Recent Developments in Physician-Assisted Suicide

June 2000

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 60Õs with cancer) filed suit in Alaska Superior Court in Anchorage challenging AlaskaÕs 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 plaintiffsÕ claims and granting summary judgment to the defendant. The plaintiffs have appealed the ruling.

2. *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 MichiganÕs 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.

3. *Sanderson v. People*, No. 99CA0203, 2000 WL 729008 (Colo.App. Jun. 8, 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 ColoradoÕs 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 courtÕs dismissal, finding that ColoradoÕs assisted suicide statute "is a valid, religiously-neutral, and generally-applicable criminal statute that prohibits conduct a state is free to regulate." Sanderson plans to appeal.

LEGISLATION

1. Alabama. In February 2000, the Alabama Senate passed Senate Bill 8, which would make assisted suicide a Class C felony punishable by up to 10 years in prison.

2. Maine. In November 2000, Maine voters will vote on the proposed Maine Death with Dignity Act, which generally is patterned after the Oregon Death with Dignity Act but mandates mental health counseling and referral to a palliative care specialist. The citizensÕ initiative measure, which will appear first on the November ballot as a result of a random drawing, asks: "Should a terminally ill adult who is of sound mind be allowed to ask for and receive a doctorÕs help to die?"

    a. Voter polls. Voter polls have produced differing results. A poll of 602 registered voters conducted by Research 2000 for the Bangor Daily News 2/27-2/29/00 showed that 38% favored the measure, 53% opposed it, and 9% were undecided. A poll conducted by RKM Research and Communication for WLBZ 2, WCSH 6, and the Bangor Daily News in May 2000 asked voters, "Do you favor a state initiative that legalizes physician-assisted deaths for patients who are terminally ill?"; 61.9% of those polled answered yes, and 30.4% answered no.

b. Campaign groups. Mainers for Death with Dignity organized the initiative and is campaigning for its approval. Opposition organizations are the Coalition for the Compassionate Care of the Dying and Maine Citizens Against the Dangers of Physician-Assisted Suicide (a coalition including the Maine Medical Association, the Maine Hospice Council, the Organization of Maine Nursing Executives, and Alpha One disability advocacy group). Campaign spending reports filed for the period through June 1 showed that supporters had raised $605,018 and spent $595,384, while opponents had raised $223,988 and spent $156,499.

c. Symposium. On 6/9/00, national and state medical experts and academics gathered at the University of New EnglandÕs campus in Portland, Maine, to debate the proposed Maine Death with Dignity Act.

3. Maryland. Arundel County prosecutors have charged a 16-year-old boy with assisting in the suicide of his 15-year-old girlfriend, Jennifer Garvey, by giving her a gun she used to kill herself as part of a suicide pact. Under MarylandÕs assisted suicide law, adopted in 1999, assisting a suicide is a felony punishable by up to one year in prison and a $10,000 fine. Maryland legislators William H. Cole and Sharon Grosfeld have introduced a bill limiting prosecution under the assisted suicide law to adults.

4. Oregon

a. New medical school seminar. In response to the recommendations of the Oregon Task Force on Pain and Symptom Management, Oregon Health Sciences University has adopted a new required seminar for third-year medical students on helping patients with chronic pain. Instructors include an internal medicine physician, a pain management specialist, and a psychiatric expert on behavioral approaches to treating pain.

b. OHSU study. In May 2000, researchers from Oregon Health Sciences UniversityÕs Center for Ethics in Health Care reported results of a study in which the families of dying patients were interviewed two to four months after the patientÕs death. The study asked the same 58 questions at two different times during 1997-98. The most surprising statistic was a significant increase in reported pain levels in hospitals, from 33% in an earlier study conducted during November 1996 through September 1997, to 57% late in 1997 and 54% late in 1998. In contrast, pain levels remained stable for patients who died in nursing homes (30%) or at home (28%). Representatives of the Oregon Hospice Association, Oregon Medical Association, and Oregon Board of Medical Examiners expressed concern that the increase in pain levels in late 1997 might be due to physiciansÕ concerns about the November 1997 referendum vote on repealing the Oregon Death with Dignity Act and threats of criminal prosecution from the administrator of the U.S. Drug Enforcement Agency. OHSU has received a $600,000 grant from the National Institute of Health to conduct a two-year study to find out why dying patients experience more pain in hospitals as compared to other settings.

