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BACKGROUND PAPER

# Euthanasia and Assisted Suicide: International Experiences

**Publication No. 2011-67-E**
**8 April 2011**
***Revised 25 October 2013***

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Parliamentary Information and Research Service

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*Euthanasia and Assisted Suicide: International Experiences*
(Background Paper)

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Ce document est également publié en français.

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# EUTHANASIA AND ASSISTED SUICIDE: INTERNATIONAL EXPERIENCES

## 1 INTRODUCTION

Over the last few decades, movements have arisen in a number of jurisdictions in favour of the legalization of physician-assisted suicide and, in some cases, euthanasia. At the same time, there continues to be vocal opposition to the elimination of criminal sanctions for individuals who either assist in or cause the death of a person who has requested that his or her life be terminated. Although there are many possible definitions of euthanasia and assisted suicide, this paper uses the following:

- "Euthanasia" is the deliberate act undertaken by one person with the intention of ending the life of another person in order to relieve that person's suffering.
- "Assisted suicide" is the act of intentionally killing oneself with the assistance of another person who provides the knowledge, means or both.[1]

This paper reviews developments in jurisdictions that already permit physician-assisted suicide or euthanasia (or both) in certain contexts, as well as developments in some jurisdictions that appear to be moving toward greater acceptance of these practices.[2] An appendix at the end of this paper provides an overview, in chart format, of the current legal status of euthanasia and assisted suicide in various jurisdictions. Note that in Canada, both euthanasia and assisted suicide are illegal.[3]

## 2 THE UNITED STATES

To date, Oregon, Washington State and Vermont are the only states that have passed laws explicitly permitting some form of physician-assisted suicide. In addition, Montana's Supreme Court concluded that doctors could use the defence of consent to protect themselves, if certain conditions are met, should they be prosecuted for assisting a suicide.[4] There is little case law in the United States relating to state laws that permit physician-assisted suicide; most case law relating to this issue addresses state laws that explicitly prohibit the practice.

### 2.1 CHALLENGES TO STATE LAWS THAT PROHIBIT PHYSICIAN-ASSISTED SUICIDE

The majority of American states have laws explicitly prohibiting assisted suicide, while some rely on common-law crimes, which have developed through judicial decision-making, to prohibit the practice. No American state has legalized euthanasia. The prosecution of cases of euthanasia is addressed through regular homicide laws.[5]

### 2.1.1 Washington and New York State Laws Prohibiting Assisted Suicide Upheld

On 1 October 1996, the Supreme Court of the United States agreed to hear an appeal of two Court of Appeal rulings from the states of Washington and New York, which had concluded that laws prohibiting physician-assisted suicide in those states were unconstitutional. The Supreme Court had previously refused to hear an appeal of a Michigan State Court decision that upheld a Michigan law prohibiting assisted suicide. The law had been passed after high-profile advocate Dr. Jack Kevorkian began his campaign of assisting terminally ill people to die.

On 26 June 1997, the Supreme Court reversed both decisions and upheld the Washington and New York statutes prohibiting assisted suicide. Since that decision, the appellate courts of other states such as Alaska and Colorado have also upheld laws criminalizing assisted suicide, concluding that they do not violate the states' respective constitutions.[6] While the courts have found that these statutes are constitutional, this does not mean that a law permitting assisted suicide would automatically be found unconstitutional. Oregon, Washington State and Vermont have passed such laws. Oregon's laws were challenged but eventually upheld in the courts (see section 2.2.2, "Legal Challenges to the *Death with Dignity Act*").

### 2.1.2 Defence of Consent for Doctors in Montana

In October 2007, in another challenge to laws against assisted suicide, two terminally ill patients, four doctors and a patients' rights organization in Montana brought a lawsuit before the District Court claiming the "right to die with dignity." They alleged that the "application of Montana homicide statutes to physicians who provide aid in dying to mentally competent, terminally ill patients" contravened Article 2 of the state constitution, which protects the right to privacy and human dignity. The District Court, the court where the lawsuit was initiated, concluded that the constitutional protection of these rights included the right for competent, terminally ill patients to die with dignity. In turn, this right was found to include protection from prosecution for a physician who might assist such a patient.[7]

The Montana government appealed the decision to the Montana Supreme Court, which decided the case without addressing the constitutional question. The majority of the Court concluded in its December 2009 judgment that doctors could use the existing defence of consent, if charged with homicide for assisting a mentally competent, terminally ill patient to commit suicide.[8] The consent defence allows a defendant to argue that the victim consented to the act that the defendant committed, and that the defendant should thus not be convicted.[9] In this way, where the patient is mentally competent and terminally ill, physicians who prescribe medication so that a patient may commit suicide have a defence against homicide charges in Montana. Non-physicians may not benefit from the same protections, since the December 2009 decision only addressed the situation of doctors.[10]

Though the decision provided a defence for doctors in the state, it did not outline any procedures, standards or safeguards. In Montana, the practice of assisting a suicide is not regulated in any way, unlike in Washington, Oregon and Vermont where safeguards are outlined in the legislation on assisted suicide. Montana House Bill 505, which proposed to overturn the state Supreme Court decision and make assisted suicide illegal in Montana, was defeated by the state Senate in April 2013.[11] Montana Senate Bill 220, which would have legalized assisted suicide and provided a framework to regulate the practice, was defeated the same month.[12]

### 2.1.3 Constitutional Challenges by Final Exit Network

#### 2.1.3.1 Georgia

In 2008, a terminally ill patient died in Georgia, allegedly with the assistance of the Final Exit Network (FEN), a right-to-die organization. FEN, along with four of its members – Thomas (Ted) Goodwin, Dr. Lawrence Egbert, Nicholas Sheridan and Claire Blehr – were charged with assisting John Celmer to commit suicide and other related charges after Mr. Celmer's death.

