circuits held that the New York and Washington statutes criminalizing physician-assisted suicide were unconstitutional as applied to competent, terminally ill patients. The cases were argued before the Supreme Court on 1/8/97. Most commentators believe the Court will reverse.

2. *Lee v. Harcleroad*, 1997 WL 80783 (9th Cir. 1997). On 2/27/96, a 3-judge panel of the Ninth Circuit held that the plaintiffs lacked standing to challenge Oregon's Death with Dignity Act and ordered U.S. District Judge Hogan to dismiss the case; the court did not rule on the merits as to the plaintiffs' arguments. Plaintiffs are expected to seek review by the Supreme Court and to request a stay pending the appeal.

3. *Kevorkian v. Arnett*, 939 F.Supp. 725 (C.D. Cal. 1996), appeal pending sub nom. *Kevorkian v. Lungren* (9th Cir. No. 96-56405). Dr. Kevorkian and an AIDS patient brought this suit to invalidate California's statute criminalizing physician-assisted suicide as applied to competent, terminally ill patients. On 9/11/96, U.S. District Judge Consuelo B. Marshall invalidated the statute on Fourteenth Amendment due process grounds. Judge Marshall dismissed Kevorkian's claims for lack of standing, declined to rule on the Fourteenth Amendment equal protection claim, and held that the statute did not violate either the right to privacy or equal protection under California's Constitution. California's Attorney General appealed to the Ninth Circuit; proceedings have been stayed until 3/15/97 pending resolution of *Washington v. Glucksberg* and *Vacco v. Quill*, with opening brief due 7 days after expiration of stay. On 11/4/96, the U.S. Supreme Court denied immediate review [*Lungren v. Doe*, No. 96-531; *Doe v. Lungren*, No. 96-547].

4. *Kevorkian v. Thompson*, 947 F.Supp. 1152 (E.D. Mich. 1997)(No. CV-96-73777). Dr. Kevorkian and Michigan activist Janet Good filed 13 lawsuits on 8/13/96 asking for an injunction forbidding prosecutors in Wayne, Oakland, or Macomb Counties from using Michigan's temporary criminal statute (now expired) to prosecute various assisted suicides that occurred from May 1992 to February 1993. On the same day, plaintiffs withdrew all the lawsuits except one that had been assigned to Judge Paul Borman; attorney Geoffrey Fieger later apologized to a panel of federal judges for judge-shopping and agreed to pay associated court costs. On 1/6/97, U.S. District Judge Gerald Rosen (to whom the remaining case had been assigned) ruled against the plaintiffs, finding that: (1) the court should abstain under *Younger v. Harris* from deciding Dr. Kevorkian's claims because they could be raised by him in defending actions pending against him in state courts, (2) Janet Good had no constitutional right to assisted suicide under the Fourteenth Amendment, and (3) Michigan laws regarding assisted suicide were unconstitutionally vague prior to December 1992, when a state criminal statute was enacted. Plaintiffs are expected to appeal to the Sixth Circuit Court of Appeals.

5. *McIver v. Krischer* (No. CL-96-1504-AF, 15th Judicial Circuit Court, Palm Beach County, FL, phone (407) 355-2986). Under the sponsorship of the Florida Hemlock Society and the ACLU chapter of Palm Beach County, Dr. McIver and three terminally ill patients (two of whom later died) brought this suit seeking an injunction allowing McIver to assist in the patients' suicides without being prosecuted under Florida's statute criminalizing physician-assisted suicide. The plaintiffs' claims were based on Fourteenth Amendment due process and equal protection grounds and on the Privacy Amendment to Florida's Constitution. On 1/31/97, Judge S. Joseph Davis, Jr. ruled in favor of plaintiffs on equal protection and Florida Privacy Amendment grounds while denying the due process claim; the ruling applies only to Dr. McIver and Charles Hall. The 4th District Court of Appeal forwarded the broad question of physician-assisted suicide directly to the Florida Supreme Court as an issue "of great public importance." On 2/11/97, the Florida Supreme Court issued a stay pending the appeal and scheduled argument for 5/9/97; many experts predict the plaintiffs will prevail on appeal. A second suit, brought by Hall in Leon County but now on hold, seeks an injunction to prevent the Florida Board of Medicine from disciplining Dr. McIver if he assists in Hall's suicide. On 2/8/97, the Board of Medicine voted 9 to 6 to oppose physician-assisted suicide and 14 to 1 to investigate Dr. McIver if he assists in Hall's suicide; however, the Board had previously stipulated to a court order providing that McIver would not violate medical practice standards by assisting Hall if the plaintiffs prevailed in their lawsuit.

