"A Perfection of Means, and Confusion of Aims": Finding the Essence of Autonomy in Assisted Death Laws

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“A perfection of means, and confusion of aims, seems to be our main problem.”

Albert Einstein

PART I. INTRODUCTION

Assisted death, that is, death brought about with the assistance of a third party at the individual’s voluntary request, continues to be one of the most controversial issues of our time and seemingly intractable.

Assisted death is an unfathomably complex tangle of moral, ethical, social, medical, economic, political and legal crises. The moral enters because the choice for death over continued life depends on the accumulated values and beliefs of the individual, alongside the unique duties of the state in protecting its citizens. The ethical enters because it searches for universal justifications that permit or disallow the practice. The social enters because it scrutinizes the motivations of the individual wishing to die, as well as the potential impact of assisted death practices on society at large and on those who are particularly vulnerable, such as the elderly and those with disabilities. The medical enters because it sits at the frontline in partnership with the patient, and must address the question of what to do when healing is not perceivably possible. The economic enters because it questions access and adequacy of medical care, as well as the offsetting of state health care costs to the individual (and family). The political enters because it is the forum for public engagement, seeking to funnel pluralistic ideas into a monistic formula for conduct. The legal enters because the practice of ending or helping to end the life of another human being, for all of the foregoing reasons, demands definition and regulation.

In the last ten years, The Netherlands, Belgium and Luxembourg, and the states of Oregon and Washington in the United States, have passed express legislation to permit assisted death (“AD”) by doctors. Broadly speaking, the AD schemes in The Netherlands, Belgium and Luxembourg employ a similar regulatory framework, allowing both AD by direct lethal injection or facilitating access to a lethal medical prescription for the purposes of self-administration. Similarly, the states of Oregon and Washington have comparable AD schemes; however, these schemes are restricted to allowing physicians to prescribe lethal drugs for self-administration. Furthermore, the American schemes are similar to the practice of AD in Switzerland, where doctors are also limited to prescribing lethal drugs for self-administration. Switzerland does not have express legislation to regulate AD, instead experiencing an evolution of AD practice facilitated by a particular penal code provision that criminalizes AD only when it is done for “unselfish” reasons.¹
Although the regulatory design of these two basic models — the European schemes and the American plus Switzerland schemes — are similar, the ethical underpinnings or political/legal evolution of these models are not equally analogous. Intriguingly, while there is some uniformity in the AD laws, notably with respect to “safeguards” put in place to help ensure that AD is only provided to certain individuals, the resolutions captured by these laws are actually solutions tailored to unique jurisdictional perspectives on the conflicts, principles and policy concerns at play. These perspectives in turn have been framed not only by moral and philosophical considerations, but also by the reality of who must shoulder the practical responsibility for carrying out AD practices. There are also cultural expressions and memories, and the nature of the legislative reform process specific to each jurisdiction, which are vital to the perceived legitimacy of the law.

The heterogeneous foundations and meanings for the different AD schemes in each jurisdiction are critical to identifying how far AD practices should or may be interpreted and expanded. As will be discussed, what appear to be the broader AD schemes, *i.e.*, the schemes that provide the more expansive relief (*e.g.*, lethal injection) are grounded in narrower ethical justifications, such as the relief of suffering, whereas the AD schemes with the apparently more limited relief (*e.g.*, obtaining a prescription drug for self-administration) are premised on the more expansive ethical justification of respect for autonomy: the individual’s right to self-govern and self-determine, freely in accord with a self-chosen plan. Thus the respective AD schemes seem to possess internal balances which could serve to limit their evolution beyond that originally contemplated by the lawmakers as well as by the majority of organizations in favour of AD.

When taken together however, justifications for establishing the most extreme vision of AD — *assisted death for anyone for any reason* — are revealed and early signs of such a convergence of thought are emerging. Even the principle of autonomy, and its counter-part, self-determination, did not start out as the most significant elements in the emergence of the first European laws to legalize AD. However, they have since been glossed to become the most identifiable justifications for AD in the current global debate. The objective of this paper is to begin to explore the question of how far can or should assisted death practices be expanded based on jurisdictions that have to date legalized AD by
assessing the role that the concept of autonomy has played in the development of these laws.

While the two most commonly asserted justifications for “limits” to autonomy-based AD are the concepts of the “sanctity of life” and the “slippery slope”, these concepts are arguably of limited utility in the AD debate under its current formulation. They have been frequently advanced or attacked as sweeping conceptual road blocks, frequently divorced from the specific legal system or process of the state considering legislative reform. Thus, the aim of this discussion is to go beyond a simple enumeration of reasons why a state might choose to not legalize AD. Rather, the aim of this discussion is to be able to identify the ways in which states have thus far constructed the notion of “autonomy”, in the context of assisted death in order to begin to understand where its limits might legitimately or logically lie.

This discussion is solely concerned with the situation whereby a competent adult voluntarily requests another person(s) to provide assistance in ending life. The term AD in this discussion does not include other life-shortening medical practices that, to a greater or lesser extent, are now considered to be within the bounds of “normal” medical practice and include: withholding or withdrawing of life-sustaining treatment; medically-indicated pain relief in doses that might hasten death; or palliative/terminal sedation. That said, these practices will be referred to from time to time, for example, when describing the scope of a particular AD scheme or the particular safeguards introduced to prevent certain abuses.

Accordingly, Part II (and the majority of this paper) provides a comprehensive and comparative examination of the AD laws in the jurisdictions that have promulgated express legislation to regulate assisted death — The Netherlands, Belgium, Luxembourg, Oregon and Washington as well as Switzerland, which does not currently have express legislation but does have a long legal history concerning the practice of AD. This approach has been taken in order to provide the reader with information cogent to the evolution of the AD laws that can enable the reader throughout the discussion, to formulate his or her own opinions with respect to the essence of these laws and the different principles and policies at play in their development and legal manifestation.

Thus, for each jurisdiction, the following aspects of the AD laws are presented:

- the national debates and discussion providing the foundations and underpinnings of the law;
- the framework of the law, including the due care criteria that must be satisfied to qualify for access to AD (substantive criteria) and the safeguards in place to help prevent abuses from taking place (procedural criteria); and
- recent statistics and trends in the law’s application in order to gain further perspectives on the possible evolutionary directions of AD regulation and practices.

The concept of autonomy is explored throughout and offers the author’s reflection on the extent to which this principle has been applied or incorporated into the respective laws as well as to identify how it has been constrained — not simply by enumerating competing principles (such as a state interest in protecting vulnerable persons) or limiting factors (such as a requirement of “unbearable suffering”, for example) — but by attempting to understand how these particular counter-points have themselves come to be identified and incorporated by each jurisdiction. That is, the discussion explores how each jurisdiction has framed the assisted death conflict and the limits to autonomy that arise from each unique construction. Of particular note here is the varying treatment and relevance of the “suffering” requirement and the interplay between medicine, suffering and autonomy (self-determination) particularly in terms of how these requirements have been translated into the laws and in terms of how the laws have come to be been justified.

Part III of the discussion is a summary of the construction and subsequent limits to autonomy from the perspective of how the conflict has been framed by a particular jurisdiction (internal policy constraints). This summary attempts to clarify the specific role that autonomy plays, relative to other competing principles inherent in the respective AD laws, in order to test the durability of the autonomy principle in advancing the assisted death movement.

Part IV of the paper concludes by offering a preliminary response to questions of how far AD practices should be expanded through the logic of autonomy; and, if there ought to be limits to autonomy in driving the assisted death agenda, on what might they be premised? By offering a perspective on autonomy based on limits arising from its practical application, the author hopes to provide a form of
comparator for conceptions of autonomy arising from other disciplines like philosophy and ethics — disciplines that will arguably become of increasing importance as we redefine ourselves in the modern technological and secular age.

The author also hopes to re-introduce a largely untapped yet critical perspective on the assisted death debate: that assisted death should not be “treated out of context”. Current practical limits to autonomy provide insight into potential pathways for the role that it can or should play in advancing assisted death. Obtaining and disseminating this kind of insight is critical to ensuring that the further evolution of assisted death law is not reduced to attempts to mimic or streamline the importation of assisted death regulations from foreign jurisdictions, but rather is a result of enlightened discussion that considers the unique personality, qualities and obligations of individual states not the least of which includes the processes that lead to legal reform. After all, if ending one’s own life can be said to be the ultimate expression of autonomy, and if autonomy can be said to be the ultimate expression of a secular society, then the legitimacy of any “right” to assisted death surely depends on the legitimacy of the processes by which that particular expression of autonomy has come to be defined and regulated.

PART II. ASSISTED DEATH LAWS

A. DEFINITIONS

Prior to commencing the jurisdictional review, it is necessary to first define some of the AD terminology utilized throughout this discussion:

Assisted Suicide (“AS”): Any action taken to encourage or help someone commit suicide (end their own life). It usually involves providing a lethal medication (for example, a high dose of an oral barbiturate) or sometimes other means (for example, helium gas) to the person who plans to end their life. The final act (for example the swallowing of pills or the inhaling of the gas) must be taken by the individual committing suicide.

Physician Assisted Suicide (“PAS”): PAS is a form of AS. PAS involves a physician intentionally helping his or her patient to end their life at the patient’s express and voluntary request by providing or prescribing the lethal medication to the patient. Again, the final step (such as swallowing the pills or opening the intravenous valve) must be taken by the person who is ending their life. Note: The physician may or may not be present when the patient self-administers the lethal medication. In North America, particularly where PAS is legal as is the case in Washington and Oregon, the term “physician assisted death” or “PAD” is also utilized.

Euthanasia: The direct administration (usually by injection) of a lethal medication (such as a high dose of barbiturate) by a physician to intentionally end the life of a patient at the patient’s express and voluntary request. This definition of euthanasia, one which incorporates the voluntariness of the individual, is based on the Dutch definition of euthanasia and is also described by the Dutch as “euthanasia proper”. The Dutch definition of euthanasia is understood to be the current standard in international literature. The Dutch formulation of “euthanasia” tends to be qualified as “voluntary active” euthanasia in United Kingdom and North American discussions, which from the Dutch perspective, would be an exercise in redundancy.

Assisted Death (“AD”): The author uses the term “assisted death” throughout this paper to broadly describe death brought about with the assistance of a third party at the individual’s express and voluntary request. Therefore, for the purposes of this discussion, AD includes assisted suicide, physician assisted suicide as well as euthanasia.

These particular terms and definitions have been chosen because they are reflective of the terminology applied in much (though admittedly not all) of the AD literature to date as well as reflective of the language utilized in certain AD legislation and medical guidelines. Additionally, while commentators from a North American or German perspective may at first have some difficulty with the terminology, in particular the term, “euthanasia”, it needs to be pointed out that for others, like the Dutch, the term does not have a similar provocative effect. In light of the lengthy experience of the Dutch in evolving AD as a regulated medical practice and in consideration of the fact that the Dutch have been establishing benchmarks for global reflection, the word “euthanasia” has been retained in this discussion. Likewise, the use of the word “suicide” in the phrase “physician assisted suicide” and more particularly, the acronym “PAS” have also been utilized in order to promote clarity in the discussion as opposed to inflame Western perspectives.

While these definitions are relevant to the full discussion herein, it must also be pointed out that there are some variations to these definitions
dependent on the jurisdiction at issue. These definitional variations are drawn to the attention of the reader as required throughout this paper.

B. JURISDICTIONS

As already described, this section undertakes a comprehensive comparative examination of the AD laws in jurisdictions that have promulgated express legislation to regulated assisted death.

The order of this examination is by jurisdiction implementing similar regulatory schemes and then chronologically. Thus this section begins with a review of The Netherlands, Belgium and Luxembourg, followed by Switzerland and then Oregon and Washington. It should be noted from the outset that the Oregon and Washington AD laws are very similar. Thus the review of assisted death in Oregon provides more detail on the legal framework, while the review of Washington tends to focus more on the aspects of the assisted death scheme of particular relevance to Washington.

1. The Netherlands

a. Historic Overview

In The Netherlands, the term “euthanasia” means the termination of life upon request. In practice, however, the term is sometimes used to indicate both “euthanasia proper” (the termination of life upon request by a medical doctor through direct injection) and PAS (the provision of lethal medication to the patient for self-administration upon request). The reason for this definitional flexibility is that Dutch law does not draw any distinction between the two practices in terms of how they are legally justified. That is, both practices will be considered legal if carried out by a doctor who has acted on a patient’s express request and has adhered to the requirements of due care (discussed further below).

Thus, for the purposes of the following review of Netherlands law, the term “euthanasia” is used to reflect Dutch practice, indicating both euthanasia proper and physician assisted suicide. The terms physician assisted suicide and assisted suicide, however, are used independently from time to time when it is necessary to specifically distinguish these practices from euthanasia as earlier defined.

In April 2002, with the passing of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act (“the Dutch Law of 2002”), The Netherlands became the first country to formally effect through statute, the practice of euthanasia.

Prior to 2002, however, The Netherlands Supreme Court had already effectively legalized euthanasia practice in the 1984 Schoonheim case, where the Supreme Court held that notwithstanding the absolute prohibition of the practice in the Dutch Penal Code, euthanasia by a physician might be legally justifiable on the basis of “necessity” or “overmacht” (discussed in more detail below). Furthermore, even before the clear articulation of the necessity defence by the Supreme Court in Schoonheim, many physicians were not being prosecuted for euthanasia practice on the basis that they had met the requirements of “careful practice” — requirements that had been developed, refined and articulated over the course of two decades through Dutch courts, prosecutorial practices and professional guidelines such as those issued by the Royal Dutch Medical Association (“KNMG”).

By the 1990s, an intricate pre-statutory regulatory scheme had emerged. For example, a non-prosecution agreement entered into by the KNMG’s executive board and the Dutch Ministry of Justice set out due care criteria and reporting requirements to be followed by physicians who were providing euthanasia to their patients. Additionally, to encourage doctor reporting of these “non-natural” deaths, the Dutch government established five Regional Review Committees to act as a type of “buffer” between the physician and the public prosecutor. These committees were tasked with assessing whether a case of euthanasia was in compliance with the due care requirements. The public prosecutor in turn would take the committee reports into account when making a determination on whether to proceed with a criminal investigation and prosecution. A project entitled, Support and Consultation in The Netherlands (“SCEN”) was also implemented throughout The Netherlands to train physicians to act as consultants to other physicians considering euthanasia requests from their patients. Under SCEN, consultant physicians provide consulting physicians with information and advice and assist in ascertaining whether the requirements of careful practice are being met.