To be convicted of the crime of assisting a suicide, Georgia's statute required a public advertising of assisted suicide, or a public offer to assist in the act, as an element of the crime. Assisted suicide was legal as long as it remained a private matter.[13] The accused challenged the constitutionality of the law, based on both the federal and state constitutions, arguing a number of issues, including a violation of the right to free speech because of the public advertising element of the crime. On 6 February 2012, the Supreme Court of Georgia (the state's highest appellate court) found that the statute restricted free speech and was unconstitutional under both the United States and Georgia constitutions. The charges against all of the accused were dismissed. In response, the state legislature passed legislation on 29 March 2012 criminalizing assisted suicide. The new legislation eliminates the advertising element of the offence but also narrows the scope of the assisted suicide provisions.[14]

#### 2.1.3.2 Minnesota

As a result of the investigation in Georgia, information came to light that a woman in Minnesota, Doreen Dunn, may also have been assisted by FEN members in committing suicide in 2007. FEN and four of its members, including two of the accused in the Georgia case (Mr. Goodwin and Dr. Egbert), were charged with various offences, including assisting a suicide.[15]

The accused challenged Minnesota's law on assisted suicide on grounds similar to those of the Georgia challenge. The law criminalizes "advis[ing], encourag[ing], or assist[ing] another in taking the other's own life." In September 2013, in an unpublished decision that is not binding in future cases, the State of Minnesota Court of Appeals found that the prohibitions on advising and encouraging unjustifiably infringed on free speech and were overbroad. The case will be sent back for a retrial on the charges of assisting a suicide. Media reports state that the Dakota County Attorney (Minnesota) plans to appeal the decision.[16]

That decision appears to contradict an earlier State of Minnesota Court of Appeals decision which concluded that the same statute *was* constitutional. In that case, a former nurse, William Melchert-Dinkel, had communicated over the Internet and encouraged a Briton and a Canadian to kill themselves. His motivation appears to have been entirely different from that of the individuals in FEN, as he wanted to watch the suicides and pretended also to be suicidal. The Court of Appeals concluded that the type of speech used by Melchert-Dinkel was not protected speech and that the statute was neither overbroad nor vague. That case is before the state's Supreme Court.[17]

#### 2.1.3.3 Arizona

Another case involving four FEN members, including Dr. Lawrence D. Egbert, resulted in pleas to misdemeanours (minor charges) for two of the defendants. A jury exonerated Dr. Egbert in 2011 and could come to no conclusion with respect to the final defendant, who later pleaded guilty to a misdemeanour rather than face a retrial.[18]

### 2.1.4 Some Other Recent American Cases

In Connecticut, two doctors initiated a lawsuit similar to the one undertaken in Montana. They challenged the state law on assisted suicide, but not in relation to any specific patients. The Connecticut Superior Court, in its June 2010 decision, dismissed the case. It found that determining whether doctors should be allowed to assist patients to commit suicide is an issue for the Connecticut legislature rather than the courts.[19]

Two doctors and a woman with advanced ovarian cancer launched a challenge of New Mexico's law against physicians assisting terminally ill patients to commit suicide in March 2012. The matter is scheduled to be heard in December 2013. The plaintiffs argue that the state's law against assisted suicide does not encompass a situation where a physician provides a prescription to a mentally competent, terminally ill person. They have also made constitutional arguments. If they win their case, it could have ramifications for other states with similarly written legislation.[20]

## 2.2 Oregon's *Death with Dignity Act*

### 2.2.1 Requirements under the *Death with Dignity Act*

In November 1994, Oregon voters passed Measure 16, a legislative proposal that had been put to a referendum and that allows terminally ill adult residents of Oregon, with a prognosis of less than six months to live, to obtain a prescription for medication for the purpose of committing suicide. Before a physician can issue such a prescription, certain conditions have to be met. For example:

- The patient has to make two oral requests at least 15 days apart and one written request for medication. The written request must be signed before two witnesses and criteria are outlined in the law regulating who may be witnesses. Forty-eight hours must elapse between the written request and the provision of a prescription.
- A second medical opinion is required.

- The patient has to be capable, meaning that

> in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, psychiatrist or psychologist, a patient has the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available.[21]

If either of the physicians is of the opinion that a patient's judgment may be impaired by a psychiatric or psychological disorder or depression, the physician must refer the patient for counselling and cannot prescribe medication to end the patient's life until it is determined that the patient's judgment is not impaired.

- The physician must verify that the patient is making an informed decision, which is defined in the statute as a decision based on an appreciation of the relevant facts and made after the patient has been fully informed by the attending physician of:
  - his or her medical diagnosis and prognosis;
  - the potential risks associated with taking the medication to be prescribed;
  - the probable result of taking the medication to be prescribed; and
  - the feasible alternatives, including, but not limited to, comfort care, hospice care and pain control.[22]
- The physician must request that the patient inform his/her next of kin of his/her request for a prescription, though the physician cannot obligate an individual to do so.

Details must be included in the patient's medical record concerning the requests, diagnosis, prognosis, any counselling that occurred and the doctor's offers to rescind the request. Doctors also have reporting obligations to Oregon's Department of Human Services once a prescription is written.[23]

### 2.2.2 Legal Challenges to the *Death with Dignity Act*

A legal challenge to the legislation prevented the proclamation of Measure 16 until the end of 1997. The Oregon legislature then voted to have another referendum on the law, in which Oregon voters reaffirmed their support by a 60% majority and the Act came into effect in November 1997.[24]

Opponents of the *Death with Dignity Act* quickly began lobbying for federal intervention against the state initiative. They initially appeared unsuccessful, but with a change in government at the federal level in 2001, an Interpretive Rule was issued to clarify the legal situation in federal law for doctors who might assist a patient to commit suicide. The Interpretive Rule stated that physicians who prescribed, dispensed or administered federally controlled substances to assist a suicide would be violating the federal *Controlled Substances Act*.[25] However, in January 2006, the Supreme Court of the United States in *Gonzales v. Oregon* ruled that the Interpretive Rule was invalid because it went beyond the federal Attorney General's authority under the *Controlled Substances Act*.[26]

### 2.2.3 *Death with Dignity Act* Annual Reports

The *Death with Dignity Act* requires Oregon's Department of Human Services to annually review and report on information collected in accordance with the Act. Table 1 highlights some statistics that reports have provided since the legislation came into force.