6. Rhode Island litigation. The American Civil Liberties Union of Rhode Island announced in late September that it was preparing to challenge in federal court Rhode Island's new statute criminalizing physician-assisted suicide.

LEGISLATION

1. Florida. The Hemlock Society of Florida contacted all 160 state legislators in an effort to push a law allowing physician-assisted suicide, with restrictions similar to those in Oregon's Death With Dignity Act. Several legislators expressed willingness to co-sponsor the bill, but no one agreed to file it. Such a law is considered unlikely to pass in Florida, given the makeup of the state legislature.

2. Massachusetts. A bill that would legalize physician-assisted suicide for terminally ill patients has been modified from prior bills to require that patients first be referred for psychiatric and hospice care.

3. Michigan

a. Before adjourning in December 1996, the legislature adopted the Death with Dignity Act requiring doctors to inform gravely ill patients of treatment alternatives, including pain management, and that physician-assisted suicide is illegal.

b. On 2/11/97, Sen. William Van Regenmorter, chairman of the Senate Judiciary Committee, reintroduced a bill in the legislature that would make helping a person commit suicide a crime punishable by two years in prison; he hopes to begin public hearings on the proposal by early March. Other legislative proposals may be taken up during 1997, including a bipartisan proposal to refer the issue of physician-assisted suicide to voters in 1998.

c. The group Merian's Friends, which supports physician-assisted suicide, intends to gather voter signatures between 5/15 and 11/15/97 in an attempt to put the issue to a vote of the people in November 1998.

4. Nebraska. Nebraska State Senator Ernie Chambers introduced into the Nebraska legislature a proposed new law that would permit physician-assisted suicide for the terminally ill (LB-406, Physician Aid-in-Dying Act).

5. New York. Sen. Roy Goodman (R-Manhattan) announced that he would introduce legislation during January that would legalize and regulate physician-assisted suicide with a waiting period and guidelines similar to those in the Oregon Death With Dignity Act.

6. Oregon. At the request of opponents of Oregon's Death With Dignity Act, the Oregon House Judiciary Committee has introduced seven bills that would repeal, delay, refer back to the voters for a new vote, or restrict application of the Act. Preliminary hearings were conducted during January 1997; additional hearings on the proposed bills are scheduled for 3/11-3/13/97.

7. Virginia. On 2/4/97, Virginia's Senate passed SB 788 by a vote of 27-12. The bill would impose a fine of up to $100,000 on any health care provider who assists in a suicide and allows family members to sue the provider for "any losses suffered." The bill also contains a provision allowing family members or medical professionals to obtain an injunction to stop an assisted suicide. Medical professionals could face the permanent loss of their licenses if they assist a suicide. The bill does not contain an outright ban of assisted suicide but states that euthanasia is not condoned.

8. Federal legislation

a. Congressional report critical of the Netherlands. In September 1996, Rep. Charles T. Canady, chairman of the Subcommittee on the Constitution of the House Committee on the Judiciary, released a report he compiled, titled "Physician-Assisted Suicide and Euthanasia in the Netherlands," taking a critical view of practices in the Netherlands.

b. Assisted Suicide Funding Restriction Act of 1997. On 1/8/97, Sen. John Ashcroft (R-Mo.) and Sen. Byron Dorgan (D-N.D.) began circulating a letter seeking support for proposed legislation that would ban use of federal tax dollars to pay for physician-assisted suicide under such programs as Medicaid, Medicare, federal employee health benefits plans, medical services for federal prisoners, and military health care. They plan to introduce on 2/12/97 a proposed bill known as the "Assisted Suicide Funding Restriction Act of 1997." The bill's sponsors cite a national Wirthlin poll conducted in November 1996 in which 87% answered "no" when asked, "Should tax dollars be used to pay for the cost of assisting suicide and euthanasia?"

OTHER NATIONAL DEVELOPMENTS

1. Michigan

a. Dr. Kevorkian's recent assisted suicides (since 10/8/96):

(1) 42nd suicide 10/10/96 = Wallace Joseph Spolar (69-year-old man with MS + bad heart)--death by carbon monoxide.