The Dutch assisted death scheme was able to evolve despite clear prohibitions on the practice in the Dutch Penal Code. Prior to 2002, the provisions of the Dutch Penal Code relevant to euthanasia and assisted suicide in The Netherlands were as follows:

- Article 289: Anyone who deliberately and wilfully takes another person’s life is guilty
of murder. The maximum sentence is life imprisonment.

- Article 293: It is an offence for anyone to take the life of any person at his express and serious request. The maximum sentence is twelve years’ imprisonment.
- Article 294: He who deliberately incites another to commit suicide, assists him to do so, or provides him with the means of doing so, commits an offence if the suicide takes place. The maximum sentence is three years’ imprisonment.
- Article 40: It is a defence to a criminal charge if the accused was forced by overmacht [circumstances beyond one’s control] to commit an offence.28

Therefore, notwithstanding the clear prohibition of euthanasia and assisted suicide in Articles 293 and 294, Article 40 provided the court in Schoonheim with the opportunity to expressly permit the practices of euthanasia and PAS under specific circumstances. As described by Griffiths, Weyers and Adams:

Since 1923 this provision had been interpreted to include the defence that the act took place in a situation of necessity in which the actor made a justifiable choice between two conflicting duties. Based on this existing doctrine, the Supreme Court held in Schoonheim that a doctor, confronted by the request of a patient who is unbearably and hopelessly suffering, can be regarded as caught in a situation of conflict of duties. On the one hand, there is a duty to respect life, as reflected in articles 293 and 294 of the Penal Code. On the other hand, there is the doctor’s duty to relieve suffering. If in such situation of conflict of duties, the doctor chooses a course of action that, considering the norms of medical ethics, is ‘objectively’ justifiable, he is not guilty of an offence ... 29

Hence, in The Netherlands, euthanasia developed into a permissible course of action if the physician experienced a conflict of duties — the duty to respect life and the duty to relieve suffering. It would appear, in this formulation that the duty to “respect life” is also a duty to “protect life” otherwise the conflict as articulated, would be less perceptible. Under these circumstances, the physician must, out of necessity, make a choice and the choice must be objectively justifiable. Thus, it is the physician’s conflict of duties that “forms the basis of the justification of necessity” and which is codified in the Dutch Law of 2002.30

Accordingly, the legality of euthanasia in The Netherlands is grounded in the duties that a physician has to his or her patient.31 On its face, this policy foundation functions as an important limit on assisted death practices that do not involve a similar conflict of professional duties.32 Moreover, the legitimacy of the physician’s assistance in dying that arises from this formulation of professional duty and competence also necessitates that the type of suffering that can be properly relieved by a doctor is suffering arising out of a medically classifiable disorder — physical or psychiatric.

b. Legislative Framework

The Dutch Law of 2002 is for the most part, a codification of the rules of careful practice developed over the years and, in principle, euthanasia remains punishable under Articles 293 and 294 of the Dutch Penal Code. The Dutch Law of 2002, however, amends these articles by providing physician immunity from criminal liability when a physician has complied with the statutory due care criteria and the reporting requirements pursuant to the Law of 2002.33

i. Due Care Requirements

Under Article 2(1) of the Dutch Law of 2002, in order for the attending physician to be exempt from criminal liability when he or she “terminates a life” (i.e., euthanasia) or “assists in a suicide” (i.e., PAS) of a patient, the physician must meet the requirements of due care, meaning that the physician:

a. holds the conviction that the request by the patient was voluntary and well considered;
b. holds the conviction that the patient’s suffering was lasting and unbearable;
c. has informed the patient about the situation he was in and about his prospects;
d. and the patient hold the conviction that there was no other reasonable solution for the situation he was in;
e. has consulted at least one other, independent physician who has seen the patient and has given his written opinion on the requirements of due care, referred to in parts a – d; and
f. has terminated a life or assisted in a suicide with due care.
The due care requirements are generally understood as being comprised of both “substantive” and “procedural” criteria despite the fact that the legislator failed to make this distinction. Substantive criteria are concerned with the conditions that “qualify the patient as a candidate”, i.e., “the patient’s request, the patient’s suffering and the doctor-patient relationship”. Therefore the substantive criteria include: voluntariness, competency and a free and informed request; that it is a medical measure of last resort because the suffering has become unbearable; and there are no other reasonable solutions for improvement (these latter two criteria discussed further below). With respect to the doctor-patient relationship, while the legislative provisions do not expressly require the attending physician to have a medical treatment history/relationship with the patient, the Regional Review Committees have identified that there must be a doctor-patient relationship that will allow the doctor to form a judgment concerning the requirements of due care.

The procedural safeguards on the other hand are “mechanisms designed to ensure that the substantive criteria are in fact satisfied”. Thus the procedural criteria include consultation with an independent consultant and that the termination of life or assisted suicide be carried out with due care i.e., in a professionally responsible manner with appropriate attention to the patient. A “professionally responsible manner” has been interpreted to include: use of the appropriate method, substance and dosage as recommended by professional guidelines; that the physician stay with the patient until death occurs, or, in the case of PAS, that the physician hand the euthanatics to the patient and remain until the patient is pronounced dead in case complications arise which might then indicate that euthanasia be administered.

It should be pointed out that the lines between substantive (qualification as a candidate for AD) and procedural due care requirements (safeguards in place to make sure patients are indeed qualified) are not always entirely clear. For example, while The Netherlands appears to position the physician-patient relationship within that which qualifies a patient (conceptually tying into the physician conflict and necessity defence), other jurisdictions, as will be seen, position the physician-patient relationship more towards the procedural due care requirements, i.e., in order to ensure that a patient’s request is voluntary for example.

With respect to patients who are minors, the Dutch Law of 2002 allows physicians to provide euthanasia to minors as young as 12 provided they are “deemed to have a reasonable understanding of his interests”. For a minor between the ages of 16 and 18, in addition to having a reasonable understanding of his or her interests, a physician may grant a request for euthanasia provided that the patient’s parents or guardian have been “involved in the decision-making process” but they don’t necessarily have to agree with the decision. With respect to minors between the age of 12 and 16 however, the parents or guardian must agree with the request for euthanasia.

There is no express requirement that the patient be a Dutch citizen or resident, relying instead on the doctor-patient relationship to restrict euthanasia to appropriate candidates.

ii. Reporting and Review

The Dutch Law of 2002, establishes reporting requirements through amendments to the Burial and Cremation Law. When death is the result of a termination of life on request (euthanasia proper) or assisted suicide, the attending physician must, in appropriate form, notify and provide a detailed written report to the relevant municipal pathologist showing that he or she has complied with the due care criteria. The pathologist in turn is required to conduct an examination of the deceased patient, determine cause of death, substances used, ascertain completeness of the physician’s report, compile findings, reports, advance directives (if any), and notify the relevant Regional Review Committee (“RRC”) submitting all required and relevant documents.

The five RRCs hold the major responsibility for reviewing euthanasia cases. Each RRC must be comprised of an uneven number of members, and at minimum must include a lawyer, a physician and an ethics or philosophy expert. An RRC determines whether a doctor has conducted “careful” practice by acting in accordance with the statutory due care criteria and is to report its findings, with reasons, back to the doctor.

The most significant change from the pre-statutory rules is the expanded authority of the RRCs. Prior to the Dutch Law of 2002, the RRCs simply played an advisory role by providing their opinion to the public prosecutor as to whether the due care requirements had been met in a given case. Under the Dutch Law of 2002, however, the initial review by the RRC of a reported case of euthanasia lies entirely outside the criminal law system. It is only when an RRC has determined that the due care requirements have not been met, that the public prosecutor is notified. The
public prosecutor then has the authority to commence a criminal investigation. Thus, if the RRC forms the opinion that the due care criteria have been met in a particular case, the case will not be reviewed any further.

The RRCs are required to issue a joint annual report which includes information related to the number of reported cases of termination of life on request and assisted suicide, the nature of the cases and the opinions and considerations involved.52 The RRCs are the principal source of information for ongoing public debate and awareness as well as for the ongoing transparency in the development of Dutch euthanasia law.53

c. Compassion and Suffering, Autonomy and Self-Determination

As described above, the type of suffering that can be relieved by a physician under the Dutch Law of 2002 is suffering that arises out of any medically classifiable disease or condition.54 That said, the medical condition does not have to be considered “terminal” or in a terminal phase. So, for example, a condition such as multiple sclerosis would qualify for assistance, provided the suffering is unbearable, lasting and with no other reasonable solution. Furthermore, requisite suffering can arise from a somatic (physical) or non-somatic (non-physical) disease or condition such as a psychiatric condition.55 Justifiable suffering can also arise as the result of a combination of conditions that overwhelm the patient to the extent that suffering becomes unbearable.56 Psychiatric patients or patients with early stage dementia, provided they are competent and have made a voluntary request, can receive assistance with suicide as long as the physician proceeds with great caution.57 It should be pointed out that in practice, however, there exists an assumption that physicians are only permitted to provide PAS (and not euthanasia) in cases of non-somatically based medical disorders,58 notwithstanding the lack of legal distinction between the justifiability of euthanasia and PAS.

Prior to and pursuant to the Dutch Law of 2002, the requisite suffering must be both unbearable and lasting, with no other reasonable solution.59 The notion of assessing unbearable suffering poses practical difficulties as suffering is both a highly subjective experience and potentially prospective or anticipatory in nature — for example, when it takes the form of fear of a loss of dignity or fear of increasing physical debilitation and dependency. While the acceptance of non-somatic suffering might resolve some of the subjectivity dilemma, it does not resolve the dilemma with respect to anticipatory suffering which can be the case where the individual has been diagnosed with a progressively debilitating disease such as multiple sclerosis, amyotrophic lateral sclerosis, Parkinsons Disease or Alzheimers at its beginning stages — when suffering may not as yet have become “unbearable”. Another situation that raises a similar conundrum is that of a patient who has made a request for euthanasia in an advance statement but is currently in a coma or suffering from dementia. The patient at that point is arguably not suffering unbearably if at all because of the apparent lack of awareness of their physical deterioration.60

With respect to the general difficulty in assessing suffering on account of its subjective nature, the RRCs have resolved the dilemma by identifying that unbearable suffering is to be assessed objectively — it must be understandable or “palpable” to a physician.61 With respect to anticipatory suffering, “unbearable” is again qualified by what is “palpable” to the physician.62 The RRCs and prosecutorial guidelines have come to identify that requisite grounds of suffering are not only comprised of pain, but also include “fear of future suffering”63 related to personal deterioration, immobility, dependency, suffocation and other circumstances that “increase the prospects of not being able to die in a dignified manner”.64

With respect to the suffering of an unconscious or unaware patient, the Dutch Law of 2002 has addressed this directly, expressly allowing a physician to provide euthanasia to an incompetent patient (“no longer capable of expressing his will”) pursuant to an advance written statement, so long as it was made by the patient when the patient was still competent (“deemed to have a reasonable understanding of his interests”).55 The physician is still obligated to comply with all due care requirements in this circumstance.66 In sum, competency does not have to temporally coincide with suffering, and suffering does not actually have to manifest, keeping in mind that a medical condition is always required.

The requirement that suffering be “lasting” and “without a reasonable solution” has posed the least interpretive difficulty. The RRCs have interpreted this requirement to mean that the condition causing the suffering is incurable and that “there is no realistic prospect of alleviating the symptoms”.67 In determining whether symptoms can be “realistically” relieved, any improvements that might be achieved by treatment are to be balanced against the burden that such treatment might place on the patient.68 Thus, symptom relief is to be assessed from the patient’s perspective.

This balancing of available treatment options is also in keeping with and perhaps also extended by the legal principle that a patient always retains the right to refuse treatment. Thus euthanasia will not be denied if the patient who is suffering unbearably69 refuses treatment that could alleviate his or her suffering, provided that the refusal is “reasonable” or “acceptable” in the
circumstances. As expressly required by the Dutch Law of 2002, a physician must discuss the patient’s situation and prospects with the patient but whether there exists a solution for the patient’s situation is again, dependent upon the patient’s “conviction”, not the doctor’s, as to what is reasonable.

The doctor-centered approach that underlies the justification for the Dutch practice of euthanasia and PAS reflects how the notion of autonomy is not a central value to AD practice either as developed by the courts or indeed under the Dutch Law of 2002 which makes absolutely no mention of autonomy or self-determination. Again, the codification of euthanasia practice in the Dutch Law of 2002 stems from an acknowledgment that the physician must necessarily make a choice — a choice that will have to be justified — if faced with a conflict of duties. Self-determination is not the grounding principle underlying legalization; it is only a “precondition for the doctor’s behaviour, in the sense that relief of suffering in such a drastic way is usually done at the explicit and well-considered request of the patient”. Thus, the scope of assisted death practice based on the autonomy principle in The Netherlands AD law can be located where a request for death intersects with the doctor’s conflicting duties and might be conceptualized as follows:

Figure 1: AD Advanced through Conflicting Duties of Physician

That said, this foundational formulation (i.e., that a physician may be justified to terminate the life of a patient on the basis of “necessity”) allows the scope of the medical choice made by the physician to be interpreted more broadly and thus, in turn, allows for the practice of both euthanasia and PAS. And, notwithstanding the medical professional judgment filter that such a foundation imposes, it may also potentially increase the scope of AD practice to cases of suffering that are not clearly linked to a specific enumerated medical or psychiatric condition because of the reliance on individual physicians’ interpretations of concepts of “disease” and “justifiable” suffering.

Thus, as further contemplated by the Chairman of the Royal Dutch Medical Association in 2000:

As the criterion of unbearable and hopeless suffering is extended, the request of the patient becomes the central issue and the medical professional judgment disappears to the background. Such a route leads ultimately to self-determination, as the NVVE [Dutch Voluntary Euthanasia Society] calls it ... This differs from our ideas about how to deal with death ... and the role doctors play.

Not long after this statement, however, the Dutch Supreme Court in 2002, ruled on the case of Dr. Sutorius who had provided euthanasia to his patient, 86-year-old former member of Dutch senate, Edward Brongersma. Although Mr. Brongersma had a number of age-related conditions such as incontinence and loss of balance, the Supreme Court found that Mr. Brongersma’s suffering did not arise primarily out of a medically classifiable disease or disorder, but rather because his life had become “meaningless”. In other words, his suffering was primarily existential. According to the Supreme Court, if a doctor provides euthanasia in this type of situation, the doctor will be acting outside the scope of his professional competence. The court did not, however, impose any punishment on Dr. Sutorius.