5. 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.

Senate Judiciary Committee. On arrival in the Senate, the Senate parliamentarian referred HR 2260 "by mistake" to the Senate Judiciary Committee (chaired by Senator Orrin Hatch, who opposes assisted suicide). Senate Jim Jeffords, a moderate Republican from Vermont, objected unsuccessfully to the departure from normal Senate procedure, which would have assigned the bill to the Health, Education, Labor and Pensions Committee which he chairs. On 4/25/00, in response to requests from OregonÕs 258ojym84.5 5.7m

(2) Add Congressional findings.

(3) Change references to "palliative care" to read "pain management and palliative care."

(4) Define pain management as "the evaluation, diagnosis, treatment, and management of primary and secondary pain, whether acute, chronic, persistent, intractable, or associated with the end of life."

(5) Declare the "Decade of Pain Control and Research" beginning 1/1/01.

(6) Confirm that the states shall retain the sole authority to regulate the practice of medicine, by stating that:

> (a) "Nothing [in the bill] shall be construed to alter the roles of the Federal and State governments in regulating the practice of medicine."
>
> (b) "[I]t remains solely within the discretion of State authorities to determine whether action should be taken with respect to the State professional license of the practitioner or State prescribing privileges."
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> (c) "Nothing [in the bill] shall be construed to provide the Attorney General with the authority to issue national standards for pain management and palliative care clinical practice, research, or quality."

(7) Impose on the Attorney General the burden of proving the practitionerÕs intent by clear and convincing evidence.

Further Senate action

MEDICAL DEVELOPMENTS

1. Duke Institute for Care at the End of Life. Duke University has opened a $13.5 million research center devoted to the care of terminally ill patients and their families. The Institute for Care at the End of Life is housed in DukeÕs School of Divinity and includes faculty drawn from DukeÕs medical school and hospital and from the schools of nursing, divinity, and arts and humanities. The Institute also has links to the school of social work at the University of North Carolina at Chapel Hill, to North Carolina Central University (a predominantly black college), and to St. ChristopherÕs Hospice in London.

2. Study shows physiciansÕ reluctance to give patients accurate survival estimates. On 5/20/00, Drs. Elizabeth Lamont and Nicholas Christakis presented research results at the opening of the annual scientific meeting of the American Society for Clinical Oncology in New Orleans, Louisiana. The researchers had previously reported in a February 2000 article in the British Medical Journal [320 British Med. J. 469] that physicians who referred patients to five outpatient hospice programs in Chicago over 130 days in 1996 were inaccurate in their survival estimates for terminally ill patients, primarily by overestimating survival. The latest research involved 258 physicians caring for 326 cancer patients. Nearly all the physicians were willing to estimate their patientsÕ survival time for the researchers, but only about one-third said they would give truthful information if a patient insisted on knowing the physicianÕs prediction. One-quarter said they would refuse to answer. Another 40% said they would give an inaccurate estimate, with nearly three-quarters of these physicians saying they would tell patients they will live longer than the true estimate.

3. Survey of nurses on care of the dying. Researchers from City of Hope Cancer Center conducted a survey (reported in Oncology Nursing Forum) of 2,300 nurses on care of the dying, including subjects ranging from education to pain management. Only 13% of nurses rated their end-of-life training in nursing school as "very adequate," but 66% said that care of the dying is better than it was five years ago. Problem areas reported by participants included pain management techniques, dealing with the needs of family caregivers, and responding to rare requests for assisted suicide and euthanasia. About 23% of nurses said they had requests from patients for assisted suicide, but only 1% said these requests were common.