**Table 1 – Annual Statistics Relating to Oregon's *Death with Dignity Act*, 1998–2012**

| Year | Reported Prescriptions Written for Medication to Commit Suicide | Reported Deaths by Ingestion of the Prescribed Medication[a] | Reported Deaths by Physician-Assisted Suicide per 1,000 Deaths |
|---|---|---|---|
| 1998 | 24 | 16 | 0.55 |
| 1999 | 33 | 27 | 0.92 |
| 2000 | 39 | 27 | 0.91 |
| 2001 | 44 | 21 | 0.71 |
| 2002 | 58 | 38 | 1.22 |
| 2003 | 68 | 42 | 1.36 |
| 2004 | 60 | 37 | 1.23 |
| 2005 | 65 | 38 | 1.2[b] |
| 2006 | 65 | 46 | 1.47 |
| 2007 | 85 | 49 | 1.56 |
| 2008 | 88 | 60 | 1.94 |
| 2009 | 95 | 59 | 1.93 |
| 2010 | 97 | 65 | 2.09 |
| 2011 | 114 | 71 | 2.25 |
| 2012 | 115 | 77 | 2.35 |

Notes: a. The Oregon Department of Human Services reports also note cases where the status of individuals who received a prescription is unknown.

b. The figure of 1.2 deaths due to physician-assisted suicide for every 1,000 deaths in 2005 is an estimate only, though the annual report for 2005 does not explain why. See Oregon Department of Human Services, Office of Disease Prevention and Epidemiology, *Eighth Annual Report on Oregon's Death with Dignity Act*, Portland, Oregon, 9 March 2006.

Sources: Oregon Department of Human Services, *Prescription History – Oregon Death with Dignity Act*, 1998–2012; and Oregon Health Authority, "Death with Dignity Act Annual Reports" (1998–2012).

Though the number of prescriptions written and deaths due to ingestion have increased almost every year since the law was passed, relatively few prescriptions have been written considering that almost four million people live in Oregon. The number of deaths by physician-assisted suicide out of all deaths was a little more than two of every 1,000 deaths in Oregon in 2012.

The annual reports provide aggregate statistics about who is choosing assisted suicide:

- 52% were men;
- 69% were 65 or older;

- 98% were white;
- 45% had a baccalaureate degree or higher;
- 90% were enrolled in hospice care and 95% died at home;
- 65% had private health insurance and 34% had some form of government health insurance; and
- 80% had cancer.

The three most common reasons for choosing assisted suicide were concerns about losing autonomy, being less able to engage in activities that make life enjoyable and loss of dignity.[27]

## 2.3 WASHINGTON STATE'S *DEATH WITH DIGNITY ACT*

The State of Washington passed its *Death with Dignity Act* by referendum on 4 November 2008 and it came into force on 5 March 2009.[28] The law is based on the law in Oregon and includes reporting requirements, with the Washington State Department of Health playing a collection and monitoring role similar to Oregon's Department of Human Services.[29] Table 2 highlights some statistics that reports have provided since the legislation came into force.

**Table 2 – Annual Statistics Relating to Washington State's *Death with Dignity Act*, 2009–2012**[a]

| Year | Reported Prescriptions Written for Medication to Commit Suicide | Reported Deaths of "Death with Dignity Participants" (individuals who had received a prescription) |
|---|---|---|
| 2009[b] | 63 | 36 |
| 2010 | 87 | 51 |
| 2011 | 103 | 101 |
| 2012 | 121 | 83 |

Note:
a. The statistics in the Washington State Department of Health annual reports about the people who died due to assisted suicide differ from those in the Oregon Department of Human Services reports, summarized in Table 1. In its total, Washington includes both individuals who died due to ingestion of the prescribed medication and individuals with a prescription but who died due to other reasons, such as terminal illness. Oregon's statistics relate only to deaths due to ingestion of the prescribed medication. However, the demographic profile of the individuals involved is similar. The reports for both states also note cases where the status of individuals who received a prescription is unknown.

b. The numbers for 2009 represent the period beginning 5 March 2009 with the entry into force of the law.

Sources: Washington State Department of Health, *Death with Dignity Act* (annual reports, 2009–2012).

## 2.4 CONCERNS WITH THE LAWS IN OREGON AND WASHINGTON STATE

A number of concerns have been raised with respect to Oregon's *Death with Dignity Act*, as well as with Washington's similar law. Some commentators and organizations that oppose assisted suicide fear that it will be seen by insurers as an economically attractive alternative, in contrast to costly life-sustaining care for the terminally ill. Fox News and other media have reported that, for reasons of cost, Oregon's

Medicaid has refused to cover patients' access to life-sustaining but non-curative cancer treatment because it would not cure their cancer – even though the treatment could prolong and improve the quality of the patients' lives. (Medicaid is state-funded health care for low income residents.) However, the patients were reportedly told at the same time that the program would cover comfort care, including the cost of the prescription for medication to commit suicide, if they wanted assistance in ending their lives.[30] Nonetheless, Oregon's 2012 annual report on the state's *Death with Dignity Act* reports that only 2.7% of those who died between 1998 and 2012 after ingesting the prescribed medication had concerns about the financial implications of treatment when they decided to seek assistance to commit suicide.[31] In Washington, the figure was 5% in 2012 and 4% in 2011.[32]

According to Oregon's 2012 annual report, 39% of individuals who died between 1998 and 2012 after ingesting the prescribed medication were concerned about becoming a burden at the end of their life.[33] In Washington State, 63% of those who ingested the medication in 2012 and 54% of those who did in 2011 voiced such concerns.[34] Because a doctor does not need to be present at the time of death, some commentators worry about the risk of abuse if individuals are pressured or forced to take the medicine. Other concerns include inadequate identification and referral for mental health issues prior to issuing a prescription, under-reporting by doctors, lack of sanctions for those who do not comply with the legal requirements and lack of enforcement mechanisms to ensure compliance with the law.[35]

## 2.5 Vermont's *Act Relating to Patient Choice and Control at End of Life*

On 20 May 2013, Vermont's Governor Peter Shumlin signed the Patient Choice at End of Life Bill into law. This is the first law permitting physician-assisted suicide to be passed by a legislature in the United States; the Oregon and Washington laws were passed by referendum. This law is modelled on Oregon's law. However, the provision outlining requirements similar to Oregon's will expire on 1 July 2016. After that date, the requirements change, and a person expected to die within six months would potentially be able to get a prescription after a single consultation with a doctor.[36]