Notwithstanding the position taken by the Supreme Court in the 2002 Brongersma case, the apparent exclusion of euthanasia for emotional, existential or life-fatigue suffering exists without full professional consensus in The Netherlands and tensions continue to expand.

It is important to underscore that the medical policy behind the statutory legalization of euthanasia in The Netherlands is not expressly acknowledged in the Dutch Law of 2002. Even so, the Dutch Law of 2002 (as is the case with all the AD laws under review in this paper) does not provide patients with an absolute right to assisted death; physicians are not under a duty to provide euthanasia — they can and do refuse. If they refuse, however, physicians appear to be under an obligation to refer their patient to another doctor. Furthermore, the KNMG has from time to time indicated that it believes euthanasia should indeed be available to all patients.

Finally, it ought to be pointed out that in The Netherlands, a national health insurance scheme provides broad and extensive coverage to all Dutch citizens. National health insurance is “regarded by
the Dutch as the cornerstone of their euthanasia policy\textsuperscript{79}, meaning that for the Dutch, euthanasia is perceived as a measure of last resort.

d. Statistics and Trends

According to the RRC 2009 Annual Report there were 2636 AD cases reported from January 1, 2009 to December 31, 2009. This number represents an increase of 13.1% from 2008, where 2331 cases were reported.\textsuperscript{80} According to the RRC, since 2006, notifications have been increasing by approximately 10% every year\textsuperscript{81} and the trend has been apparent since 2003.\textsuperscript{82} It is unclear whether the increase is an indicator of increased physician willingness to notify or whether there has been an increase in euthanasia numbers overall.\textsuperscript{83} An evaluation has been recently commissioned by the Dutch Health Ministry to determine the actual number of cases of euthanasia and the causes of the increase.\textsuperscript{84}

Of the 2,636 reported cases in 2009, 2,443 were euthanasia, 156 were PAS and 37 were a combination of both.\textsuperscript{85} The majority of reported cases involved the “classic” category of cases, that is, cancer (2,153).\textsuperscript{86} Other conditions involved: cardiovascular disease (54); neurological disorders (131); other conditions (168); and a combination of conditions (130). In the majority of cases (2,117), patients died at home.\textsuperscript{87} Of the 2,636 cases reported in 2009, the RRC only found nine cases where the physician had not acted with due care.\textsuperscript{88}

In recent years, patient advocates and organizations (as well as supporters of the 2002 legislation) see the self-determination principle as the de facto justification underlying the legalization of euthanasia and PAS in The Netherlands, as opposed to only a pre-condition to be met before assisted death can be contemplated as a medical option. On the basis that self-determination is the justification for the practice of AD, these groups are seeking expansion of the practices beyond medically-classifiable suffering, arguing that “respect for life” includes not just protecting life but also avoiding an “undignified” death.\textsuperscript{89}

This evidences a significant evolution in thinking from a justification of AD based on a physician’s conflicting duties (the duty to respect life versus the duty to relieve suffering) to justification of AD based on the merging of these duties provoked by a re-conceptualization of respect for life not through the physician’s medical lens but rather through the patient’s dignity lens — a much more individual and subjective viewpoint. This perspective sets the foundation for both a potential expansion in the scope of the physician’s obligations to the patient, as well as for the potential expansion in the type of suffering that might justify assisted death.

Figure 2: Merging of physician duties compelled by patient perspective of death with dignity

The most visible activity from this perspective to date is the emergence of a Dutch citizens group that includes legal scholars, physicians and politicians, collectively known as the “Out of Free Will” organization.\textsuperscript{90} This organization has launched a petition to lobby the Dutch government to legalize access to assisted death on demand for citizens who have reached the age of 70 or over.\textsuperscript{91}

2. Belgium

a. Historic Overview

After a relatively brief political and public discussion, Belgium passed \textit{The Law Concerning Euthanasia} in 2002 (the “Belgian Law of 2002”).\textsuperscript{92} The Belgian Law of 2002 is very similar to the Dutch scheme, permitting euthanasia (although not expressly PAS)\textsuperscript{93} since September 2002.\textsuperscript{94} Unlike The Netherlands, however, Belgium did not experience the lengthy history of physician prosecution or professional medical guidance on the matter of euthanasia from which to formulate perspectives, precedents and practices for potential legislative intervention.\textsuperscript{95} While there were certainly elements of a euthanasia discussion taking place in both private and public sectors since the 1980s,\textsuperscript{96} these discussions could not be said to possess a comprehensive evolution similar to that observed in The Netherlands.

The general ambivalence for euthanasia reform in Belgium has been largely attributed to the dominance of the government by the Christian democrats during the 1980s and early 1990s\textsuperscript{97} as well as to the Belgian medical profession which was largely opposed to euthanasia. Indeed, into the 1990s, Belgian physician codes of professional conduct explicitly opposed the practice of euthanasia.\textsuperscript{98} From the perspective of one physician organization post-legalization, “euthanasia was imposed on the medical profession and exemplifies
the intrusion of politics into the practice of medicine”.99

This is not to say, however, that euthanasia and PAS were not occurring in Belgium despite their illegality100 and that there weren’t Belgian doctors who supported such practices.101 Although no physician had ever been the subject of a euthanasia prosecution in Belgium until 2000 (after the formal legislative process was already underway),102 studies conducted in Belgium revealed that euthanasia was a part of medical end-of-life practice for many physicians.103

Perhaps spurred on by events taking place in The Netherlands104 (although there is no specific evidence to support this), Belgium began its own political discussion on euthanasia sometime after a 1987 national colloquium, entitled, “Bioethics in the 90s”.105 Following the colloquium in 1993, an independent Advisory Committee on Bioethics (the “Advisory Committee”) was established.106 Its mandate was and remains twofold:107

• to provide advice on the problems raised by research and research applications in the fields of biology, medicine and health care; these problems are studied from the ethical, social and legal points of view, particularly from the angle of the respect for human rights;108
• to inform the public and the authorities about these problems.

At the request of the presidents of the Chamber and the Senate, the Advisory Committee provided its first opinion in 1997 on “the advisability of a legal regulation of euthanasia” (“Opinion 1”).109 The Advisory Committee restricted Opinion 1 to euthanasia proper which, similar to the Dutch standard, was defined as, an “act performed by a third party who intentionally puts an end to a person’s life at the request of the said person”.110

In accordance with the Advisory Committee’s non-consensus rule,111 Opinion 1 did not articulate a unified view, rather, it presented the following four possible alternatives:112

1. Legislative amendment to decriminalize euthanasia provided the doctor has fulfilled specific conditions: advanced under the concept that the law cannot prohibit acts that do not cause harm to others or society;113 a form of ex post facto control.
2. Maintain criminal prohibition but regulate the procedure ex post facto: similar to the Dutch scheme, the doctor relies on the legal justification of “necessity” when certain substantive conditions are present and complies with procedural safeguards;
3. Regulate procedure a priori: compulsory consultation and ethical debate imposed prior to a decision on a case by case basis with shared decision-making by the patient and the doctor; also advanced under the legal justification of necessity.
4. Maintain status quo: on basis of the “eminent value of life as the natural medium for all the other rights of the person” and requires medicine and law to give precedence to the “right to live”, by seeking relief of suffering through other means such as palliative care.

Opinion 1 stimulated and framed the euthanasia debate in Belgium and six months later led to majority support in the Senate for the a priori regulation of euthanasia.114 Progress on a draft bill however, was stalled because of a re-polarization in the Senate due to a differing viewpoint from the socialist faction of government115 (who preferred an ex post facto approach like the Dutch scheme), and because of complexities generated by the next Advisory Committee report, Opinion No. 9.116 This opinion revealed that there was little consensus on the issue of euthanasia for individuals incapable of expressing their wishes. Consequently, the political consensus to take an a priori approach had been lost.

An election in June 1999 produced a new coalition government (comprised of Socialists, Liberals and Greens) and the Christian Democrats, formerly the majority, became the opposition.117 Led by the Liberals, the coalition government made it clear that Parliament had a responsibility to address medical matters including euthanasia and that its responsibility must be fulfilled on “the basis of each individual’s convictions”.118 By December 1999, a common bill, similar to the Dutch scheme was achieved and a mixed Senate Committee was established to hear additional views from expert groups and to debate the draft bill.

During Senate discussions in late 2000, the results of a second study of euthanasia practices in Flanders (the Dutch speaking part of Belgium) were published.119 The main objective of the study was to estimate the frequency of euthanasia, PAS and other end-of-life decisions. While the study confirmed that euthanasia and PAS were part of medical end-of-life practice among Belgian doctors (1.1% and 0.2%
respectively out of total deaths examined) it also showed that other medical practices, such as pain relief in doses with a potential life-shortening effect and the withholding or withdrawing of treatment (39% of total deaths examined) were much more common.\textsuperscript{120} The study also revealed that termination of life without a request was almost three times more common than euthanasia and PAS combined (3.2% of total deaths examined).\textsuperscript{121} Despite this striking latter statistic, Belgium parliamentary debate remained exclusively focused on the less frequent practice of euthanasia proper.

After hundreds of amendments, the bill was approved by a majority of the Belgian Senate in October 2001 and encompassed \textit{ex post facto} regulation — a physician exemption from criminal liability provided certain conditions were met. The bill was approved by the Chamber of Representatives in May 2002 and came into force 22 June 2002.

In 2003, a scheme similar to The Netherlands SCEN scheme was established for Belgian doctors considering euthanasia for their patients. The Forum for End of Life Information (“LEIF”) was established in Flanders to provide consultation services and training to doctors with respect to euthanasia requests. A similar programme was also set up for nurses in 2006.\textsuperscript{122}

**b. Legislative Framework**

Substantively speaking, the legal rules regulating euthanasia and PAS in Belgium are largely the same as those in The Netherlands,\textsuperscript{123} however, the rules have been articulated in greater detail under the Belgian law.

Additionally, s. 2 of the Belgian Law of 2002 defines euthanasia as “intentional life-terminating action by someone other than the person concerned, at latter’s request”. Although this in plain reading excludes assisted suicide, it has since been settled by the reviewing authority, the Federal Control and Evaluation Commission\textsuperscript{124} that PAS falls within the law’s definition of euthanasia.\textsuperscript{125} The use of the term “intentional” serves to exclude other medical acts such as pain relief with life shortening effect.

**i. Due Care Requirements**

As with Netherlands, the Belgian Law of 2002 does not expressly distinguish between substantive and procedural due care requirements. This categorization, however, is helpful for the purposes of comparing the assisted death regulations and thus is used as a focusing tool throughout this paper.

With respect to the substantive requirements, in order for the attending physician to be exempt from criminal liability when terminating the life of a patient, the attending physician must:\textsuperscript{126}

- be sure that the patient is over the age of majority (or an emancipated minor),\textsuperscript{127} and is conscious and competent when making the request;
- be sure that the request is voluntary, well considered, repeated and not the result of external pressure; and
- be sure that the patient is in a medically futile condition and the patient’s suffering (physical or mental) is constant and unbearable, arising from a serious and incurable disorder caused by illness or accident.

Under the Belgian law, it appears that the doctor-patient relationship falls under the procedural safeguards as opposed to the substantive safeguards, meaning that the relationship is viewed more as a requirement to ensure the substantive elements have been met, as opposed to being a substantive element in and of itself. This makes sense given that the Dutch law evolved through physician conflict and the defence of necessity, whereas the Belgian law, appears to more strongly assert AD on the basis of the individual’s personal convictions.

Procedural requirements involving the physician-patient relationship require that the attending physician:

- inform the patient about his/her condition and life expectancy and discussed euthanasia (and PAS) together with therapeutic options, including that of palliative care;
- through several conversations with the patient over a reasonable period of time, be certain of the patient’s constant physical or mental suffering and durability of the request; and
- together with the patient, come to the belief that there is no reasonable alternative.\textsuperscript{128}

Similar to The Netherlands legislation, there is no express requirement that the doctor have a history with the patient, nor is there a requirement that the patient be a Belgium citizen or resident, potentially introducing the possibility of euthanasia for non-residents.\textsuperscript{129} However, the legislation implies that the doctor have a fairly strong degree of familiarity with the patient given that the strength of the request must
be ascertained over time and through several conversations. The only exception to this familiarity requirement is when a request is pursuant to an advance directive. Requests must be in writing but can be revoked at any time.

Procedural safeguards under the Belgian Law of 2002 also include consultation with another physician independent of the patient and consulting physician. The consultant physician must be competent on that particular condition and must review the medical record, examine the patient, and ensure that the patient’s suffering is constant and unbearable and cannot be alleviated. The consultant physician report is shared with the patient.

The Belgian Law of 2002 imposes additional safeguards for individuals who are “not expected to die in the near future” that is, individuals who are not in a terminal phase or not suffering from a terminal condition (i.e., an illness expected to end in death) such as those with neurological conditions like quadriplegia or are experiencing anticipatory suffering. In these situations, there must be at least one month between the request and the termination act. Furthermore, a second consultant (a psychiatrist or specialist in the condition) must be contacted to examine the patient and the medical record to ascertain whether the request is voluntary and the suffering persistent and unbearable. The patient is to be informed of the results of this second consultation.

ii. Reporting and Review

Unlike The Netherlands which requires a pathologist to conduct the post-mortem examination and to report findings, Belgian doctors under the Belgian Law of 2002 can conduct the post-mortem examination and issue a death certificate. Also distinct from the Dutch Law of 2002, under the Belgian Law of 2002, euthanasia can be considered a natural cause of death and doctors routinely fill in “no medical-legal objection”. Thus in Belgium there is again little opportunity for the prosecutorial authorities to learn of a case of euthanasia (or PAS) unless it is brought to their attention via the Federal Control and Evaluation Commission (“FCEC”).

The FCEC consists of 16 members including medical doctors, lawyers, professors and individuals who routinely deal with problems of incurable patients. A physician who has performed euthanasia or PAS must notify the FCEC within four working days. The physician must provide information including details of the termination of life act, the patient’s condition and nature of suffering, and the procedures that have been fulfilled in compliance with the law. The FCEC can turn a case over to the public prosecutor if a two-third majority of the FCEC is of the opinion that the required conditions haven’t been fulfilled. The FCEC is required to submit a biennial report to parliament identifying statistical information, evaluation of implementation of the law and recommendations, if any, on potential changes to the law.

c. Compassion and Suffering, Autonomy and Self-determination

As described above, the Belgian Law of 2002 allows euthanasia (or PAS) for unbearable physical or “mental” suffering and the requesting individual does not have to have a terminal illness. However, the patient must be in a “medically futile condition” as the result of an “incurable disorder” caused by “illness or accident”. This requires that the disorder be medically classifiable and might therefore operate to exclude the availability of euthanasia (and PAS) for existential suffering. On the other hand, commentators have argued that because the law considers a mental condition that leads a patient to wish to die as an accepted grounds for euthanasia (and PAS), the Belgian law opens the door for otherwise physically healthy persons to request AD on the basis of being “tired of life”, notwithstanding the difficulty in assessing whether the criteria for euthanasia have been satisfied in the absence of symptoms related to a physical condition.