(2) 43rd suicide 10/17/96 = Nancy DeSoto (55-year-old woman with Lou Gehrig's disease)--death by carbon monoxide--police broke up a meeting with Dr. Kevorkian in her motel room the prior evening.

(3) 44th suicide 10/23/96 = Barbara Collins (65-year-old woman terminally ill with ovarian cancer--death by lethal injection--police allegedly used excessive force in questioning Kevorkian.

(4) 45th suicide admitted 11/4/96 = Loretta Peabody (54-year-old woman with multiple sclerosis)--death on 8/30/96 originally reported as being of natural causes.

(5) 46th suicide 2/3/97?? = Lisa Lansing (42-year-old woman with severe intestinal problems)--death by lethal injection--Dr. Kevorkian has not claimed responsibility, and investigators indicate he will not be charged.

(6) 47th suicide 2/3/97?? = Elaine Day (79 years old with Lou Gehrig's disease)--death by lethal injection--Dr. Kevorkian has not claimed responsibility, and investigators indicate he will not be charged.

b. Criminal prosecutions of Dr. Kevorkian

(1) Criminal charges pending in Ionia County. Dr. Kevorkian and Janet Good were indicted on 11/16/96 in Ionia County for the common law crime of assisting in a suicide in connection with the 8/30/96 death of Loretta Peabody, which was reported as being from natural causes. At a hearing held on 2/19/97, Circuit Judge Charles Miel allowed Voet to keep a videotape and other evidence seized by Bloomfield Township police and obtained by prosecutor Raymond Voet through a search warrant, ruled that Dr. Kevorkian must abide by tightened bond restrictions barring him from any involvement in an assisted suicide in Ionia County (but would continue to be barred in other counties only from being present at further assisted suicides), and set a trial date of 6/10/97.

(2) Criminal charges dropped in Oakland County. On 1/10/97, David Gorcyca (successor to Oakland County prosecutor Richard Thompson) dropped all pending charges against Dr. Kevorkian, Neal Nicol, and Dr. Georges Reding in connection with 10 deaths occurring between 6/20 and 9/7/96.

(3) Contempt action pending in Oakland County. After U.S. Supreme Court denied review in *Kevorkian v. Michigan* on 10/15/96, Oakland County prosecutor Richard Thompson served Kevorkian with notice to show cause why he should not be held in contempt of court for violating the state court injunction against using his "suicide machine" in connection with four deaths occurring in August and September 1996 (Isabel Correa, Judith Curren, Patricia Smith, Pat DiGangi). If found in contempt, Kevorkian could be subject to 30 days in jail and a $250 fine for each violation. On 11/6/96, Circuit Judge Denise Langford Morris refused to postpone a hearing until January and set the next hearing for 12/18/96.

c. Dr. Kevorkian's civil action against Oakland County officials. A $50 million civil lawsuit brought by Dr. Kevorkian and Janet Good is pending against two Oakland County prosecutors and five Bloomfield Township police officers in connection with the 9/6/96 raid against Isabel Correa's motel room, in which a suicide machine and other evidence was seized.

2. Oregon. A complaint was filed by the State Board of Medical Examiners against Dr. James Gallant of Corvallis for engaging in active euthanasia with respect to his patient, Clarietta Day, who died 3/22/96, allegedly as a result of a lethal injection administered by a nurse. The Board held a closed hearing in January 1997 but is not expected to decide until April.

3. Florida. On 10/22/96, the state Agency for Health Care Administration suspended the license of Dr. Ernesto Pinzon after investigators charged him with intentionally giving deadly drugs on 10/6/96 to a man dying of cancer, Rosario Gurrieri of Sebring, Florida. On 11/21/96, Pinzon was indicted for first-degree murder. Pinzon is charged with administering six shots of morphine and two of Valium during a half-hour period, then injecting potassium chloride. Gurrieri's relatives did not know about or approve of Dr. Pinzon's actions. The case may be tried as early as spring 1997.

4. Rhode Island. Noel Earley, a 48-year-old man with Lou Gehrig's disease, died on 1/15/97 before he could carry out his plan to kill himself to protest Rhode Island's ban on physician-assisted suicide.