## 2.6 Other State Initiatives

Since 1991, four proposals to legalize euthanasia and/or assisted suicide by referendum (including an earlier one in Washington State) have been defeated. Since 1994, 135 bills have been proposed on the topic in 27 states, with only the Vermont law being passed.[37] Massachusetts recently held a referendum in which voters rejected an attempt to legalize physician-assisted suicide in that state by a very small margin.[38] In addition to the legislature of Montana, which is mentioned above, a number of state legislatures dealt with assisted suicide bills in 2013, including the legislatures of the following states:

- Connecticut (House Bill 6645, House Bill 6217, Senate Bill 48 and Senate Bill 229), Hawaii (House Bill 606) and Maine (Legislative Document 1065), though all of these initiatives were defeated; and
- Kansas (House Bill 2068 and House Bill 2108), Massachusetts (House Bill 1998), New Jersey (Assembly Bill 3328 and Senate Bill 2259) and Pennsylvania (Senate Bill 1032), where initiatives were still before the respective state legislatures at the time of writing.

# 3 UNITED KINGDOM

## 3.1 ENGLAND AND WALES

End-of-life decisions have caused considerable controversy in the United Kingdom (U.K.). Euthanasia is unlawful throughout the U.K. While assisted suicide also remains illegal, a person assisting will not necessarily be prosecuted, as a result of developments discussed in this section.

The European Court of Human Rights heard the case of Diane Pretty on 19 March 2002. Ms. Pretty, who was paralyzed from the neck down as a result of a motor neuron disease (a neurological disorder), had unsuccessfully sought assurances from the Director of Public Prosecutions (DPP) that her husband would not be prosecuted if he assisted her suicide. The Court found that the DPP's refusal of her request and the U.K.'s prohibition of assisted suicide did not infringe on any of her rights under the Council of Europe's *European Convention on Human Rights*.[39]

In March 2004, Lord Joel Joffe introduced the Assisted Dying for the Terminally Ill Bill in the House of Lords, and a Select Committee was established to review the bill in November of the same year. The bill was similar to the Oregon *Death with Dignity Act* in many ways. Lord Joffe's bill differed, however, in one major respect from the Oregon model, in that it not only allowed a physician to provide a patient with the means to end his or her life (assisted suicide), but also allowed the physician to end the life of a patient who was physically unable to do so himself or herself (euthanasia). The bill also differed from the *Death with Dignity Act* by requiring that a patient who makes a declaration seeking assisted suicide do so in front of a solicitor who, in order to witness the declaration, must find the patient to be of sound mind and be satisfied that the patient understands the effect of the declaration. The Assisted Dying for the Terminally Ill Bill also contained a clause preventing a physician with a conscientious objection from being obligated to participate in an assisted death.

The Select Committee released its report on the bill in March 2005 and, while noting that there was insufficient time to proceed with the bill in that session, made a number of recommendations with respect to any similar bills that might be introduced at a later date. For example, a new bill should draw a clear distinction between assisted suicide and euthanasia. Also, such legislation should spell out what actions a physician may or may not take in assisting a suicide or in administering euthanasia.[40] The committee report was debated in the House of Lords in October 2005. A subsequent bill

introduced by Lord Joffe was effectively defeated by the House of Lords on 12 May 2006.

In the mid-2000s, Debbie Purdy, who suffered from multiple sclerosis, made it known that she wanted to obtain the assistance of a Swiss clinic to end her life. She was afraid, however, that her husband, Omar Puente, would be prosecuted in the U.K. if he accompanied her to Switzerland. She wanted to determine the DPP's official policy in this regard, and clarify whether it was legal under British law for a British citizen to assist someone to commit suicide in a country like Switzerland where assisted suicide is legal.

The House of Lords concluded that the DPP should be required to make the policy public.[41] A final policy, published in February 2010, states clearly that assisted suicide remains a criminal offence. However, it outlines a two-stage process to determine whether charges will be brought: first, it must be determined if there is sufficient evidence of an offence having been committed and, second, it must be decided whether a prosecution is in the public interest. Specific factors, such as whether the person who committed suicide clearly stated the intention to do so and the motivation of the person who assisted, are to be considered.[42]

In September 2010, a non-governmental Commission on Assisted Dying was set up to study the issue of assistance in dying. Lord Charles Falconer acted as the Chair.[43] The commission concluded in its 2011 report that assisted suicide should be legalized in England and Wales, though it outlined recommendations for improved health and social services as well as for eligibility criteria to ensure sufficient safeguards are in place to protect vulnerable individuals.[44] Critics allege that the report was flawed because the commission's funders and a majority of the commissioners supported changing the law prior to the commission starting its work. Critics also stated that groups on the other side of the debate were excluded and/or refused to take part.[45]

On 16 May 2013, Lord Falconer introduced a new bill in the House of Lords to legalize physician-assisted suicide (not euthanasia). The bill is quite similar to those in Oregon and Washington State, though there are some differences. A doctor or a nurse authorized to do so may go so far as to assist an individual in ingesting or self-administering the drug, though the final act of taking the medicine must be completed by the patient. The assisting health professional must remain near the patient until they either die or decide not to administer the medicine.[46]

In a July 2013 decision, the England and Wales Court of Appeal (Civil Division) rejected a challenge to the country's laws on assisted suicide and euthanasia. Tony Nicklinson and an individual known as AM, both of whom were paralyzed, had initiated the case, with another plaintiff, Paul Lamb, joining later (Mr. Lamb was also paralyzed). When Mr. Nicklinson died shortly after a lower level court decision came out, his wife also became a plaintiff. The Court of Appeal refused to create a common-law defence of necessity for individuals charged for committing euthanasia or assisting a suicide. However, the Court found that the DPP policy mentioned above was not sufficiently clear for individuals in all situations to have a good

understanding of whether they would be prosecuted for assisting a suicide. This was found to be a violation of section 8 of the *European Convention on Human Rights*.[47]