Persistent and unbearable suffering is to be determined from the patient’s perspective only; there is no requirement that suffering must be understandable or palpable to the physician as required under the Dutch law. Furthermore, the requirement that the patient be in a medically futile condition that cannot be alleviated, does not imply that a patient must undergo alternative treatments before a doctor can agree to a request. As is the law in many jurisdictions, including The Netherlands as discussed, patients are entitled to refuse treatment. This, taken together with mental suffering provides the latitude to allow for euthanasia on the basis of prospective or anticipatory suffering.

The Belgian Law of 2002 overcomes the dilemmas posed by the apparent lack of suffering in an unconscious patient, by expressly removing the “unbearable” requirement in this circumstance and allowing euthanasia for irreversibly unconscious patients pursuant to a written advance request of the patient, which among other things, gives the patient the opportunity to identify “persons of confidence”
who can later inform the attending physician of the patient’s wishes. An advance directive is only valid for the five years prior to a patient’s loss of ability to express his or her wishes and doctors must still meet all basic due care requirements.

The Belgian Law of 2002 is similar to the Dutch Law of 2002 in terms of it being an ex post facto form of regulation, protecting a physician from criminal liability if he or she can demonstrate, after the fact, that he or she has complied with specific conditions set out in the AD law. However, the Belgian Law of 2002 is distinct from the Dutch Law of 2002, in that it did not arise solely in response to a perceived conflict in a physician’s professional duties to his or her patient — namely, the duty to respect life versus the duty to relieve suffering. Beginning with the Advisory Committee’s mandate, the Belgian AD law explored legal regulation of euthanasia from the perspective of a human rights issue, notwithstanding that the physician defence of necessity was also introduced into these discussions early on. Thus the Belgian Law of 2002 appears to be more squarely premised on the principle of self-determination of the suffering patient; the justification for euthanasia and PAS being the patient’s free and informed request. Indeed, during its debates, the Belgian Senate identified that the scope of the duty to protect the right to life imposed by human and civil rights conventions had to be interpreted pursuant to the right to self-determination and reflect the will of the individual.

Notwithstanding the influence of a self-determination perspective, the legal requirement that unbearable suffering be rooted in a medical disorder indicates that additional medico-ethical principles, such as physician beneficence and mercy are also implicitly incorporated into the law. On the other hand, because it is the patient who fully identifies whether the suffering is unbearable, the question is raised as to what exactly is the ethical function of the suffering criteria. At this point in the discussion one can only surmise that the suffering criteria somehow relates back to the authority given to the Belgian physician to actively terminate a life, though not necessarily an authority rooted in a professional conflict of duties. Thus what appears to be occurring here is a theoretical expansion of the doctor’s obligations to the patient with respect to assisted death as a medical practice provoked by an expansion of a patient’s right to self-determine what is and what is not acceptable suffering, again keeping in mind that under the Belgian Law of 2002, there is currently no positive right to AD. It should also be noted that in all the AD regimes under discussion, the physician is playing an important gate-keeping role in terms of confirming voluntariness and capacity, notwithstanding that the gate-keeping role (or aspects of it) might also be performed by trained professionals other than physicians.

### Figure 3. AD advanced when patient suffering arises from a medical condition

Interestingly, the Belgian Law of 2002, despite all of its similarities to the Dutch Law of 2002 does not include a provision that requires physicians to terminate the life with due care as is the case under the Dutch law. Perhaps such a provision was considered redundant, particularly with respect to the practice of euthanasia which necessarily requires that the physician be present during the terminating act. However, in the case of PAS, said to be included under the Belgian law (as already discussed), the terminating act itself does not require the physician’s presence. The absence of a due care provision regarding the terminating act might perhaps also signal or trigger a conceptual shift in focus and responsibility away from the physician towards the patient. As will be seen later in this discussion, this type of patient-oriented responsibility is reflected in the AD laws developed in the United States.

### d. Statistics and Trends

Pursuant to the Belgian Law of 2002, the FCEC is responsible for reviewing and reporting euthanasia cases on a biennial basis. To date, the FCEC has issued four biennial reports which cover all reported euthanasia cases up to 2009. According to the biennial reports, reported cases have been increasing — from 259 in 2002-2003 to
(0.2% of all deaths) to 642 in 2004-2005 (or 0.36% of all deaths) and 924 in 2006-2007 (0.44% of all deaths). In 2008, the FCEC attributed the increase to an increase in physician awareness of the law, taking the position that “clandestine euthanasia” is “dying out”. However, the results of the fourth biennial report (2008-2009) show a much more significant increase in reported euthanasia cases (1,526 and 0.7% of all deaths) and question if that is indeed the case, particularly in light of current research that indicates an ongoing issue of physician underreporting. For example, research conducted on deaths in 2007 by Smets et al., estimates that only one out of two cases of euthanasia in the Flanders region are being reported to the FCEC and that the incidence of euthanasia in 2007 is closer to 1,040 (or 1.9% of all deaths). Regardless, the FCEC maintains that the amount of illegal euthanasia “can only be very low”.

While reported cases under the Belgian Law of 2002 have been increasing, the profile of patients requesting euthanasia over the years 2002-2008, has remained fairly consistent. Of the reported cases, the vast majority come from the Flemish/Dutch-speaking part of Belgium (80%). Further, the majority of patients who receive euthanasia are suffering from cancer (80%) with the remainder of the patients suffering from other disorders such as progressive neuromuscular diseases like ALS. Approximately half the number of cases of euthanasia takes place in patients aged 66-79.

From 2002-2007, half the number of euthanasia cases took place in the hospital setting with a smaller number occurring in the home. This trend appears to be shifting with euthanasia now occurring more frequently at the patient’s “residence” for the years 2008-2009, with 44% at home and 8% in a nursing or care home.

Almost all of the reported cases of euthanasia were the result of a direct personal request. Euthanasia for unconscious patients by advance request has risen slightly over the years but remains low at approximately 0.02% of the cases. To date, the FCEC reports that physicians are in compliance with due care criteria; none of the cases reported to the FCEC over the years 2002-2009 have been sent to the public prosecutor, although in some cases, the FCEC made further inquiries.

Recently, it has been argued that there is increasing opinion in Belgium that the practice of euthanasia is “normal medical practice” and part of the palliative care spectrum, an opinion which would not be inconsistent with the rights-focused underpinnings of the law nor with the language of “natural death” utilized in the Belgian Law of 2002. To a certain extent, however, this view is challenged by the evidence of ongoing physician underreporting as well as a possible growing preference in doctors for other end-of-life practices such as palliative or terminal sedation over the practice of euthanasia.

Griffiths et al. make the further argument that legally speaking, “normal medical practice” cannot include euthanasia. Under the Belgian Law of 2002, the physician is obliged to discuss all options with the patient including palliative care. The Law of Palliative Care June 14, 2002, approved by Belgium parliament at the same time as the Belgian Law of 2002 specifically states that “every patient has a right to palliative care at the end of life”. Accordingly, if euthanasia was normal medical behaviour and part of the palliative care spectrum, then this would create a right to euthanasia along with an obligation for doctors to perform it. This is clearly not the situation — a physician cannot be compelled to perform euthanasia or PAS. As with the Dutch Law of 2002, the Belgian law only provides the opportunity to request euthanasia. Thus under the current scheme, euthanasia (and PAS) cannot legally be considered “normal” medical practice. That said, since 2003, proposals have been introduced into Belgium parliament to amend the law to identify euthanasia as normal medical practice. That said, since 2003, proposals have been successful to date.

Furthermore, at the time of writing, the public debate regarding euthanasia for “tired of life” has commenced in Belgium with the publication of a news story of 93-year-old Amelie Van Esbeen. Ms. Van Esbeen went on a hunger strike to hasten her own death after her request for euthanasia was denied. Ms. Van Esbeen was not suffering from a terminal illness but believed her quality of life was not sufficient to warrant living. According to Wim Distelmans, the head of the FCEC, the “ills of the elderly”, such as “poor sight, poor hearing, poor verbal skills and dependence on others”, could amount to unbearable suffering and “the euthanasia law should be changed to enable seniors who are tired of life to be able to request this method”. Ms. Van Esbeen’s request was eventually granted. It should be noted however that the usage of the term “tired of life” by Distelmans connects with physical forms of suffering arising out of age-related medical conditions as opposed to a less tangible form of mental suffering unrelated to physical symptoms.
It is also of interest to note that both the Dutch Law of 2002 and the Belgian Law of 2002 rely on the safeguards (substantive or procedural) requiring the existence of a fairly close relationship between the doctor and patient in order to restrict AD to their respective citizens as opposed to setting out an express provision limiting the practice to residents which is the case in other jurisdictions such as Oregon and Washington. While the potential practice of AD to non-residents has not made Belgium or Netherlands targets of international criticism to the same extent as Switzerland (discussed in Part II.B.4 below), this is not to say that this practice has not occurred in these jurisdictions.182

3. Luxembourg

a. Historic Overview

In 2009, Luxembourg became the third European country to introduce express legislation to permit euthanasia and PAS. The Law of 19 March 2009 on Euthanasia and Assisted Suicide (the Luxembourg Law of 2009)183 not only “draws heavily” on the Belgian Law of 2002184 it was similarly advanced without any significant consultation with the medical profession.185 Prior to the Luxembourg Law of 2009, euthanasia was strictly prohibited under Article 397 of the Luxembourg Penal Code.186 Assisted suicide on the other hand was not expressly illegal under the Luxembourg Penal Code but may have been be caught by a provision related to the failure to assist a person in danger.187

Deputy Jean Huss of the Green Party introduced the topic of euthanasia into the Chamber of Deputies in 1994188 and a full debate was held in 1996.189 During this debate, a special Parliamentary committee was established to begin preparing the framework for future discussion on death of persons suffering from serious and incurable diseases.190 In February 1998, the Luxembourg National Commission on Ethics (the “LEC”) issued a special report regarding the issues of palliative medicine, the intensive use of medication and euthanasia.191 While the LEC demonstrated consensus on a number of points including the importance of palliative care, the inappropriateness of aggressive medical treatment and the relief of suffering that may also have life shortening effect, it did not come to any consensus with respect to the practice of euthanasia.192 Although, the LEC considered euthanasia from the same point of view that drove the Dutch AD reform, i.e., that at the end of life, there may be medical situations where a physician will not be morally blameworthy — the LEC decided that there was no need to change the current laws or medical code of ethics.193

A second policy debate held in Luxembourg Parliament in the spring of 1999,194 however, led to the majority support for a possible a priori approach to regulating euthanasia whereby doctors would be protected from criminal liability for assisting with the death of a patient if they had first consulted with an ethics committee.195 This approach was similar to that being considered by the Belgium Senate at the time. Two resolutions related to living wills and the possible modification of the Penal Code to permit euthanasia were considered but later rejected and the possibility of the a priori approach was never followed up.196 By 2001, however, Prime Minister Jean-Claude Juncker (head of the majority — the Christian Social Peoples Party), announced he was ready to re-open the debate, notwithstanding that he himself was personally opposed to any change to the law.197

On February 5th, 2002, “inspired” by developments in Belgium198 Huss and Socialist deputy Lydie Err — both members of the Association for the Right to Die with Dignity (ADMD-L)199 — tabled a bill modeled on the Belgian Law of 2002200 (the Right to Die bill).201 Prime Minister Juncker submitted the bill to the Council of State for its opinion.202 The discussions on the Right to Die bill provoked parallel discussions on the state and expansion of palliative care services in Luxembourg as well as identified the need to include the Luxembourgish medical community in the euthanasia debate.203

In an explanatory memorandum accompanying the Right to Die bill, Huss and Err identified that the debate centered around two conflicting fundamental human rights — the right to life and the right to self-determination.204 Huss and Err reiterated the Belgian Senate position that the obligation to protect the right to life must be interpreted in terms of self-determination, meaning that the right to life must also reflect the will of the person.205

The bill was met with strong opposition from the Catholic Church,206 palliative care organizations,207 and the Luxembourg Medical College (the “College”). In a 2002 opinion statement, the College emphasized its disagreement with the Right to Die Bill208 arguing instead for the “ethics of life” to be based on support and symptom relief, “not on the acceptance of killing”209. The College voiced its concern for potential abuses such as patients opting for euthanasia because
of feelings of being a burden, including an economic burden, on family and society.\textsuperscript{210}

The College also took the position that Article 43 of the Law on Hospitals\textsuperscript{211} — which required doctors to relieve suffering of terminally ill patients in accordance with the patient’s choice and respect for dignity — made any changes to the current law or the 1991 Code of Medical Ethics\textsuperscript{212} unnecessary.\textsuperscript{213} That said, the College further acknowledged that there was always the possibility of the “exceptional” case where a doctor could face a desperate situation and be unable to resist a request evidencing a position consistent with the Dutch necessity defence (see Figure 1 above). In those circumstances the College recommended that a doctor could make a decision of conscience after multi-disciplinary consultation (doctors, palliative care specialists, ethicists and so forth). If there was any doubt as to the propriety of the doctor’s final decision, the matter could be referred to the College for investigation and possible disciplinary action.\textsuperscript{214}

The Christian Social Peoples Party (“CSV”), the dominant partner in the governing coalition was opposed to the Right to Die Bill which continued to be held in abeyance awaiting the Council of State’s opinion.\textsuperscript{215} In the interim, the government began to focus more intensely on its palliative care initiatives.\textsuperscript{216} A palliative care bill tabled in 2004 and its revised version tabled in 2006 were both rejected.\textsuperscript{217}

On June 7, 2006, a new bill on palliative care, advance instructions and end-of-life accompaniment was tabled by the Minister of Health (the “Palliative Care Bill”).\textsuperscript{218} The Palliative Care Bill was aimed at establishing a right to palliative care for any person in an advanced or terminal phase of a serious and incurable disease, whatever the cause.\textsuperscript{219} From that point on, discussions regarding the Right to Die Bill adhered to the discussions concerning the Palliative Care Bill (the “two bills”).