4. Kappa-opioids. Researchers at the University of California, San Francisco have discovered that a class of drugs known as kappa-opioids may provide a viable alternative to morphine for pain relief, with minimal side effects. These drugs have been available clinically for 40 years but were thought to be ineffective pain killers because only men were included in earlier clinical trials. After a recent study revealed that kappa-opioids provided substantial pain relief after jaw surgery for women, but not men, researchers combined a low dose of nalbuphine with naloxone and found that patients of both sexes experienced very effective, prolonged pain relief.

5. Recent articles

    a. Harold I. Schwartz et al., *The Physician-Assisted Suicide Policy Dilemma: A Pilot Study of the Views and Experiences of Connecticut Physicians*, 27 J. Am. Acad. Psychiatry & L. 527 (1999) [397 Connecticut psychiatrists, internists, and family practitioners completed self-administered questionnaire regarding five end-of-life interventions including physician-assisted suicide and active euthanasia; 32% supported physician-assisted suicide and 26% supported active euthanasia, with psychiatrists being significantly more likely to support these practices; 9% of those who supported both practices acknowledged having already written lethal prescriptions, as opposed to 3.4% among all other respondents; study also gathered data on physician characteristics, factors influencing their attitudes, and their concerns about the role of depression in patients].

    b. L. Grassi et al., *Attitudes of Italian Doctors to Euthanasia and Assisted Suicide for Terminally Ill Patients*, 354 Lancet 1876 (1999) [a euthanasia attitude questionnaire completed by 148 physicians at a local university-based hospital and 182 general practitioners in Ferrara, Italy, showed that 3.1% had received requests for physician-assisted suicide and 8.8% requests for active euthanasia; 31.2% favored legislation legalizing physician-assisted suicide and 26.7% favored legislation legalizing active euthanasia; Catholic physicians more firmly opposed physician-assisted suicide and active euthanasia than non-Catholics (86.7% vs. 50.7%)].

    c. Alida Westman et al., *Relationships Among Assisted Suicide and Religiousness, Resources Available, Denial of Dying, and Autonomy*, 85 Psycholog. Rep. 1070 (1999) [nonrandom sample of 218 Michigan voters conducted two weeks prior to voting on physician-assisted suicide ballot measure showed that opponents were more religious, believed that only a person with a troubled mind would favor assisted

suicide, and believed that vulnerable individuals would suffer if it became legal; supporters perceived assisted suicide as a medical rather than a moral issue, believed in making oneÕs own decisions on moral issues, and believed that people may have different individual opinions on assisted suicide;

consensus process were published in the Annals of Internal Medicine:

(1) Lois Snyder and Arthur L. Caplan, *Assisted Suicide: Finding Common Ground*, 132 Annals Internal Med. 468 (2000) [describing project].

(2) Franklin G. Miller et al., *Assisted Suicide Compared with Refusal of Treatment: A Valid Distinction?*, 132 Annals Internal Med. 470 (2000) [panel uses three illustrative cases to argue that assisted suicide can be distinguished from withdrawal of artificial nutrition and hydration and from the decision to stop eating and drinking; three panel members dissent].

(3) Arthur L. Caplan et al., *The Role of Guidelines in the Practice of Physician-Assisted Suicide*, 132 Annals Internal Med. 476 (2000) [panel reviews sample guidelines, finding consistent core content, and identifies concerns that cause some to reject use of guidelines].

(4) Kathy Faber-Langendoen & Jason H.T. Karlawish, *Should Assisted Suicide Be Only Physician Assisted?*, 132 Annals Internal Med. 482 (2000) [panel concludes that physicians have limited competence in this area and that other professionals such as nurses, social workers, and clergy should participate and even take the lead; three panel members dissent].

(5) Timothy E. Quill et al., *Palliative Treatments of Last Resort: Choosing the Least Harmful Alternative*, 132 Annals Internal Med. 488 (2000) [panel illustrates, through summaries of real clinical cases, five practices that might be used for terminally ill patients: accelerating opioid therapy for pain, forgoing life-sustaining therapy, voluntarily stopping eating and drinking, administering terminal sedation, and physician-assisted suicide].