### 3.2 Northern Ireland

The DPP's jurisdiction is limited to England and Wales, but Northern Ireland has a similar policy, developed in collaboration with the DPP.[48]

### 3.3 Scotland

Scotland does not have a statutory offence of assisted suicide as do England, Wales and Northern Ireland. Depending on the facts, a case of assisted suicide might be addressed through homicide laws.[49] In an attempt to eliminate this risk, Margo MacDonald, an independent member of Parliament living with Parkinson's disease, introduced a bill in the Scottish Parliament in 2010 that would have legalized assisted suicide. According to the website of the Scottish Parliament, "Parliament disagreed to the general principles of the Bill," so the bill was defeated on 1 December 2010.[50] Ms. MacDonald has begun the process to introduce another bill to legalize assisted suicide.[51]

## 4 THE NETHERLANDS

### 4.1 Development of the Law

Traditionally, euthanasia was prohibited under the Dutch penal code, which states that anyone who terminates the life of another person at that person's explicit request is guilty of a criminal offence. Nonetheless, those who practised euthanasia in the Netherlands were not prosecuted as long as they followed certain guidelines. The guidelines were developed through a series of court decisions in which physicians who had been charged with practising euthanasia were found not to be criminally liable. Under the guidelines, all of the following requirements had to be met:

- The patient must repeatedly and explicitly express the desire to die.
- The patient's decision must be well-informed, free and enduring.
- The patient must be suffering from severe physical or mental pain with no prospect of relief (but need not be terminally ill).
- All other options for care must have been exhausted (so that euthanasia is a last resort), or the patient must have refused other available options.
- The euthanasia must be carried out by a qualified physician.
- The physician must consult at least one other physician (and may also consult other health care professionals).
- The physician must inform the local coroner that the euthanasia has been carried out.

In February 1993, the Netherlands passed legislation on the reporting procedure for euthanasia. Although it did not legalize euthanasia, the legislation provided a defence to physicians who followed certain guidelines. In effect, this provided doctors with protection from prosecution.

In 1994, the Supreme Court of the Netherlands decided the controversial Chabot case, finding Dr. Boudewijn Chabot technically guilty of assisting a suicide. Dr. Chabot's patient, 50-year-old Hilly Bosscher, had simply not wished to live because of a violent marriage, the death of two sons and 20 years of depression. After working with the patient for some time and believing the situation to be hopeless, Dr. Chabot considered that the lesser evil would be to provide his patient with the means to commit suicide painlessly and with as little violence as possible.

The Supreme Court accepted the principle that assisted suicide could be justifiable in cases where, although no physical illness was present, the patient was experiencing intense emotional or mental suffering. However, the Court found that Dr. Chabot had violated procedural requirements. Nonetheless, the Court declined to impose a penalty on Dr. Chabot. The issue of assisting a suicide in order to relieve non-somatic (non-physical) suffering remains a contentious one.

With respect to infants, in 1995, Dutch courts dealt with two separate but similar cases in which doctors had ended the lives of severely disabled infants, both of whom were in pain and were not expected to survive their first year. In each case, the doctor had acted at the explicit request of the child's parents. The courts concluded that the doctors had met the requirements of good medical practice in those cases.[52] In 2004, some doctors and the district attorney in Groningen, Netherlands, developed a protocol to identify when euthanasia of infants is appropriate. The Groningen Protocol has been ratified by the National Association of Pediatricians, and doctors who respect the protocol's requirements appear not to be prosecuted in the Netherlands, though the protocol is not an actual law.[53] The Royal Dutch Medical Association is reportedly advising that a new test be established to determine when euthanasia of a newborn is allowed. It recommends that a factor for consideration in such cases be the anguish of the parents watching their baby suffer.[54]

## 4.2 Current State of the Law

In August 1999, the Minister of Justice and the Minister of Health tabled a legislative proposal in the House of Representatives – the lower house of Parliament – legalizing euthanasia and assisted suicide as long as certain conditions are met. The bill was passed by the House of Representatives on 28 November 2000 by a vote of 104 to 50 and by the Senate on 10 April 2001 by a vote of 46 to 28.[55]

The new statutory provisions make no substantive change to the grounds on which euthanasia and assisted suicide are permitted based on the case law, but do spell out in more detail the existing criteria for due care. The physician must:

- be satisfied that the patient's request is voluntary and well considered;

- be satisfied that the patient's suffering is unbearable and that there is no prospect of improvement (not necessarily a terminal illness);
- inform the patient of his or her situation and further prognosis;
- discuss the situation with the patient and come to the joint conclusion that there is no other reasonable solution;
- consult at least one other physician with no connection to the case, who must then see the patient and state in writing that the attending physician has satisfied the criteria for due care; and
- exercise due medical care and attention in terminating the patient's life or assisting in his or her suicide.

Individuals may write an advance directive outlining the circumstances in which they would want euthanasia to be performed. Physicians must report cases to a regional review committee. That committee decides by a majority whether the criteria were respected. It refers cases where one of the criteria is not met to the Public Prosecution Service and the Health Care Inspectorate.[56]

The most controversial aspect of the legislation was a proposal that children as young as 12 be permitted to request euthanasia or assisted suicide. However, the legislation as passed follows the Netherlands' *Medical Treatment Contracts Act*, and parental consent is required for persons under the age of 16. In principle, 16- and 17-year-olds can decide for themselves, but their parents must always be involved in the discussion.