The government continued to informally hear from interested parties including the College, private and public employee organizations, professional caregivers, health care and palliative care experts and disability rights groups among others.\textsuperscript{220} During these discussions, public opinion polls showed that the Right to Die Bill was supported by somewhere between 50-70\%\textsuperscript{221} of the population while the Catholic Church continued to mount an “aggressive campaign” against it.\textsuperscript{222}

On July 13, 2007, the Council of State finally issued an opinion on the Right to Die Bill and advised that a “reserved” approach be taken. In support of its opinion, the Council of State cited both the 2005 Code of Medical Ethics\textsuperscript{223} which continued to prohibit doctors from performing euthanasia and assisted suicide\textsuperscript{224} and the Parliamentary Assembly of the Council of Europe’s 1999 recommendation to maintain a prohibition on the intentional taking of the life of the terminally ill and dying.\textsuperscript{225} In a supplementary opinion issued later that same year, the Council of State determined that the Right to Die Bill was not compatible with the Palliative Care Bill because of, among other things, a lack of consistency in terminology and provisions concerning living wills.\textsuperscript{226}

Notwithstanding the position of the Council of State, on February 19, 2008, the Chamber of Deputies unanimously passed the Palliative Care bill and also passed the Right to Die Bill but by a much slimmer margin (30 in favour, 26 against).\textsuperscript{227} The Chamber of Deputies requested the Council of State to waive the second vote of the bills.\textsuperscript{228} The Council of State refused the request\textsuperscript{229} because of the ongoing incompatibilities between the two bills\textsuperscript{230} and instead required that the Right to Die bill be amended. The Council of State further stipulated that both bills would have to pass the second reading simultaneously.\textsuperscript{231} A suspected political calculation behind this move was that if both bills were bound, the Right to Die Bill would be more likely to fail because it had been advanced by two members of parliament as opposed to the Palliative Care Bill which had been endorsed by a government majority.\textsuperscript{232}

Work by the Ministry of Health in consultation with the Council of State culminated in two sets of amendments adopted in June and November 2008 respectively.\textsuperscript{233} Voting on the bills was delayed, however, due to the anticipated refusal of the Grand Duke of Luxembourg (who personally opposed the Right to Die Bill) to sign the law into force as required under the Luxembourg Constitution. A vote was thus held to permit an amendment to the language of the Luxembourg Constitution so that the Grand Duke would be able to promulgate laws without also having to “sanction” them.\textsuperscript{234} The constitutional amendment was passed at the first vote and on December 18, 2008, the Palliative Care and Right to Die Bills were subsequently passed by the Luxembourgish Parliament by 60 out of 60 votes and 30 out of 59 votes (one abstention) respectively.\textsuperscript{235} The requirement for a second vote was waived.\textsuperscript{236} After the second vote in favour of amending the Constitution,\textsuperscript{237} the Luxembourg Law of 2009 and the Palliative Care Law\textsuperscript{238} were promulgated on March 16, 2009.\textsuperscript{239} Both laws entered into force on April 1st, 2009.\textsuperscript{240}
By implementing discrete legislation, Luxembourgish lawmakers established a distinction between the practice of palliative care and the practice of AD, arguably leaving little scope for the argument that AD is part of the palliative care spectrum. On the other hand, it is important to point out that the Luxembourg Law of 2009 and the Palliative Care Law are linked, namely that doctors are required to inform patients who have requested euthanasia or PAS of their palliative care rights and options. Likewise, doctors providing palliative care are required to respect and comply with a patient’s treatment directions including those that may have the effect of advancing the end-of-life.

b. Legislative Framework

Euthanasia is illegal and considered to be a form of murder under Article 397 of Luxembourg’s Penal Code. However, similar to the *ex post facto* regulatory approach taken by The Netherlands and Belgium, Article 397 has been amended by the Luxembourg Law of 2009 by the insertion of Article 397.1 which states that the prohibition will not apply to a physician who has fulfilled the conditions under the Luxembourg Law of 2009 when responding to a request for euthanasia or assisted suicide. The Luxembourg Law of 2009 exempts a physician from civil liability in addition to criminal liability if the substantive and procedural conditions are met.

Article 1 defines both euthanasia — an act performed by a doctor, intentionally ending the life of a person on their express and voluntary request — and assisted suicide — a doctor intentionally assisting another person to commit suicide or providing the means to that end on their express and voluntary request. The “intentional” criteria again operates to exclude other medical practices such as pain relief with life shortening effect, withdrawal or withholding of treatment on the basis of futility or direction of the patient and palliative sedation.

i. Due Care Requirements

Consistent with both the Dutch and Belgian Laws of 2002, the substantive due care conditions that exempt a physician from criminal liability under the Luxembourg Law of 2009 include that:

- the patient is competent and conscious;
- the patient is in a hopeless medical situation with constant and unbearable suffering (physical or mental) and without prospect of improvement and arising from a pathological illness or accident;
- the request is made voluntarily, after reflection and does not result from external pressure;
- the request does not necessarily have to be repeated but it must be in writing.

Unlike the Dutch and Belgian Laws of 2002, the substantive criteria also require that the patient be an “adult”. The Luxembourg Law of 2009 also expressly distinguishes the substantive “fundamental” criteria from the “formal and procedural” conditions to be satisfied. The procedural safeguards include that the doctor:

- must inform the patient of his or her condition and life expectancy;
- must be convinced of the patient’s voluntariness;
- must discuss the request and therapeutic alternatives;
- must ensure the persistence of suffering and believe that there is no other acceptable solution (from the patient’s point of view) through a series of interviews at reasonable intervals;
- must consult an impartial doctor (impartial from patient, treating physician and pathology) who will review the medical file, examine the patient and confirm suffering and lack of improvement; and
- must check to see if the patient has registered a “disposition de fin de vie” (“end-of-life provision”) with the control and assessment authority (discussed further below).

It is interesting to note that the parameters of the doctor-patient relationship are expressly contained within the procedural safeguards as opposed to in the substantive safeguards or in a vague combination of both. This distinction is compelling for at least two reasons. First, it is only non-compliance with the enumerated substantive conditions that warrant notification to the public prosecutor. Non-compliance with the enumerated procedural requirements on the other hand only trigger notification to the Medical Council for possible disciplinary action. Placing the details of the patient-physician relationship within the procedural safeguards, as opposed to being a substantive qualifier for AD, arguably demonstrates a viewpoint that is more patient-focused and in turn denotes the primacy of the principle of self-determination with
physician participation leaning more towards the role of gatekeeper to ensure that the substantive criteria have been met.

Second, the distinction is interesting from a non-resident perspective as again there is no clause regarding residency or nationality under the Luxembourg legislation. Thus, while the law implicitly imposes a close relationship between the doctor and the requesting patient, if a doctor is not in compliance with this aspect, as might arise with a non-resident patient, this will be a matter for the Medical College to address, not the public prosecutor.

Like The Netherlands and Belgium, the Luxembourg Law of 2009 permits euthanasia for a patient in an irreversible state of consciousness. Under the law, if the patient has drafted, signed and registered an end-of-life provision with the National Control and Assessment Commission (the “CNCE”), a physician may provide euthanasia provided substantive and procedural conditions have been met. Any reiteration, adaptation or withdrawal of the provision must also be registered with the CNCE. However, regardless of any registration, a doctor must always take into account the patient’s wishes. Thus, if the doctor becomes aware of a different expression of the patient’s wishes, euthanasia cannot take place.

ii. Reporting and Review

Doctors must submit a registration document in the appropriate form to the CNCE within eight days of the euthanasia or PAS. The CNCE mandate is to examine the document and make a ruling within two months of the submission as to whether the conditions have been met. If the CNCE rules that a doctor has not complied with the due care requirements it will notify either the public prosecutor or Medical College depending on whether the breach involves a substantive or procedural condition as described earlier. The CNCE is also tasked with maintaining a registry for the registration of end-of-life provisions and producing a report every two years for the Chamber of Deputies. The biennial report is to contain statistical data, an assessment of the law and any recommendations for legislative change.

c. Compassion and Suffering, Autonomy and Self-Determination

Some commentators have interpreted the Luxembourg Law of 2009 as only being applicable to those who are “terminally ill”. This interpretation is consistent with language used in the English version of the Ministry of Health Euthanasia Guide (the “Euthanasia Guide”) which appends an English translation of the Luxembourg Law of 2009. In this translation, Article 2.1.1, sets out that a patient must be “in a terminal medical situation”. The Euthanasia Guide also uses the phrase “terminal state of health” when describing the disorders for which euthanasia may be possible. Unfortunately, the guide does not provide a definition of “terminal”. However, the Euthanasia Guide does go on to state that the legal conditions could be met by “any severe, incurable and irreversible disorder” in addition to the more common “advanced cancers or neuro-muscular illnesses”. This description is consistent with the French legislative language “sans issue” which is perhaps more accurately translated as “hopeless” rather than “terminal”. The accuracy of the statement that the law is limited to the “terminally ill” is thus dependent on how “terminally ill” is defined. It would appear that in the case of the Luxembourg Law of 2009, the definition of “terminal” is not restricted to illnesses that end in death but extends to any medical disorder considered incurable or irreversible.

That said, the Luxembourg Law of 2009 does not expressly include the more stringent safeguards contained in the Belgium Law of 2002 for patients who are not expected to die within a short amount of time, i.e., individuals with incurable neurological conditions like quadriplegia or those whose suffering at the time of request is more prospective or anticipatory. In this way, the Luxembourg law appears slightly more relaxed than the Belgian law.

As noted earlier on, when the Luxembourg Law of 2009 was first introduced, Huss and Err described that the euthanasia debate centered around two fundamental yet conflicting human rights — the right to life and the right to self-determination making the argument that the right to life must be interpreted with reference to the will of the individual. This perspective appears to connect with both the Belgian discussion and the current arguments for a broader approach to AD under the
Dutch Law of 2002. It should be noted that the way in which Huss and Err (and others) have described the conflict of rights advances AD more strongly as some form of positive right in itself, reflective of the will of the individual, as compared to the Dutch perspective which advances AD on the basis of the physician’s duty to respect life, the scope of that positive duty to be interpreted in relation to the will of the individual.

Figure 4. AD advanced as a right to self-determination in conflict with protection of the right to life

In the Euthanasia Guide, the conflict at issue is described as a conflict between respecting the freedom of conscience of a doctor to respond (or not) to a request for euthanasia or PAS and respecting the freedom of choice of patients in terminal situations who are suffering unbearably. Thus Luxembourg lawmakers held a concern that physicians would impose their will on these patients under their care, as opposed to patients being able to direct their own death. Under the law prior to 2009 such a doctor-focused over-ride would have been an appropriate and legal response. It therefore appears that the Luxembourg Law of 2009 is not so much responding to a conflict between a doctor’s freedom of conscience and a patient’s freedom of choice, so much as facilitating the patient’s freedom to choose while respecting the physician’s freedom of conscience.

Indeed, as described, the main catalyst for the change to the law came from proponents of the right to die with dignity who justified AD practices in a manner similar to that of Belgium — from the perspective of the autonomous individual. On the other hand, the Luxembourgish medical community took the position that AD law was interfering with the special trust relationship between doctor and patient. To date, the 2005 Code of Medical Ethics has not been adapted to conform with the liberalization of euthanasia and PAS and still maintains a prohibition against euthanasia. Hence a doctor who carries out a request under the requisite conditions will be in compliance with the law but in breach of the current Code of Medical Ethics.

The framing of the conflict at issue in the Luxembourg AD debate is therefore particularly interesting in that it shows a further evolution in thinking with respect to the substance of patient “rights” in terms of accessing AD as well as the balancing of rights as between doctors and their patients. On one hand the language of self-determination within the context of AD includes the idea of a “right to decide on the end of their life in accordance with their beliefs” while on the other hand there is greater recognition that the conscience of the physician may be in conflict with that “right”. The legalization of AD under the Luxembourg Law of 2009 appears to be grounded on respect for the autonomy of the suffering patient. However, by passing both the Palliative Care Law and the AD Law of 2009 simultaneously and overtly managing their distinction, Luxembourg parliament appears to have equalized, rather than merged, the agendas of the duty to relieve suffering and the duty to protect life, limiting AD to circumstances where the patient’s right to self-determine coincides with the physician’s conscience. Within this balance, Luxembourgish lawmakers protect doctors who accede to the individual’s request for euthanasia or assisted suicide from criminal or civil liability.

Figure 5. AD advanced on basis of the patient’s freedom to choose constrained by physician freedom of conscience
But as with The Netherlands and Belgium, there is no absolute right to euthanasia or PAS under the Luxembourg Law of 2009. In the event that a doctor conscientiously objects and does not wish to grant a request for euthanasia or PAS, the doctor is obligated to inform the patient (or their person of trust/spokesperson) within 24 hours and transfer the file to another doctor identified by the patient.265

According to the Ministry of Health Euthanasia Guide, the freedom of conscience to be exercised is an individual one, thus an institution (such as a hospital or retirement home for example) cannot impose its institutional view to prevent a doctor from exercising his or her individual freedom to grant a request.266

d. Statistics and Trends

The first biennial report of CNCE was released in March 2011. For the years 2009 and 2010, only five declarations of euthanasia were submitted to the CNCE (one in 2009 and four in 2010).267 All five requests were from patients suffering from terminal cancer (three women, two men) and over the age of 60.268 According to the CNCE, all five cases were found to be in compliance with the legal requirements and all took place either at the home of the patient concerned or in a hospital.269

Despite the small numbers, which do not provide much information for statistical analysis, the CNCE reached consensus that unbearable suffering must be assessed through thorough consultation between patient and physician. The CNCE did not elaborate on the reasons underlying this statement. Nor did the CNCE offer an opinion as to the relatively small number of cases or the possibility of physician under-reporting. It should be observed, however, that the population of Luxembourg is very small, estimated in 2010 at 502,100 of which 86% is less than 65 years of age.270 43.1% of the population belonged to the foreign community.271 The five deaths under the Luxembourg Law of 2009, represents approximately 0.001% of the total annual deaths in Luxembourg.272

In stark contrast to the small number of euthanasia cases is the number of end-of-life provisions registered with the CNCE. A total of 681 provisions were registered, with women disproportionately represented at 396 compared to 285 for men. The majority of registrations were made by individuals in the age range of 51-90.