(6) James A. Tulsky et al., *Responding to Legal Requests for Physician-Assisted Suicide*, 132 Annals Internal Med. 494 (2000) [panel provides guidance to physicians in responding to requests for assisted suicide where such requests are legal].

m. Walter J. Kade, *Death with Dignity: A Case Study*, 132 Annals Internal Med. 504 (2000) [Oregon physician (writing under pseudonym) describes the experience of assisting in a patientÕs death under the Oregon Death with Dignity Act].

n. David E. Joranson et al., *Trends in Medical Use and Abuse of Opioid Analgesics*, 283 JAMA 1710 (2000) [despite substantial increase in medical use of opioid analgesics to treat pain from 1990 to 1996, researchers found that the percentage of hospital emergency department admissions resulting from drug abuse that was attributable to opioids declined from 5.1% to 3.8%].

INTERNATIONAL DEVELOPMENTS

1. Australia

a. State legislation. Every state in Australia has now considered and rejected legalizing euthanasia. In May 2000, the Western Australia state government and parliament refused to debate the proposed Voluntary Euthanasia Bill 2000.

Euthanasia clinics

d. Physician and family members charged with murder. A Western Australia urologist, Dr. Daryl Allan Stephens, has been charged with the murder of 48-year-old Freeda Patricia Hayes on 2/4/00 at the Murdoch Community Hospice in Perth. Hayes, who was suffering from terminal cancer of the kidney, allegedly died after being given a lethal intravenous injection of atracurium and midazolam. If convicted, Stephens would face a mandatory sentence of 15 years without parole. HayesÕ brother and sister, Warren Hayes and Lena Vinson, also have been charged with murder for allegedly being present while the lethal injection was being administered. All three defendants have been released on bail.

2. Canada

Senate Subcommittee to Update *Of Life and Death*. On 5/15/00, the Subcommittee to Update *Of Life and Death* of the standing Senate Committee on Social Affairs, Science and Technology finished its hearings on developments during the five years since the June 1995 report, *Of Life and Death: Report of the Senate Special Committee on Euthanasia and Assisted Suicide*. The subcommitteeÕs charge was limited to the unanimous recommendations made in *Of Life and Death*, which covered palliative care, pain control and sedation practices, withholding and withdrawal of life-sustaining treatment, and advance directives. The subcommitteeÕs charge did not include assisted suicide and euthanasia, as to which the

nutrition, hydration, or medical treatment was to end life. MP Peter Brand, a physician from the Isle of Wight, is being investigated by Hampshire police after revealing during parliamentary debate that he participated in withdrawing treatment from a two-year-old leukemia patient in 1973 at the request of the childÕs parents.

b. Bereaved relatives to sue government. The group SOS-NHS Patients in Danger plans to sue the British government in High Court after the 1998 Human Rights Act goes into effect in October, claiming that the government has failed to carry out its statutory duty to protect vulnerable elderly patients from physicians who deliberately withhold intravenous fluids to hasten death. The group will challenge the legality of guidelines for physicians introduced in 1999 by the British Medical Association after consultation with the Department of Health. The guidelines allow physicians to deny artificial nutrition and hydration for stroke victims and those suffering from dementia, even when the patients are not terminally ill, if thought to be "in their best interests."

c. British Medical Association. At a consensus conference in February 2000, the British Medical Association rejected moves to change the law on physician-assisted suicide but strongly supported continuing improvements in the care of the dying.

Public opinion survey. A survey of more than two million Britons who have visited the Millennium Dome in London showed that 80% favor having the right to end their own lives by euthanasia.

A survey of Israeli physicians revealed widespread ignorance about the uses and effects of opium-derived edication such as morphine and oxycontin. For example, physicians overestimated the chances of n by a factor of 10 to 100 times greater than the actual figure of one to four persons in 10,000. In an effort ter the stigma associated with the drugs, the DoctorsÕ Association for Pain Treatment in Israel is d to publish information on the use of opium derivatives, including a list of medicines, their effects, and ommended dosages.

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