In June 2004, an article in the medical journal *The Lancet* suggested that the strict regulations governing euthanasia in the Netherlands might be loosened, in part because of a concern that they might be causing under-reporting. The situation with respect to persons with Alzheimer's disease or other non-terminal illnesses remains somewhat contentious. There has also been some discussion in the Netherlands of allowing euthanasia and/or assisted suicide for people who are simply "tired of life."[57] In 1998 (before the current law was in place), a doctor assisted an 86-year-old former senator who had no physical or psychiatric illness or disorder to die because he no longer wanted to live. At the appellate level, the doctor was found guilty of assisting a suicide since he had not respected the requirements set out in the case law, though he received no punishment because, as was reported in a January 2003 *British Medical Journal* article, "he had acted out of great concern for his patient."[58]

### 4.3 Statistics and Reviews of the System

Most cases of reported deaths by euthanasia and assisted suicide involve individuals suffering from cancer. There have been significant increases in reported deaths by euthanasia and/or assisted suicide in recent years (as high as 19% between 2009 and 2010). Though regional review committees have been examining the reasons for these increases, they have not come to any clear conclusions as to whether there has been an increase in euthanasia and/or assisted suicide or whether doctors are simply reporting more often, given that reporting had not been universal in the past. Multiple reviews and studies of the system, both official and independent, have been

undertaken in recent years.[59] Table 3 highlights some statistics that reports have provided in recent years.

**Table 3 – Annual Statistics Regarding the Netherlands' Law Relating to Euthanasia and Assisted Suicide, 2003–2011**

| Year | Reported Deaths by Euthanasia | Reported Deaths by Assisted Suicide | Reported Deaths by a Combination of Euthanasia and Assisted Suicide |
|---|---|---|---|
| 2003 | 1,626 | 148 | 41 |
| 2004 | 1,714 | 141 | 31 |
| 2005 | 1,765 | 143 | 25 |
| 2006 | 1,765 | 132 | 26 |
| 2007 | 1,923 | 167 | 30 |
| 2008 | 2,146 | 152 | 33 |
| 2009 | 2,443 | 156 | 37 |
| 2010 | 2,910 | 182 | 44 |
| 2011 | 3,446 | 196 | 53 |

Sources: Annual reports published by regional euthanasia review committees, including the following: *Annual Report 2011*, The Hague, August 2012; *Annual Report 2010*, The Hague, August 2011; *Annual Report 2009*, The Hague, May 2010; *2008 annual report*, The Hague, April 2009; *2007 annual report*, The Hague, April 2008; *2006 annual report*, Arnhem, (The Netherlands), May 2007; *2005 annual report*, Arnhem, April 2006; *2004 annual report*, Arnhem, March 2005; and *2003 annual report*, Arnhem, September 2004.

# 5 AUSTRALIA

## 5.1 THE NORTHERN TERRITORY'S RIGHTS OF THE TERMINALLY ILL BILL

In February 1995, the Chief Minister of the Northern Territory of Australia introduced a private member's bill, the Rights of the Terminally Ill Bill (1995) (NT), in the territory's Legislative Assembly. The bill was intended to provide a terminally ill person with the right to request assistance from a medically qualified person in voluntarily terminating his or her life. A Select Committee on Euthanasia was established to study the bill and report back to the Legislative Assembly. In May 1995, after more than 50 amendments had been made to the original bill, the Legislative Assembly passed the legislation by 15 votes to 10.

The bill created considerable controversy, both within Australia and internationally. There were calls for its repeal, and for the Governor-General of Australia to disallow it under the *Northern Territory (Self-Government) Act, 1978*; however, the administrator of the Northern Territory assented to the Act in June 1995, and to regulations under the Act in June 1996. These came into effect, with the Act itself, on 1 July 1996. The Northern Territory thus became the first jurisdiction in the world to legalize physician-assisted suicide and euthanasia.

Between May 1995, when the bill was passed, and July 1996, when it came into force, the Northern Territory Legislative Assembly passed further amendments to the legislation whereby the number of doctors to be involved was increased from two to

three, one of whom must be a qualified psychiatrist and another a specialist in the patient's illness. The *Rights of the Terminally Ill Act 1995* (NT) included many administrative safeguards as well as numerous references to treatment and levels of suffering "acceptable to the patient."

In an attempt to prevent the bill from becoming law, the president of the Northern Territory Branch of the Australian Medical Association, Dr. Christopher Wake, and an Aboriginal leader, Reverend Dr. Djiniyini Gondarra, challenged its validity. One of the grounds for challenging the bill was that the exercise of legislative power by the legislative assembly is constrained by an obligation to protect an inalienable "right to life" that is deeply rooted in the democratic system of government and in the common law. By a two-to-one majority, the Supreme Court of the Northern Territory upheld the legislation, stating that it need not decide whether the legislation infringed any fundamental right because, in the absence of a constitutionally enshrined Bill of Rights, that issue was "ethical, moral or political," rather than legal, in nature.

Some critics had argued that the amended bill was too cumbersome to be workable, but in late September 1996, a Darwin resident became the first person to use the new legislation successfully. As a result, controversy erupted again. The patient had suffered from prostate cancer for five years and, according to press reports, the lethal injection was triggered by a laptop computer through which the patient confirmed his wish to die. (According to a 27 July 1996 *Chicago Tribune* article, special computer software activated a syringe filled with pentobarbital sodium and a muscle relaxant. The syringe featured an intravenous line to the patient and a cable to the laptop.) Three other people used the provisions of the Act before it was soon overruled by the national Parliament.

Under Section 122 of the Australian Constitution, the Commonwealth Parliament has a plenary power to pass legislation overriding any territorial law. In September 1996, Kevin Andrews, a government backbencher, introduced a private member's bill to overturn the Northern Territory's euthanasia law. The bill, the *Euthanasia Laws Act 1997*, was passed in the House of Representatives on 9 December 1996 and in the Senate on 24 March 1997, meaning that the *Rights of the Terminally Ill Act 1995* (NT) was no longer of any force or effect.

Since 2007, senators have introduced a number of bills in the Commonwealth Senate (national level) to repeal the *Euthanasia Laws Act 1997*. To date, none of the bills have passed.[60]

## 5.2 Other Legislative Proposals

In recent years, there have been numerous legislative proposals relating to euthanasia at the state level, with all states except Queensland considering the issue. A bill introduced in New South Wales was defeated in May 2013.[61] A bill in South Australia was postponed at second reading in March 2013. In Tasmania, the premier and the leader of the Greens political party published a consultation document in February 2013 and introduced a private member's bill, the *Voluntary Assisted Dying Bill,* in September 2013. The bill failed to pass when put to a vote in

October 2013 (the vote was 11 to 13).[62] As of October 2013, none of the various legislative initiatives across the country had passed.