A 2009 case in Luxembourg is set to provoke further clarification on the scope of the “right” to request euthanasia or PAS under the law. A patient suffering from the terminal stages of cancer was denied euthanasia at a Catholic clinic even though his doctor had authorized the procedure. The board of the clinic refused the request. As described above, while doctors individually have the right to refuse on grounds of personal conscience, an institution does not share that right. The investigation is currently ongoing.273

Pursuant to requirements under the Luxembourg Law of 2002, a national debate on the entire issue is anticipated for the fall of 2011.274

4. Switzerland

a. Historic Overview

Article 115 of the Swiss Penal Code275 reads:

**Inciting and assisting someone to commit suicide**

A person who, for selfish reasons, incites someone to commit suicide or who assists276 that person in doing so shall, if the suicide was carried out or attempted, be sentenced to a term of imprisonment.277

Thus, in Switzerland, assisting someone to commit suicide is not a punishable offence when it is done for “unselfish” reasons. Euthanasia278 on the other hand is illegal under Article 114 of the Swiss Penal Code, albeit is treated as a lesser offence than murder or manslaughter.279 The practices of increased pain and symptom relief with possible life-shortening effect280 and non-treatment decisions (withdrawal or withholding life sustaining treatment)281 are considered to be acceptable medical practices under both Swiss law282 and professional medical guidelines.283

Assisted suicide practice pursuant to the word “unselfish” in Article 115 does not require that a physician be involved or that the patient be suffering from a particular medical condition, such as a terminal illness. Because of this, Switzerland has been able to develop an open practice of assisted suicide separate from the activities of the medical profession. Furthermore, the introduction of Article 115 did not arise out of medico-ethical discussions on patient suffering, rather, Article 115 was “inspired by romantic stories about people committing suicide in defence of their own, or their family’s, honour and about suicides committed by rejected lovers.”284 So although Swiss legislators believed it necessary to include a criminal provision for assisted suicide in order to prevent abuses from occurring (suicide itself not being illegal), they did so in such a way as to not incriminate individuals who had assisted others in committing suicide for “altruistic” reasons.285

As a consequence, over the past two decades, Swiss assisted suicide practice has largely developed
through right-to-die organizations whereby assisted suicide is perceived as more of a human rights issue rather than a medical one; to a great extent existing at the edges of mainstream medical care. Having said this, if assistance with a suicide involves a lethal barbiturate, a physician must be involved as a physician’s prescription is required pursuant to the Narcotics Law and the Pharmaceutical Law (the “Swiss Narcotics laws”). Because current standard practices by Swiss right-to-die organizations involve the use of barbiturates, the majority of cases of assisted suicide facilitated by these organizations are captured by the Swiss Narcotic laws and can therefore be classified as PAS. Swiss physicians may also independently assist the suicide of a patient without being brought to the patient by a right-to-die society, although the latter is usually the case.

PAS in Switzerland has historically been discouraged by the Swiss Academy of Medical Sciences (the “SAMW”). Since 2004, however, the SAMW has expressly recognized that a decision to assist a suicide is ultimately a matter of the individual physician’s conscience. This development is discussed in further detail below.

In 1982, two right-to-die organizations emerged in Swiss society, Exit Deutsche Schweiz (“Exit DS”) for German-speaking Switzerland (headquartered in Zurich) and Exit Association pour le Droit de Mourir dans la Dignité (“Exit ADMD”) for French-speaking Switzerland (headquartered in Geneva).

Exit DS and Exit ADMD are the largest right-to-die organizations in Switzerland.

In 1997, the executive director of Exit DS and protestant minister, Rolf Sigg, left Exit DS to form Ex-International, “Association for assistance in autonomous dignified death” (“Ex-International”). In 1998, a second member of Exit DS (and human rights lawyer), Ludwig A. Minelli, broke away to form a fourth end-of-life organization, Dignitas.

And in January 2002, psychiatrist Peter Baumann, resigned from Exit DS over the issue of assisted suicide for patients with mental illness — Baumann being in favour. Baumann and 27 other members of Exit DS, formed Suizidhilfe which defends the absolute right of individuals to determine their time of death, including individuals who do not suffer from a somatic illness and who have been diagnosed as mentally ill. These organizations strongly affirm the absolute right of self-determination and autonomy of the individual, with a limited or no role desired from “paternalistic” medicine. While some of these organizations are also active in promoting the use of advance directives for medical treatment, the Swiss AD organizations are more widely known for their assisted suicide services.

### i. Swiss AD Organizations

Exit DS currently has over 50,000 members in Switzerland and is Zurich’s largest right-to-die organization. The early activities of Exit DS involved the distribution of suicide manuals to its members providing detailed instructions regarding lethal combinations of drugs and the use of plastic bags for asphyxiation. Over the years, Exit DS has increased its activities in respect of guiding individuals through the suicide process. These activities include: the evaluation of patients by volunteer assistants; the review of requests and medical files by Exit DS officials; the conducting of a second review by an ethics committee in particularly difficult cases; if needed, the facilitation of access to a physician who can prescribe the lethal drug, typically sodium pentobarbital (“NaP”); the presence of attendant/witness at the terminating act; and the reporting of assisted suicides to the appropriate authorities. As is the case with all AD in Switzerland, in order to not fall afoul of Article 114, the final step (for example, the taking of the oral medication or the opening the valve of an intravenous line or feeding tube) must be carried out by the individual wishing to die.

Exit DS will assist in a suicide provided the patient is competent, has a persistent desire to die and is suffering unbearably. In accordance with its philosophy which stresses self-determination and autonomy of the individual, Exit DS sanctions assistance to those who are not only terminally ill, but also to those who have severe disabilities or who are experiencing other conditions such as “weariness” or “tired” of life. Exit DS limits its services to Swiss residents except in exceptional cases.

Exit DS has not been without controversy over the years, particularly with respect to questions of financial gain by its executive, lack of training for volunteers, assisted suicide for patients who lacked mental competence due to psychiatric conditions and its attempts to obtain lethal medications without a physician’s prescription. In 2009, Exit DS entered into an Agreement with the Canton of Zurich setting up due care rules to overcome these and other concerns. Two of the more notable provisions in the agreement are Article 2, which identifies NaP as the only authorized medication and Article 4.4.4 which prohibits assisted suicide to persons under age
25 unless they are experiencing severe physical suffering.312

Between 1990-2004, Exit DS facilitated 748 assisted deaths among Swiss residents.313 In the years 2007, 2008 and 2009, Exit DS facilitated 167, 175 and 217 assisted suicides respectively.314 The majority of the diagnoses were for “fatal” conditions (e.g., cancer, cardiovascular/respiratory, HIV/AIDS, neurological disease) than “non-fatal” conditions (e.g., rheumatoid arthritis/pain syndromes and mental disorders — mostly depression, osteoporosis, blindness or general weakness).315 The number of Exit DS assisted suicides in women and the proportion of older people suffering from non-fatal diseases has been increasing since the 1990s.316 Current research also indicates that the number of requests overall is increasing every year.317

Exit ADMD is the second largest Swiss right-to-die organization with currently over 15,000 members.318 Exit ADMD restricts membership to persons over the age of 20 year residing in Western Switzerland.319 Exit ADMD’s guidelines, procedures and criteria are similar to Exit DS: a prognosis of death or a significant disability; intolerable physical or psychological suffering, a written request, and serious and repeated demand.320 The moral foundation for providing assisted suicide as expressed by the current president in 2001 is, “the freedom of the individual, limited only to the extent that he/she respects the freedom of others”.321

It has been reported that 200 assisted suicides were facilitated by Exit ADMD during the years of 2001-2005,322 and 66 in 2007.323 Exit ADMD’s rate of approval of assisted suicide requests is high at 95% or above during each of the years 2004, 2005 and 2007 and every year the number of requests has been increasing.324 The patient profile is also similar to EXIT DS — during the years 2001-2005, 86.5% of diagnoses were for fatal conditions and 13.5% for non-fatal conditions with 10.5% of the latter suffering from a multitude of disabilities encompassing a fear of progressive deterioration.325 Again, Exit ADMD numbers reveal a higher representation of women326 and older people.327

Dignitas is unremarkable in the sense that its guidelines and procedures leading up to assistance with suicide are comparable to those of EXIT DS and Exit ADMD.328 However, Dignitas is generally perceived as being the most controversial of the Swiss right-to-die organizations because of its openness in providing assisted suicide services to non-residents.329 According to its founder Ludwig Minelli, it extends its services to non-residents on the basis of the ECHR which prevents discrimination on any grounds, including on the basis of where one lives.330

Dignitas’ current membership is approximately 5,989 from 52 countries. In 2009, the highest membership came from Germany (2,971), followed by Switzerland (834) and the United Kingdom (694).331 Over the years 2002-2009, 1,041 assisted suicides were carried out by Dignitas.332 Of these, 88.24% of the persons assisted were foreigners, with the highest number from Germany at 59.14%.333 Dignitas facilitates almost double the number of suicides as Exit DS, which is possibly attributable to its greater “catchment area”, i.e., foreigners.334

It is the activity of Dignitas that has connected Switzerland to the phrase “suicide tourism”335 and international criticism. This criticism has prompted debate within Swiss government regarding the possible state regulation of right-to-die organizations. Proposed responses range from regulations that restrict assisted suicide to Swiss residents to a complete ban on organized assisted suicide altogether.336 The Dignitas connection with “suicide tourism” also attracts additional international criticism to the issue of assisted suicide for individuals who do not suffer from a terminal illness337 even though both Exit DS and Exit ADMD also provide assisted suicide for non-fatal illnesses338 and the possibility of euthanasia for non-terminal illness also exists in The Netherlands, Belgium and Luxembourg.

Ludwig Minelli, the founder and general secretary of Dignitas, is unambiguous with respect to the role that autonomy plays in advancing what he describes as, “the last human right” — the right to decide when and how to end one’s life.339 Like Exit DS, Minelli describes how individuals must be free to pursue their own objectives provided that that pursuit does not harm the “public interest” or the “legitimate interests of a third party”.340

Ex-International also provides suicide assistance to non-residents, but on a much smaller scale than Dignitas.341 Membership is approximately 700-800 from various European countries.342 A 2008 estimate of assisted suicide by Ex-International ranged from 12-20 members in the district of Bern.343 According to Margrit Weibel, the successor of Rolf Sigg344 and current head of the organization, upon receipt of a request, the procedures followed by Ex-International include: establishment of a relationship between patient and assistant, evaluation of whether the condition is unbearable without any hope of relief; voluntariness; production of doctor’s certificate with
diagnosis; and examination by a Swiss doctor to ensure patient is “lucid and discerning”.

Suizidhilfe was founded in 2002 by Peter Baumann, a psychiatrist, who defends the individual’s “absolute right” to determine the time and circumstances of death. Consequently, Suizidhilfe will facilitate assisted suicide in cases where a terminal illness is not present and even in cases where suffering is related to a mental illness. Membership fees are minimal.

In 2003, Baumann was arrested in connection to the deaths of three individuals suffering from depression. In 2007 he was found not guilty in one case but guilty in the second for failure to exercise due care and sentenced to three years in prison and two on probation. In the third case, Baumann had permitted the AD to be filmed and broadcast on national television. Baumann was found guilty by a trial court for assisting a suicide for selfish motivations on the basis of a desire for “publicity”. Subsequently, Baumann was acquitted of this charge by the Court of Appeal which restored the previous legal understanding of “selfish” motives to that of material gain.

The main role played by physicians is to prescribe the lethal drug NAP which, as discussed, is legally required under the Swiss Narcotics laws. These laws require that the drug be prescribed and dispensed in accordance with the acknowledged rules of medicine and science and further that they are used only to the extent that they are necessary in accordance with the acknowledged rules of medicine. The acknowledged rules of medical science allow doctors to prescribe lethal barbiturates to eliminate pain. Through court interpretation these laws have also come to mean that before prescribing a regulated drug, a doctor is obligated to examine the individual wishing to die and confirm his or her competence. Failure to do so will result in punishment and possible revocation of the physician’s licence.

Furthermore, according to the courts, if the patient’s suffering arises from a mental disorder, the individual must be examined by an expert who can confirm that the desire to die has not arisen from a curable psychiatric disorder, but rather is well-considered, permanent and rational.

ii. Medical Guidelines

As described earlier, the SAMW has maintained fairly strong opposition to PAS, noting in a 1994 guideline, that “assisted suicide is not part of a physician’s activities”. Criticism to this position, however, prompted new guidelines in 2004, Care of Patients in the End of Life [the 2004 SAMW Guidelines]. The 2004 SAMW Guidelines identify that a doctor can be faced with a conflict: on the one hand, a doctor does not have any duty to assist a suicide because it contradicts the aim of medicine but on the other hand, a doctor has a duty to take the patient’s own wishes into account. The “solution” to this dilemma is the doctor’s personal decision of conscience. The position taken by SAMW appears to be similar to the Luxembourg perspective (see Figure 4), notwithstanding that Luxembourg medical code has not yet been brought into compliance with Luxembourg AD law. Under the SAMW Guidelines, if a doctor makes a decision to assist, the doctor is obligated to: confirm a terminal diagnosis (a condition that will lead to death within a matter of days or a few weeks); discuss alternatives and, if desired, implement them; confirm decision-making capacity and that the decision is well thought out without external pressure; and obtain confirmation by a third party that all requirements have been met. The final step in the suicide must be taken by the patient him/herself.

The 2004 SAMW Guidelines also recognize a right to palliative care for patients in the final phase of life but further acknowledge the need to recognize that not all suffering associated with dying and death can be avoided. Euthanasia, however, remains strictly prohibited under the SAMW Guidelines in accordance with the Penal Code.

Thus although the SAMW discourages assisted suicide, physicians have the legal discretion like any other citizen, to altruistically assist suicide, with the exception that to be in compliance with the SAMW Guideline’s, a physician’s discretion can only be exercised with respect to cases of terminal illness.

If an individual resides in a health care facility, the individual may also be subject to the views of the particular institution which may not tolerate assisted suicide. Up until the 1990s there was a general understanding that assisted suicide was not permitted in public hospitals and nursing homes. Effective 2001 however, Zurich City Council introduced regulations permitting assisted suicide to be conducted in these institutions. Similarly, since 2006, hospitals in French Switzerland have permitted Exit ADMD to provide assistance on its premises under specific conditions such as the presence of a terminal diagnosis and consultation with health care teams. In 2007, the Geneva University Hospital agreed to allow Exit ADMD to provide assisted suicide on its premises, provided
that hospital staff members did not participate. Policies on assisted suicide in health care facilities thus vary from institution to institution.

iii. Legislative Developments

Over the years, public and political call for restricting or regulating the practices of right-to-die organizations has been primarily provoked by the suicide tourism issue and concerns of abuse of patients with psychiatric illnesses. However, the development of a more comprehensive regulatory scheme has been impeded by: added complexities arising from initiatives for legalized euthanasia; leadership changes in the Federal Department of Justice and Police (“EJPD”) which is responsible for reform initiatives; jurisdictional concerns; and debates over the appropriate role to be played by physicians and health care institutions.

