



## 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](http://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.



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.
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## 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].

- 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].

Nicholas A. Christakis & Elizabeth B. Lamont, *Extent and Determinants of Error in Doctors' Prognoses in*

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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.