5. Kansas. An appeal to the Kansas Court of Appeals is pending for Dr. Stan Naramore, who was convicted of second-degree murder and attempted murder in connection with the deaths of two patients in August 1992 following administration of medication he claims was given to relieve pain. Two Kansas medical societies and a number of

prominent physicians have offered their support to Dr. Naramore.

6. Public opinion polls. In a CNN/USA Today Gallup poll of 1,022 adults conducted during the first week of January 1997, 58% said doctors should be allowed to help a terminally ill patient die if the patient is in severe pain and asks for assistance. Forty percent said they would consider suicide themselves.

MEDICAL DEVELOPMENTS

1. AMA campaign to teach physicians how to help the dying. In December 1996, the AMA announced that it would launch a campaign early in 1997 to teach physicians how to help the dying. The campaign will focus on three areas: (1) helping patients and their families plan for dying, (2) providing effective care to eliminate pain for patients who have abandoned hope for a cure, (3) treating psychiatric complications (particularly depression) among the chronically and terminally ill. The AMA will sponsor national training conferences for medical leaders, followed by regional and local conferences. The AMA will also help local medical institutions develop their own training programs.

2. Medical guidelines. The American Board of Internal Medicine has for the first time published guidelines for eliminating pain among the dying.

3. Certification for palliative case specialists. In fall 1996, the American Academy of Hospice and Palliative Medicine gave the first certifying exam for physicians who practice palliative care.

4. Project on Death in America. The Project on Death in America, funded by international financier George Soros, has launched a variety of programs to encourage research on and training in end-of-life issues, including physician-assisted suicide. Project director is Dr. Kathleen Foley, a pain specialist at Memorial Sloan Kettering Cancer Center in New York City.

5. Training in medical schools. During the past two years, Choice in Dying has worked with 12 medical schools (including Yale, Dartmouth, University of Miami, and Hahnemann University in Philadelphia) to develop better curricula on death and dying.

6. American Medical Student Association. The 30,000-member AMSA, which has taken a position in support of legalizing physician-assisted suicide, filed amicus briefs in support of the plaintiffs in *Washington v. Glucksberg* and *Vacco v. Quill*.

7. Coalition calls for improved end-of-life care. On 1/7/97, a press conference was held in Washington, DC in which a coalition of 40 organizations (American Geriatrics Society, AARP, AMA, American Cancer Society, American Nurses Association, B'nai B'rith, Catholic Health Association, Alzheimer's Association, several hospice groups) put forward 10 principles to govern end-of-life care. These principles (or "domains") include controlling pain, giving patients and families more autonomy and control over the care they receive, planning end-of-life care in advance, limiting the overuse of high-tech machinery at the end of life, and helping patients feel that their last months and days are meaningful and satisfying.

8. Last Acts. On 2/13/97, a national coalition of 72 organizations (including the AMA, the American Hospital Association, nurses, medical schools, hospice organizations, and the AARP) launched "Last Acts," which will conduct a national campaign to improve care of the dying. The group, which opposes assisted suicide, will push for changes in the medical profession, in the insurance industry, and in public attitudes to make pain control and home care for the dying more widely available. Former first lady Rosalynn Carter will serve as the coalition's honorary chair.

9. Recent surveys

> a. Elderly patients and their families. During 1994 and 1995, a group of frail, elderly patients and their families (recruited from the Geriatric Evaluation and Treatment Clinic at Duke University Medical Center) were surveyed regarding their attitudes toward physician-assisted suicide. Harold G. Koenig, *Attitudes of Elderly Patients and Their Families Toward Physician-Assisted Suicide*, 156 Archives of Internal Medicine 2240 (1996). Relatives were more likely than patients to favor allowing physicians to assist terminally ill patients to commit suicide (59% versus 40%) and also to favor legalizing physician-assisted suicide (56% versus 34%). Attitudes of the two groups were fairly similar regarding whether physicians should be allowed to assist patients who are chronically ill (25% versus 18% in favor) or mentally incompetent (15% versus 14% in favor). The ability of relatives to predict the attitudes of patients toward physician-assisted suicide was marginal in most cases. Patients most likely to oppose physician-assisted suicide were women, black individuals, and those with less education, low incomes, and dementia or cognitive impairment.
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> b. Oregon psychiatrists. During 1995, Oregon psychiatrists were surveyed regarding their attitudes toward physician-assisted suicide. Linda Ganzini et al., *Attitudes of Oregon Psychiatrists Toward Physician-Assisted Suicide*, 153 American J. Psychiatry 1469 (1996). Two-thirds of psychiatrists endorsed the view that a physician should be permitted, under some circumstances, to write a prescription for medication the sole purpose of which would be to allow a patient to end his or her life. Fifty-six percent favored implementation of Measure 16, although 71% believed that the patient should be required to inform the family (which is not required under Measure 16). Only 6% of psychiatrists were very