In 2005, the Swiss National Advisory Commission on Biomedical Ethics (“NEK-CNE”) pursuant to a request by Ruth Metzler, the head of the EJPD at the time, issued Opinion No. 9/2005 on Assisted Suicide (Opinion No. 9). The opinion recognized the “twin poles” of the assisted suicide discussion — the conflict between providing care for people at risk for suicide and respecting the autonomy of that person, and identified that while neither should be assigned priority, both should be taken into account. Further, the state’s duty to provide care went beyond the individual desiring suicide to include “social ethics” to make sure that other individuals’ freedom of choice was not restricted by being made to feel like a burden on society and thus opt for suicide or assisted suicide.

Figure 6. AD restricted by State Duty to Protect Persons at Risk and Duty to Provide Care

Opinion No. 9 recommendations included: maintaining Article 115 but regulate right-to-die organizations; prohibiting assisted suicide when suicidality is a manifestation of mental illness; permitting suicide of non-residents but establishing conditions to ensure in-depth knowledge of the patient and the patient’s request.

In 2006, NEK-CNE released Opinion No. 13/2006 (Opinion No. 13) which recommended certain minimal duty of care criteria to be fulfilled by right-to-die organizations, and directing physicians to the 2004 SAMW guidelines.

On October 28, 2009, the Federal Council, under a new minister of justice, Eveline Widmer-Schlumpf, tabled two alternative amendments to Parliament for changes to Swiss law. The first option (“Option 1”) contemplated clear duties of care for right to die organizations, the second option contemplated a complete ban on organized assisted suicide altogether. Federal Council’s preference, Option 1, would: restrict assisted suicide to terminal illness; require two independent physicians to confirm diagnosis and legal capacity; require discussion of alternatives with the patient; limit the lethal drug to a prescription drug; and prohibit commercial gain.

Upon completion of a consultation process in March 2010, three quarters of the cantons, political parties and interested organizations that took part were in favour of legislative action at the federal level although there was no consensus as to precisely how the right-to-die organizations should be regulated. For example, limiting assisted suicide to persons with terminal illness was criticized as discriminatory and unlawful, a perspective also apparently held by a large percentage of the Swiss public. The Federal Council was set to draft a bill based on Option 1 for debate by Swiss parliament. The Federal Department of Home Affairs was also to submit a proposal to the Federal Council on how to strengthen suicide prevention and palliative care. Palliative care is not yet available to all terminally ill patients in Switzerland.

On November 1, 2010 Widmer-Schlumpf was succeeded by Simonetta Sommaruga. Sommaruga has not yet identified her position on the results of the consultation. Whether a Federal Council bill will be presented to the Swiss parliament in the near future remains to be seen.

b. Legal Framework

As described earlier, Article 115 permits assistance with suicide if done for altruistic reasons.
Mental capacity of the person requesting assistance is also required because without it, a request will not be legally valid pursuant to Article 18 of the Civil Code. Without capacity, the assist will be criminally responsible for the intentional killing under Articles 111-113 of the Penal Code because the suicide cannot be recognized as a voluntary and free decision.

If a drug like NaP is to be used in an assisted suicide, the Swiss Narcotics laws come into play and the patient must be examined by a physician in order to obtain a prescription. Controversially, right-to-die organizations have previously tried to avoid these laws by using other methods, such as helium gas. Regardless, death by assisted suicide is considered to be an “unnatural” death in Switzerland and thus requires the authorities to be notified, who will conduct an investigation to ensure that a criminal offence has not taken place.

i. Due Care Requirements

Due care criteria are currently dictated by the internal guidelines of the right-to-die organizations as opposed to legislation. The main exceptions here are the obligations imposed on prescribing doctors by the Swiss Narcotics laws as well as through the 2004 SAMW Guidelines.

With respect to the substantive criteria, the individual desiring assistance must: be competent (as assessed by volunteer assistants), be suffering unbearably (physical or mental) and have a voluntary repeated and serious demand. The precise criteria and corresponding thresholds vary from organization to organization. For example, Exit ADMD expressly restricts its membership to persons over 20 years of age whereas, Exit DS will accept members who are 18 years or older.

Notwithstanding internal guidelines, the primary procedural safeguard that ensures that the competency criteria is satisfied, appears to be imposed by the Swiss Narcotics laws along with court interpretation as discussed, which obligate physicians to confirm the patient’s competence and diagnosis before prescribing the lethal medication. In the case of suffering arising out of a mental or psychiatric condition, extra caution must be taken including expert assessment of the individual to ensure that the desire to die or suicidality is not a manifestation of the illness.

There is currently, however, no requirement that doctors get to know the patient well, although according to Exit DS, Exit ADMD and Dignitas, volunteer attendants have numerous conversations and significant contact with their respective members prior to the actual act to discuss alternatives. If the assisted suicide takes place in a public hospital there may be additional procedures to be followed pursuant to hospital rules and regulations.

Two additional and significant procedural safeguards are first, that the lethal medication is never handed directly to the member; it is always handed over to the organization or one of its volunteers in order to prevent abuse. When the time is determined by the member, the lethal dose is made available to the member by the volunteer attendant. Second, the volunteer attendant and at least one additional witness (alternatively, two attendants) remain with the member until death. As will be discussed later, these safeguards are not required by the PAS schemes of Washington and Oregon.

The substantive due care criteria or “preconditions” under the 2004 SAMW Guidelines include: a voluntary and well-thought out request, decision-making capacity, terminal illness, and discussion and implementation (if desired) of alternatives. Additionally, for patients in care homes, the SAMW guidelines, Treatment and care of elderly persons who are in need of care must also be taken into account. Among other things these guidelines recognize the particular vulnerability of the elderly person due to different dependencies, which can increase the risk of suicide requiring particular attention to carrying out necessary palliative, therapeutic and/or psychiatric measures and spiritual help if desired. Death pursuant to PAS is considered an unnatural death and as such must be reported to the authorities.

With respect to procedural safeguards, the 2004 SAMW Guidelines require that the “preconditions” have been checked by a third party and that the decision-making process has been documented.

ii. Reporting and Review

As already described, in Switzerland, death pursuant to assisted suicide is considered an “unnatural” death and must be reported to the examining authorities when the death occurs. The doctor responsible for the assisted suicide is not permitted to fill out the death certificate. Authorities are to conduct a brief investigation to ensure that a criminal offence has not taken place.

Prosecution for assisted suicide is rare.

c. Compassion and Suffering, Autonomy and Self-determination

As discussed, Article 115 of the Swiss Penal Code does not make suffering a required element for assisted
suicide. Furthermore, the practice of assisted suicide in Switzerland developed on the basis of the individual’s right to self-determination, separate from the medical profession. Nevertheless, all the right-to-die organizations discussed require some form of suffering to be present — suffering must be unbearable or unacceptable and arising out of a disease or disability (terminal or non-terminal, physical or mental). Accordingly, assisted suicide has been provided by organizations for conditions ranging from cancer to paralysis to mental disorders to “weariness of life”.

This is not to say that the individual’s autonomous view on suffering is the only relevant consideration. As already discussed, assistance typically requires a physician prescription which will constrain the working definition of suffering to a certain extent. Additionally, in the *Haas* case, the Swiss Federal Court limited assisted suicide for psychiatric illness, permitting it only when the desire to die is well-considered, permanent and rational.

Furthermore, right-to-die organizations have imposed their own limits on qualifying suffering and under the SAMW guidelines, doctors must balance the patient’s right to self-determination with their duty to support the patient.

Equally important is the interpretation of the “right” to assisted suicide as a negative right as opposed to a positive right, a position clarified by the Swiss Federal Supreme Court in the *Haas* case.

In the *Haas* case, Mr. Haas, a Swiss national suffering from a serious bipolar affective disorder was denied a prescription to NaP on several occasions. Mr. Haas applied to the Swiss courts to obtain the drug on the basis of an infringement of his right to privacy under Article 8 ECHR arguing “that his right to end his life in a safe and dignified manner had been violated in Switzerland as a result of the conditions that had to be met — and which he had not met — in order to be able to obtain sodium pentobarbital”.

In denying his application, the Swiss Federal Court found that there was a distinction between the right to decide one’s own death (established under a right to privacy) and the right to commit suicide assisted by another party. The court explained that the “right to die” is only a negative right (a liberty right) in that individuals are to be free from state intervention or prohibitions. A negative right can be restricted if other basic rights are at risk. The *Haas* case was appealed to the European Court of Human Rights which confirmed that while an aspect of the right to respect for private life includes the right of an individual to decide the manner and moment at which life should end, this right had not been violated. In so doing, the European Court of Human Rights noted that national authorities had a wide “margin of appreciation” in terms of what weight they choose to place on the protection of an individual’s life (Article 2, the right to life) and on the right to end one’s life (Article 8, right to respect for privacy).

Thus despite Ludwig Minelli’s (founder of Dignitas) frequent assertion that the Federal Supreme Court of Switzerland has recognized the human right to end one’s life and such a right is protected under Article 8 of the ECHR, this position is only accurate if it is qualified as a negative right which can in turn be limited by certain state interests.

**Figure 7. AD advanced as Privacy Right limited by Various Interests/Duties**

That there is no positive right to AD, only some form of right to request it, is a position consistent in all jurisdictions canvassed. That said, it is the Swiss (and as we shall see, also the American) requirement that the last terminating step be taken by the individual alone that appears to be more analytically consistent with the construction of AD as a negative right. In other words, the Swiss legal framework is consistent with the liberal ethical view that the exercise of autonomy (or right to privacy) includes the freedom to control the course of one’s life and death, including eliciting some participation by another individual(s) to carry out that will but it stops short of permitting that other individual(s) to perform the actual act.

**d. Statistics and trends**

Because there is no central notification system, data on the frequency and extent of assisted suicide is very limited for Switzerland and it is important to be cognizant of the fact that no validated statistics currently exist.

The frequency of assisted suicide in the 1990s was approximately 100 cases per year. This has risen to over 200 cases per year, in a large part due to increasing numbers of assisted suicide cases for
non-residents facilitated by Dignitas. The rate of assisted suicide for Swiss residents though has remained fairly consistent over the past ten years.

For example, in 2001-2002, assisted suicide accounted for 0.4% of all Swiss deaths. Assisted suicide specifically by right-to-die organizations resulted in a total of 137 cases accounting for approximately 0.2% of all Swiss deaths in 2001-2002. If assisted suicide for non-residents by Dignitas (59 cases) are included, assisted suicide accounted for approximately 0.5% of all deaths in Switzerland for 2001-2002. These numbers roughly correspond to the results of an independent 2001 study of doctors involved in assisted suicides which indicates that Swiss right-to-die organizations have been complying with reporting requirements.

In 2007, the number of annual deaths in Switzerland was approximately 64,000. In 2007, the three major right-to-die organizations reported 239 cases (167 Exit DS, 66 ADMed 6 and 6 Dignitas). Together, these numbers thus represent approximately 0.37% of all deaths in Switzerland. If Dignitas’ figure of 132 for non-residents is included, the assisted suicide figure increases to approximately 0.57% of all deaths in Switzerland for 2007.

While a significant percentage of the Swiss population supports maintaining a liberal scheme for non-residents in Switzerland, suicide tourism remains a significant and contentious political issue. Aside from a potential Federal Council bill, suicide tourism may end up being addressed by cantonal tax authorities who do not wish to subsidize the practice for non-residents. According to the public prosecutor’s office, administrative costs run between CHF 3,000-5,000 per assisted suicide, which amounts to CHF 273,000 per year in the canton of Zurich alone.

There also appears to be continued support for the practice of euthanasia by the public (71% in 1999) and some support for it among palliative care physicians (19%) if it were to be legalized. In January 2011, the Swiss euthanasia debate was re-ignited when a regional criminal court in Canton Neuchâtel acquitted a physician who triggered the lethal drip based on the patient’s cue — a foot movement. Despite the prohibition on euthanasia, the court ruled that the doctor had a medical and moral duty to violate the law and had complied with all due care criteria required by suicide assistance. This is the first acquittal for euthanasia in Switzerland and is expected to provoke the inclusion of euthanasia in future political discussions regarding assisted suicide as well as new initiatives for changes to the Swiss Penal Code.

5. Oregon

a. Historic Overview

On November 8, 1994, Oregon became the first jurisdiction in the United States to explicitly legalize PAS. The Oregon Death with Dignity Act, in full force by 1997, allows doctors to prescribe lethal medication to Oregon residents suffering from a terminal illness — defined as an illness expected to lead to death within six months. Euthanasia on the other hand remains strictly prohibited. Other medical practices such as the withholding or withdrawing of life-sustaining treatment for reasons of futility or by patient direction, pain medication in doses that may have life-shortening effect and palliative sedation, are for the most part, considered to be within the range of acceptable medical practices in the United States and are captured in numerous professional medical codes, case law and statutes.

As of the 1990s there was very little empirical data regarding the number of euthanasia or assisted suicide requests, the motivations behind the requests, the types and degrees of suffering or the numbers of requests granted by health care providers. However, despite the lack of data, there existed considerable public interest in PAS and euthanasia. This interest had been provoked by a number of developments including: controversy regarding advances in life-support technologies as illuminated by the U.S. Supreme Court case Cruzan v. Director, Mo. Dep’t of Health which confirmed the legal right to forego medical treatment necessary to sustain life; the AIDS crisis which was at its peak (at the time considered to be a terminal illness); and the highly publicized activities of right-to-die activist Dr. Jack Kevorkian.

While the first person to be assisted by Dr. Kevorkian was Oregon resident Janet Adkins who was suffering with Alzheimer’s disease, the initiative to put a ballot measure before Oregon voters to legalize PAS came from another Oregon resident, Elvin Sinnard whose wife Sara was suffering from chronic heart disease. With information obtained from the Oregon branch of the Hemlock society, a euthanasia advocacy group, Mr. Sinnard assisted his wife in taking her own life, though leaving her when she died (at her request) in order to legally protect himself.