## 6 BELGIUM

Belgium legalized euthanasia in 2002.[63] Unlike the law in the Netherlands, the Belgian Act does not regulate assisted suicide;[64] it regulates only euthanasia, which it defines as an act of a third party that intentionally ends the life of another person at that person's request. Anyone who has reached the age of majority (18 years) or is an emancipated minor (by marriage or court order), is mentally capable and is conscious may make a request if they have an incurable condition that results in constant and unbearable physical or psychiatric suffering.[65] The legislation established conditions that must be met by both the person seeking euthanasia and the physician who performs it. The physician is required to fill out a registration form each time he or she performs euthanasia; this form is then reviewed by a commission whose role it is to determine whether the euthanasia was performed in accordance with the conditions and procedures of the legislation. If two thirds of the commission members are of the opinion that the conditions were not fulfilled, the case is referred to the public prosecutor. Individuals can make an advance directive expressing their desire to be euthanized as long as certain conditions are met when the time arrives, such as loss of consciousness by an individual. Table 4 highlights some statistics that reports have provided since the legislation came into force.

**Table 4 – Annual Statistics Concerning Belgium's *Law Relating to Euthanasia*, 2002–2011**

| Year | Reported Deaths by Euthanasia | Deaths by Euthanasia per 1,000 Deaths |
|---|---|---|
| 22 Sept. 2002–31 Dec. 2003 (approximately 15 months) | 259 | 2 |
| 2004 | 349 | 3.6 (2004–2005 average) |
| 2005 | 393 | 3.6 (2004–2005 average) |
| 2006 | 429 | 4.4 (2006–2007 average) |
| 2007 | 495 | 4.4 (2006–2007 average) |
| 2008 | 704 | 7 (2008–2009 average) |
| 2009 | 822 | 7 (2008–2009 average) |
| 2010 | 953 | 10 (2010–2011 average) |
| 2011 | 1,133 | 10 (2010–2011 average) |

Sources: Belgium, Santé publique, Sécurité de la chaîne alimentaire et Environnement, Biannual reports on the *Loi relative à la euthanasie*, 2004–2012.

A number of bills proposing to amend Belgium's euthanasia law were before the country's federal legislature as of October 2013. A few of the bills sought to expand access to euthanasia to all minors and individuals suffering from dementia. Others seek to legalize assisted suicide and to require greater consideration of palliative care alternatives to euthanasia. News reports state that legislators have agreed to pass amendments to allow minors to request euthanasia if certain conditions are met.[66]

# 7 SWITZERLAND

Article 114 of the *Swiss Penal Code* prohibits euthanasia, although the crime has a lesser sentence than other acts deemed homicide; murder carries a mandatory minimum sentence of five years' imprisonment, for example, while Article 114 provides that an individual who kills a person for compassionate reasons on the basis of that person's serious request will be fined or sentenced to a maximum term of imprisonment of three years. Assisted suicide is addressed in Article 115, which provides that someone who, for selfish reasons, incites someone to commit suicide or assists a suicide will be fined or sentenced to a maximum term of imprisonment of five years. Thus, it is implicit that assisted suicide is permitted if the person assisting the suicide does so for unselfish reasons. Since Article 115 does not explicitly regulate assisted suicide for unselfish reasons, the Penal Code does not require that a physician be the person to assist a suicide, nor does it require the involvement of any physician whatsoever, which is a significant departure from legislation in other countries where assisted suicide is permitted.[67]

Assisted suicide is also not limited to those with a terminal illness or to Swiss residents. Switzerland has become a popular destination for foreigners, predominantly Europeans, seeking assistance in committing suicide.[68] For example, on 1 March 2011, Nan Maitland, an 84-year-old British advocate for assisted suicide, went to a Swiss clinic to receive assistance in committing suicide. Ms. Maitland had arthritis but was not terminally ill and simply wanted to avoid a long decline as she got older.[69] Canadian Kathleen Carter went to Switzerland in 2010 to end her life. She suffered from spinal stenosis, a compression of the spinal cord or spinal nerve roots that was painful but not fatal. A daughter and son-in-law of Ms. Carter are plaintiffs in litigation to legalize assisted suicide in British Columbia.[70] Susan Griffiths, a Canadian with multiple system atrophy, also went to Switzerland to end her life in April 2013.

In July 2008, the Swiss government called on the Department of Justice and the federal police to prepare a report on the necessity of updating the rules on assisted suicide. That report, as well as consultations undertaken in 2009 and 2010, concentrated primarily on two options: either to provide a more detailed legislative framework to regulate assisted suicide or to prohibit organizations that provide assistance to commit suicide altogether.[71] In the end, there was no consensus on the best course of action and the Swiss Federal Council decided not to make any changes to the law.[72] Referendums in Zurich to ban assisted suicide or at least to impose a residency requirement also failed to pass.[73]

In January 2011, the European Court of Human Rights held that no violation of the *European Convention on Human Rights'* protections of private life occurred when a Swiss man was unable to obtain a lethal substance that was available only by prescription. Ernst G. Haas, who suffers from serious bipolar affective disorder, had attempted suicide twice and had been unsuccessful in getting a psychiatrist to prescribe a lethal dose of a drug for him. He had also unsuccessfully sought permission from federal and cantonal authorities to receive such a dose without a prescription and had appealed those decisions in the Swiss courts before turning to the European Court. The Court recognized his right to decide to end his own life as

protected under the right to privacy in section 8 of the Convention, but concluded that the state has no obligation to assist someone to access such a drug without a prescription. The Grand Chamber of the European Court of Human Rights refused to hear an appeal.[74]

In May 2013, the European Court of Human Rights heard another case from Switzerland. This time, the case was brought by Alda Gross, who was in her 70s when the case started and, though not ill, did not want to experience the continued decline in mental and physical health that can come with age. She had repeatedly expressed the will to die over a number of years. However, doctors were unwilling to provide a prescription for a lethal substance due to concerns that this would violate professional ethics or lead to prosecution. A split four-to-three decision by the Court distinguished the question at issue from that in the Haas case. The Court in the Gross case concluded that the lack of clear, legally binding guidelines in Switzerland resulted in a lack of clarity as to the extent of Gross's right to obtain a lethal drug prescription to commit suicide. As a result, this was a violation of the right to privacy under section 8 of the *European Convention on Human Rights*. The Court left it up to the Swiss authorities to develop the necessary guidelines to remedy the violation of section 8.[75]

## 8 FRANCE

In France, Health Minister Philippe Douste-Blazy reopened the euthanasia debate in an interview published in the newspaper *Le Figaro* in August 2004. He called for a law that would ensure the right to die in dignity, but ruled out the legalization of euthanasia. He suggested that a draft law defining the legal options for terminally ill patients would be placed before the National Assembly before the end of the year. In April 2005, amendments to France's *Public Health Code* relating to end-of-life care were approved by the French Senate.[76] The legislation does not address either assisted suicide or euthanasia; rather, it addresses the cessation of treatment and the prescribing of pain medication in circumstances where such action might shorten a patient's life.