confident that in a single evaluation they could adequately assess whether a psychiatric disorder was impairing the judgment of a patient requesting assisted suicide; 43% were somewhat confident, and 51% were not at all confident. If the assessment were to be performed in the context of a long-term relationship with the patient, however, 54% were very confident and 41% somewhat confident of their ability to make an adequate assessment.

c. Oregon emergency room physicians. During 1995, Oregon emergency room physicians were surveyed regarding physician-assisted suicide. Terri A. Schmidt et al., *Oregon Emergency Physicians' Experiences with, Attitudes Toward, and Concerns About Physician-Assisted Suicide*, 3 Academic Emergency Medicine 938 (1996). Sixty-nine percent of emergency room physicians indicated that physician-assisted suicide should be legal; 73% believed that it would not be immoral for a physician to write a lethal prescription. Ninety-seven percent indicated at least one circumstance for which they would be willing to withhold resuscitation following physician-assisted suicide (81% with an advance medical directive, 73% with documentation in writing from the physician, 64% after speaking to the primary physician, 60% if a competent patient verbally confirmed intent, 52% if the family verbally confirmed intent). However, only 37% thought that Measure 16 contained enough safeguards to protect vulnerable people. In addition, many believed that patients might feel pressured to request assisted suicide because of financial concerns (69%) or concerns about being a burden to others (82%).

d. Euthanasia and Physician-Assisted Suicide in the Netherlands. On 11/28/96, two reports were published regarding euthanasia and physician-assisted suicide in the Netherlands. Paul J. van der Maas et al., *Euthanasia, Physician-Assisted Suicide, and Other Medical Practices Involving the End of Life in the Netherlands, 1990-1995*, 335 New England J. Medicine 1699 (1996); Gerrit van der Wal, *Evaluation of the Notification Procedure for Physician-Assisted Death in the Netherlands*, 335 New England J. Medicine 1706 (1996). In an accompanying editorial, Marcia Angell summarized the two reports and made the following predictions regarding future developments in the United States:

> Are the Dutch on a slippery slope? It appears not. The first report, by van der Maas and colleagues, shows that the practices in 1995 were not much different from those in 1990. Euthanasia was somewhat more frequent, but the authors believe that this can be partly explained by the aging of the population and the increased mortality from cancer, the usual underlying disease in cases of euthanasia. Assisted suicide remained rare, perhaps because it is slower than euthanasia and because the Dutch draw no moral distinction between the two acts. As in 1990, nearly all cases of euthanasia involved patients who were suffering from terminal illness and had only a short time to live. The incidence of ending life without an explicit request from the patient--the most disturbing finding in the earlier study--was slightly less in 1995 than in 1990. It would be very hard to construe these findings as a descent into depravity. As far as we can tell, Dutch physicians continue to practice physician-assisted suicide only reluctantly and under compelling circumstances.
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> As for the notification procedure, the results were mixed. Van der Wal and colleagues show that the fraction of physician-assisted deaths that were reported increased greatly, from 18 percent in 1990 to 41 percent in 1995. Still, the majority of cases continued to go unreported. Although most doctors said they thought some sort of oversight of cases of physician-assisted death was appropriate, they found the new procedure, with its multiple levels of legal review, burdensome. Furthermore, many doctors found it troublesome that euthanasia remains a crime, despite the official status of the guidelines and the legal reporting requirements. Although the risk of prosecution is exceedingly small, doctors who perform euthanasia may not wish to take any chances or to undergo scrutiny under such legally ambiguous conditions. It is likely that the rate of reporting will remain low unless the notification procedure is made less daunting and the peculiar legal situation is clarified. Ultimately, it is untenable for a medical practice to be simultaneously legal and illegal.
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> * * * Unlike the situation in the Netherlands, the focus [in the United States] will be on physician-assisted suicide, not on euthanasia. Support for decriminalizing assisted suicide has been growing, whereas support for euthanasia remains weak. This reflects the fact that we tend to draw a moral distinction between euthanasia and assisting suicide that the Dutch do not. Of greater practical consequence is the fact that euthanasia can be involuntary, whereas suicide, by definition, must be voluntary. That is important in the United States, where, because of our greater disparities in socio-economic status and the high cost of medical care, the risk of abuse of euthanasia is undoubtedly greater than it is in the Netherlands. Assisted suicide is considered less liable to abuse. For these reasons, if any form of physician-assisted dying becomes accepted in the United States, it is likely to be assisted suicide, not euthanasia.

