
Physician-Nurse

(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

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).

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