In March 2008, a court in Dijon turned down a request by Chantal Sébire, who was suffering from a rare form of cancer, to take a lethal dose of barbiturates under the supervision of a doctor. According to the court, such a request was not permitted under the 2005 legislation. Ms. Sébire was found dead in her apartment soon after the decision, apparently after taking barbiturates. No one has been charged for involvement in her death.[77]

A few years ago, the French Senate's Committee on Social Affairs studied three similar bills proposed by three different parties on the topic of medical assistance to commit suicide, from which it proposed the development of a single bill. However, on 25 January 2011, the Senate rejected the proposal.[78]

In the 2012 elections, one of presidential candidate François Hollande's campaign promises was to introduce legislation on the topic of assisted dying. After being elected, President Hollande commissioned a report on the topic. The report, published in December 2012, notes that French law is silent with respect to assisted

suicide, neither making it an offence nor regulating the practice of assisted suicide.[79] France's national ethics committee also published its opinion on the topic in July 2013 at the request of the president. The committee could not come to a unanimous conclusion on recommendations with respect to euthanasia or assisted suicide, with the majority recommending no changes to the status quo.[80] Nonetheless, media reports state that the president plans to introduce legislation before the end of 2013, though the content of such a law remains to be seen.

## 9 LUXEMBOURG

Luxembourg is the most recent country to have passed a law legalizing euthanasia and assisted suicide (in 2008). Conditions similar to those in the Netherlands are set out in the legislation, the *Loi du 16 mars 2009 sur l'euthanasie et l'assistance au suicide*.[81] There are some differences, including the age at which a person may request euthanasia. In Luxembourg, an individual must be at least 18, the age of majority.

The Act was passed in December 2008 and came into force in March 2009, though not without some controversy.[82] Luxembourg is a constitutional monarchy, and the country's monarch, the Grand Duke Henri, planned to veto the law for reasons of conscience as a Catholic. In response, Parliament amended the Constitution to reduce the Grand Duke's powers from approving laws to simply signing them.[83]

One incident of euthanasia was declared in 2009, four were declared in 2010, five were declared in 2011 and nine were declared in 2012.[84]

## 10 COLOMBIA

In Colombia, euthanasia is a criminal offence, but the maximum sentence for it is less than that for homicide. In a 1997 case, an individual initiated a constitutional challenge to this sentencing distinction based on the rights to life and equality. One argument was that individuals convicted of euthanasia should not benefit from a lower maximum sentence. Colombia's highest court, the Constitutional Court, rejected the constitutional challenge, concluding that a doctor could not be prosecuted for euthanasia for assisting an individual in ending his or her life where the person had a terminal illness and had consented. Nonetheless, "mercy killing" remains a crime in Colombia if those conditions are not met.[85] The judgment also urged legislative action in this area, but it seems that legislative efforts have not been successful to date as the issue is quite contentious in the predominantly Catholic country.[86]

## NOTES

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2. The law in a number of countries is silent with respect to assisted suicide, meaning that the practice is technically legal in those jurisdictions (e.g., Germany). Countries in such situations are not discussed in this paper, as the focus here is on legislative initiatives and court rulings. Not all countries where bills have been proposed but have not yet passed, such as New Zealand, are discussed. In addition, the policies of medical associations that regulate professions such as medical practice and nursing have not been examined. Finally, the topic of withholding or withdrawing treatment appears to be less controversial in Canada than euthanasia or assisted suicide, although there are some outstanding challenges to the application of the law in Canada. Withholding or withdrawing treatment is contentious in some other countries. However, that issue is beyond the scope of this paper.

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# APPENDIX A – CURRENT LEGAL STATUS OF EUTHANASIA AND ASSISTED SUICIDE IN VARIOUS JURISDICTIONS

**Table A.1 – Current Legal Status of Euthanasia and Assisted Suicide in Various Jurisdictions**

| Country | Euthanasia | Assisted Suicide |
|---|---|---|
| Canada | Illegal. | Illegal. |
| United States | Illegal in all states. | Legal only in Oregon, Washington State and Vermont if certain conditions are met. Where the patient is mentally competent and terminally ill, Montana doctors may use a consent defence if charged with assisting a suicide. |
| United Kingdom | Illegal. | Illegal, but a person who assists a suicide will not be prosecuted in England, Wales or Northern Ireland if certain conditions are met. No such policy appears to exist in Scotland. |
| Netherlands | Legal if certain conditions are met. | Legal if certain conditions are met. |
| Australia | Illegal in all states and territories. | Illegal in all states and territories. |
| Belgium | Legal if certain conditions are met. | Not regulated (not a criminal offence but not permitted explicitly in law either). |
| Switzerland | Illegal. | Not regulated where the assistance is for "unselfish reasons" (not a criminal offence but not permitted explicitly in law either). No requirement for a physician to be involved or for the person being assisted to be a resident. |
| France | Illegal. | Illegal. |
| Luxembourg | Legal if certain conditions are met. | Legal if certain conditions are met. |
| Colombia | The Constitutional Court found that a doctor could not be prosecuted after committing euthanasia as the patient in question had a terminal illness and had consented. No legislation on this topic has passed, and if those two conditions are not met, euthanasia remains a crime. | Current legal status unknown. |