Marcia Angell, *Euthanasia in the Netherlands--Good News or Bad?*, 335 New England J. Medicine 1676, 1677-78 (1996).

e. Study of the experiences of dying patients. On 1/15/97, researchers reported the results of a study of the experiences of dying patients who had participated in the SUPPORT and HELP studies at five hospitals around the country between 1989 and 1994. Joanne Lynn et al., *Perceptions by Family Members of the Dying Experience of Older and Seriously Ill Patients*, 126 Annals of Internal Medicine 97 (1997). The descriptions of dying patients' experiences were provided by surrogates (mostly relatives). Results of the study included the following:

(1) Symptoms. In the last 3 days of life, 55% of patients were conscious. Among these patients, pain, shortness of breath, and fatigue were prevalent: 4 in 10 patients had severe pain most of the time, more than half had severe shortness of breath, and severe fatigue affected almost 8 in 10 patients. More than 1 in 4 patients had moderate anxiety or depressed affect. Surrogates reported that 73% of patients found it difficult to tolerate physical symptoms and 62% found it difficult to tolerate emotional symptoms.

(2) Life-sustaining treatment. Overall, 56% of patients had some type of life-sustaining treatment in the last 3 days of life. About 1 in 10 patients had a resuscitation attempt; 1 in 4 were on a ventilator; and 4 in 10 had a feeding tube.

(3) Patient preferences. Fifty-nine percent of patients reportedly preferred an approach to care that focused on comfort, even if this approach shortened life. Surrogates reported that actual care was at odds with patient preferences in about 1 in 10 cases.

f. Survey of San Francisco Bay area AIDS physicians. On 2/6/97, researchers reported the results of a survey of AIDS physicians in the San Francisco Bay area conducted between November 1994 and January 1995. Lee R. Slome et al., *Physician-Assisted Suicide and Patients with Human Immunodeficiency Virus Disease*, 336 New England J. Medicine 417 (1997). Respondents reported a mean of 7.9 "direct" and 13.7 "indirect" requests from AIDS patients to assist them in suicide by prescribing a lethal dose of narcotics. In response to a case vignette, 48% of physicians said they would be likely or very likely to assist in a suicide, as compared with 28% of respondents in a similar survey conducted in 1990. Fifty-three percent of respondents said they had granted an AIDS patient's request for assistance at least once. The survey did not determine how many patients actually used prescribed narcotics to commit suicide. Results of the survey were presented in the summer of 1996 at the 11th International Conference on AIDS in Vancouver, B.C.

INTERNATIONAL DEVELOPMENTS

1. Australia

a. Northern Territory legislation. The Rights of the Terminally Ill Act (which authorizes both physician-assisted suicide and active euthanasia) went into effect on 7/1/96. Legislation to repeal the Act was introduced in the Northern Territory Legislative Assembly but was defeated on 8/21/96, by a vote of 14 to 11. The Act also was challenged in court as being outside the powers of the Legislative Assembly and not properly assented to by the Territory's Administrator, but on 7/24/96, the Supreme Court of the Northern Territory issued a 2-to-1 decision upholding the Act; the case is now on appeal to the High Court of Australia, which decided on 11/15/96 to defer judgment until the federal parliament had acted on pending legislation that would overturn the Act. Four patients have now died under the provisions of the Act (Bob Dent on 9/22/96, Janet Mills on 1/2/97, an unidentified man on 1/20/97, and an unidentified woman on 3/1/97).

b. Federal legislative proposals. Leaders of all the major Australian political parties have announced their opposition to the Rights of the Terminally Ill Act. A bill (known as the Euthanasia Laws Bill 1996) was introduced in the Australian Senate on 9/9/96, which would strip the Australian territories of the power to make laws permitting active euthanasia or assisted suicide. The bill passed the House of Representatives on 12/10/96 by a vote of 88 to 35. Evidence was gathered through a series of hearings held by the Senate Legal and Constitutional Legislation Committee, which delivered its report to the Senate on 3/6/97. The Senate is expected to vote on the bill by the end of March.

c. New South Wales. Independent New South Wales MP Dr. Peter McDonald, who supports euthanasia, called for establishment of an all-parties committee to frame a referendum question for 1999, but the NSW Premier, Mr. Carr, ruled out the possibility for insufficient public support. An extraordinary 10-hour debate was held in the NSW parliament on 10/16/96, at which 45 members put their positions on record; a substantial majority expressed opposition to legalization.

d. Australian Capital Territory. A bill legalizing euthanasia has been introduced in the legislative assembly of the Australian Capital Territory. Members were equally split during debate on 2/26/97, and a vote is likely to be delayed until fall 1997.

e. Attitudes of Australian physicians. A survey released 11/18/96 showed that nearly 9 out of 10 Australian physicians were strongly opposed to euthanasia and would turn down a request to help a

patient die. The survey was conducted by Dr. Charles Waddell of the University of Western Australia.

2. Canada

a. Prosecution of physician. Dr. Maurice Genereux, who has been charged with assisting the suicide of an HIV-positive patient, Aaron McGinn, in Toronto, could face up to 14 years in prison. A preliminary hearing will begin May 1, 1997.

b. Legislation. Proposed legislation to decriminalize physician-assisted suicide has been introduced in parliament. The Prime Minister has promised a free vote (members ruled by conscience only). On 10/27/96, delegates to the national convention of the ruling federal Liberal party voted 385-281 for a non-binding resolution in favor of repealing the statute criminalizing physician-assisted suicide. The resolution requires that the patient be terminally ill and of sound mind, as confirmed by two physicians; that the patient sign an affidavit of intent; that a provincial medical board determine if the affidavit conditions are met; and that one month pass without the patient's mind changing. Prime Minister Jean Chretien told reporters afterward that the issue is "not an urgent priority for me."

c. Latimer prosecution. Robert Latimer was convicted of second-degree murder in 1994 for the mercy killing of his disabled 12-year-old daughter. On 2/6/97, the Supreme Court of Canada issued a 9-0 decision granting Latimer a new trial because the government prosecutor had ordered police to question prospective jurors (including five who ended up on the jury) concerning their views on religion and euthanasia; however, the court rejected Latimer's request that his confession be suppressed. Latimer had been sentenced to life in prison without possibility of parole for 10 years, but spent only one day in jail before being released on $10,000 pending the appeal.

3. The Netherlands. Two reports on existing euthanasia practices and reporting procedures were issued in November 1996 [see summary above under MEDICAL DEVELOPMENTS]. Under recently revealed changes to the reporting procedures, euthanasia cases will no longer be referred to public prosecutors but instead will be submitted to an independent committee made up of legal, medical, and ethical experts. The changes are intended to increase the rate at which physicians report deaths resulting from euthanasia.

4. Japan

a. Japanese study euthanasia practices. Delegations from Japan visited Oregon, Australia, and the Netherlands during March 1997 to gather information regarding euthanasia practices. The Japanese are reviewing euthanasia in part because of two recent cases involving Japanese physicians. In the first case, a physician at Tokai University Hospital in Yokohama was convicted of murder in 1995 for administering a fatal dose of potassium chloride to a cancer patient in 1991, but the judge suspended the physician's two-year prison sentence. In the second case (which is still under investigation by Kyoto police), Dr. Yoshihiro Yamanaka administered a muscle relaxant intravenously to hasten the death of an unconscious man who had stomach cancer and was in excruciating pain; the patient's wife was not told what was done until a month later.

b. Deaths caused by failure to provide feeding tubes. Kochi Aiwa Hospital, a hospital for the aged in western Japan, reportedly allowed about 10 people to die between November 1995 and December 1996 by failing to provide artificial feeding tubes. Most patients were suffering from senile dementia and could not swallow food by themselves.

5. Scotland. On 10/13/96, a judge freed a man who had assisted in the death of his brother, a 40-year-old with Huntington's disease. Paul Brady originally was charged with murder, but the Crown accepted a reduced charge of culpable homicide. The judge said he had considered imposing a custodial sentence, but believed Brady was yacting out of compassion.

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