In 1990, Mr. Sinnard, along with a group of physicians and lawyers (eventually to become the
Oregon Right to Die political action committee), spearheaded the drafting of Ballot Measure 16, the Oregon Death with Dignity Act. On November 8, 1994, this measure was voted into law by a narrow margin of 51% in favour to 49% against (the 1994 Oregon Law).

The 1994 Oregon Law was scheduled to come into effect 30 days later but its implementation was delayed for another three years when a group comprised of patients, physicians and residential care facilities challenged the constitutionality of the law on the basis that it violated terminally ill patients’ due process and equal protection rights under the Fourteenth Amendment in Lee v. Oregon. In August 1995, the group obtained a permanent injunction from the U.S. District Court of Oregon which found that the law lacked sufficient safeguards to prevent terminally-ill adults who are incompetent (because of depression) from committing suicide. Thus, terminally-ill individuals were deprived of safeguards available to those who were not terminally ill, in violation of the equal protection right. On appeal to the Ninth Circuit Court of Appeals however, the plaintiffs’ claim was dismissed due to various factors including:

- a lack of standing;
- the plaintiff’s injury, i.e., the possibility of suicide because of undetected depression being too speculative; and
- the doctors and health care facilities’ claim not being “ripe”. That is, the law did not create any penalty for doctors who chose not to participate.

The injunction was lifted on October 27, 1997. As Lee v. Oregon made its way through the courts, two seminal cases, Washington v. Glucksberg and Vacco v. Quill, were also being decided with decisions from the United States Supreme Court on June 26, 1997. Both lawsuits had been filed within one year of one another by Kathryn Tucker, the lawyer for Compassion in Dying, a right-to-die organization. The plaintiffs in each case were terminally ill patients who were challenging Washington and New York state laws that banned assisted suicide respectively on the basis of the constitutionally protected due process and equal protection clauses under the Fourteenth Amendment.

In Washington v. Glucksberg the plaintiffs made the argument that mentally competent, terminally ill patients have a due process “liberty interest” in the right to choose PAS. PAS, like abortion, was an intimate and personal choice and criminalization interfered with the right to choose. The Supreme Court held that the due process clause did not provide a fundamental liberty interest in PAS and that the law was rationally related to legitimate government interests including: protection of life, prevention of suicide, protection of the ethical integrity of medical doctors, protection of vulnerable people from indifference, prejudice and pressure to end their lives, and protection against the “slippery slope”.

In Vacco v. Quill, the plaintiffs argued that allowing mentally competent terminally ill patients to refuse life-sustaining treatment while prohibiting them from choosing PAS as a way to end their lives violated the Equal Protection clause. The Supreme Court upheld the distinction between the two life ending activities holding that every competent person is entitled to refuse unwanted life-saving treatment but not one is permitted to assist a suicide. The Supreme Court held that the law did not violate the equality protection and that it was related to a legitimate end, citing the same compelling interests as cited in Washington v. Glucksberg.

Thus, although the U.S. Supreme Court refused to recognize a constitutionally protected right to PAS, it left the possibility for legalization of PAS as a matter to be considered by individual states.

In June 1997, before the resolution of the Lee v. Oregon litigation, the Oregon legislature authorized a referendum for the November 1997 election to repeal the 1994 Oregon Law — Ballot 51. The legislature referred Ballot 51 because of questions related to the law’s effectiveness and ongoing concerns regarding the adequacy of safeguards including those related to counseling, residency and reporting requirements.

Both the Oregon Medical Association (“OMA”) and the Oregon Association of Hospitals and Health Systems (“OAHHS”) recommended voting in favour of the repeal. According to the OMA, at the time the law was passed in 1994 the OMA had maintained a neutral position on the law because of a deep division of opinion among its 5,500 members. By 1997, having had time to study the law in more detail, the OMA stated that it considered the law to have medical deficiencies that would negatively affect the care of seriously ill patients and advocated instead for “compassionate and competent palliative (comfort) care at the end of life”. The OAHHS took a similar position advocating alternatives to PAS including: compassion and
comfort care; education for patients, families and health-care providers; and support for aggressive pain relief even if resulting in hastened death. The OAHHS also voiced concerns over the possible failure of a prescription to bring about death, the lack of mandatory psychiatric assessment and the difficulty for physicians to accurately determine when a patient will die.482

Notwithstanding the official positions of the OMA and the OAHHS, a 1995 survey of 2,671 Oregon physicians indicated that 60% of physicians thought that PAS should be legal in some cases,483 with 46% potentially willing to write a lethal prescription for a terminally ill patient if it were legal to do so.484 Additionally, a 1996 survey of 321 Oregon psychiatrists showed that 56% were also in favour of implementation of the 1994 Oregon Law.485

On November 4, 1997, the Oregon public voted on Ballot 51 and endorsed the 1994 Oregon Law by an even larger margin than before — voting 60 to 40 per cent against repeal.486 Once in effect, however, the law set off yet another complex series of challenges, this time from conservatives at the federal level who sought to nullify the state law through application of the federal 1970 Controlled Substances Act.487 Efforts were aimed at undermining the ability of physicians to prescribe controlled drugs for assisted dying and included: encouraging the U.S. Drug Enforcement Agency to investigate and penalize physicians for prescribing death-hastening drugs;488 the introduction of legislation to prohibit the prescribing of federally controlled drugs for purposes related to suicide and euthanasia;489 and a 2001 directive from Attorney General John Ashcroft (the “Ashcroft Directive”) which stated that assisted suicide was not a “legitimate medical purpose” within the meaning of the Controlled Substances Act thus exposing prescribing physicians to various penalties under the Act including suspension and revocation of registration.490 Ultimately none of these efforts proved successful. The challenges ended with the 2006 Gonzales v. Oregon case,491 where the Supreme Court upheld an injunction obtained by Oregon’s Attorney General to prevent enforcement of the Ashcroft Directive. The federal authority to issue regulations with respect to controlled substances did not include the authority to define medical practice standards.

In 1997, the U.S. Congress did, however, enact the Assisted Suicide Funding Restriction Act which prohibits the use of federal funding to pay for items and services related to assisted suicide.492 Therefore, Oregon patients or physicians in federal health care systems such as veteran or Indian health clinics cannot participate in PAS.493

It should also be briefly noted that the legalization of PAS in Oregon also led to substantial improvements in palliative care in Oregon including physician training, pain management, hospice care referrals and increases to the number of deaths taking place at home.494 However questions continue to be raised regarding the issues of adequate health care coverage and access to medications.495

b. Legislative Framework

Under the Criminal Code in Oregon, causing or aiding another person to commit suicide is a defence to the charge of murder but will be considered manslaughter.496 The 1994 Oregon Law does not mention these criminal law provisions except so far as to say that actions in accordance with the 1994 Oregon Law shall not for any purpose constitute suicide, assisted suicide, mercy-killing or homicide under the law.497 The 1994 Oregon law protects physicians and others from civil or criminal liability or professional disciplinary action who, in good faith compliance with the law, assist a patient in ending his or her life.498

The American Medical Association Code of Ethics (“AMA Code”) continues to view PAS as being “fundamentally incompatible with the physician’s role as healer”.499 Thus an Oregon physician who assists a suicide is at odds with the AMA Code even if in compliance with the 1994 Oregon Law. A similar incompatibility between medical codes and AD law has already been described for Luxembourg as well as, to a certain extent, Switzerland.

i. Due Care Requirements

The substantive requirements, that is, the criteria that qualify a patient to make a request for medication, are that the patient must:500

- be an adult (18 years of age or older);
- be an Oregon resident;501
- be diagnosed with a terminal disease (i.e., expected to lead to death within six months);
- be capable (able to make and communicate decisions about health care); and
- voluntarily express his or her wish to die.
The procedural safeguards that must be fulfilled to ensure that these conditions are met include the following:

- the patient must make a verbal request and a written request, and reiterate the verbal request no less than 15 days after the first verbal request;
- the prescribing ("attending") physician must confirm diagnosis, that the patient is capable and his or her decision is voluntary and informed;
- the prescribing physician must ensure the patient is informed by advising the patient of diagnosis, prognosis, risks and probable results of taking medication as well as alternatives such as comfort care, hospice care and pain control;
- the prescribing physician must refer the patient to a consulting physician for confirmation of the diagnosis, and for a determination that the patient is capable and acting voluntarily (confirmation must be in writing); and
- both the prescribing and consulting physician are to refer the patient to counselling if either believes the patient has depression or other psychiatric or psychological disorder causing impaired judgment;
- the prescribing physician must recommend that the patient notify next-of-kin of the prescription request; and
- the written request must be witnessed by two witnesses, at least one of whom does not have any interest in the patient and who can attest to capacity and voluntariness.

It should be reiterated that the 1994 Oregon Law focuses on the circumstances under which a physician is permitted to prescribe lethal medication. Thus to be in compliance with the law the physician cannot directly administer the medication. The requirement that the patient must self-administer the medication is considered implicit in the text of the law.

A patient can rescind the request at any time and in any manner and the physician must offer a patient the opportunity to rescind the request at the time of the second verbal request. Furthermore, at least 15 days must elapse between the initial verbal request by the patient and the writing of the prescription and at least 48 hours must elapse between the patient’s written request and the writing of the prescription. The prescribing physician is required to document the fulfillment of all the statutory conditions in the patient’s medical record including requests, offers to rescind request, diagnosis, prognosis, consulting physician’s verifications as well as the medications prescribed.

There is neither a requirement that the physician know the patient well nor a requirement that the physician hold a belief (whether from the physician’s or the patient’s perspective) that the patient is in a situation of unbearable suffering. It would appear that the primary legal responsibility of the physician under the 1994 Oregon law is to confirm the voluntariness of the patient’s decision to die in order to provide a prescription for the lethal medication. Along these same lines, the patient can obtain the medication directly from the physician or the pharmacist and the physician is not required to be present when the patient takes the lethal medication. The physician is not responsible for what happens after the prescription is written, although he or she must “counsel the patient about the importance of having another person present when the patient takes the medication”.

No physician or healthcare provider is obligated to participate in providing medication to end the life of a patient, but the physician or provider must transfer the patient’s records to any new physician or health care provider upon the patient’s request.

ii. Reporting and Review

The Oregon Health Division ("OHD") is tasked with monitoring compliance, collecting information on patients and physicians participating in PAS and publishing an annual statistical report. Under the administrative rules enacted pursuant to the Act, within seven days of writing a prescription for medication to end the life of a qualified patient, the prescribing doctor is to file a prescription report with the OHD documenting compliance with the AD law. Pharmacists are also required to file a dispensing report with the OHD.

The OHD reviews a sample of the reports and contacts physicians for any missing data. The OHD cross-references reports with patient death certificates held by Vital Records to confirm deaths and obtain additional demographic information such as age and education. The OHD also conducts in-person telephone interviews with prescribing physicians after receipt of the patient death
certificates to obtain further information not available from the prescription reports or death certificates such as: insurance status; end-of-life care; medical and functional status at the time of death; the physician characteristics (age, sex, years in practice, medical specialty); and so forth.\textsuperscript{521}

The OHD destroys all source documentation approximately one year after the publication of each Annual Report.\textsuperscript{522}

c. Compassion and Autonomy, Self-Determination and Suffering

As with the other jurisdictions discussed thus far, the 1994 Oregon Law does not create any right to assisted death, only an opportunity to request assisted death.

The 1994 Oregon Law does not include suffering as a requirement for access to PAS. This is distinct from the laws of The Netherlands (unbearable and lasting, palpable to the physician), Belgium (persistent and unbearable — from the conscious patient’s perspective), Luxembourg (unbearable and hopeless) and even Switzerland (unbearable or unacceptable). The Oregon legislation replaces the suffering justification with the requirement that patients are diagnosed with a terminal disease, \textit{i.e.}, incurable, irreversible and which will produce death within six months.\textsuperscript{523} In so doing, legal access to PAS is denied to persons experiencing suffering related to chronic but not terminal diseases or disabilities and to persons experiencing prospective suffering in connection with the early stages of diseases like ALS, dementia and Alzheimer’s. Furthermore, while some diagnoses might eventually meet the terminal requirement, diseases such as dementia and Alzheimer’s will continue to be excluded because of the additional requirement that a patient be capable and able to make an informed decision.

\textbf{Figure 8: AD advanced on basis of autonomy but limited by terminal diagnosis}

Oregon thus stands apart from the other jurisdictions discussed by requiring that a terminal medical illness be present in lieu of the suffering criteria, and has to a certain degree, been criticized because of the difficulty in making an accurate prediction as to when a patient will die.\textsuperscript{524}

Furthermore, the Oregon law is subject to the ongoing criticism that limiting assisted suicide to persons with terminal illness is discriminatory, a concern reflected in the current Swiss debate. The terminal diagnosis requirement is interesting because the language of the 1994 Oregon law emphasizes “death with dignity”, (the actual name of the law) and the ending of life in a “humane and dignified manner”.\textsuperscript{525} As put by John B. Mitchell however, “... neither of the two primary metaphors weaving in and out of the current PAS dialogue — “death with dignity” and “unbearable suffering” — correlate strongly with six months to live”.\textsuperscript{526} Indeed, the European schemes draw attention to the distinction between pain and suffering (the former more readily treated than the latter) and have thus created more intricate legal frameworks under which physicians must exercise their conscience and compassion in response to a patient’s request to die.

Some commentators have criticized the Oregon PAS scheme as being more oriented towards the protection of physicians than patients\textsuperscript{527} — medical malpractice and litigiousness being a peculiarly American attribute.\textsuperscript{528} On the other hand, it can be observed that in all AD schemes examined thus far, legalized AD practice is expressed as or includes a form of physician immunity. Furthermore, the terminal diagnosis requirement embodies a certain legal logic if the 1994 Oregon Law is perceived as a statutory extension of the common law regarding non-treatment decisions and an amendment to the result in the cases \textit{Washington v. Glucksberg} and \textit{Vacco v. Quill} which failed to convince the courts that the right to forego life-sustaining treatment should extend to the right to seek life-ending medication for the terminally ill. In other words, the quasi-bright line established by the “six months to live” requirement is perhaps an incremental step, consistent with and particularly reliant on the line of cases sanctioning the practice of “letting die”.\textsuperscript{529}

Taken together with what appears to be a reduced legal expectation (comparatively) for physician involvement in the patient’s decision-making\textsuperscript{530} and for physician attendance when the patient ingests the medication, it might be argued that the Oregon PAS scheme is more significantly connected with the expressions of autonomy and self-determination like Switzerland than the other schemes discussed, in
spite of the fact that PAS schemes are arguably the most narrow of the AD schemes, in terms of AD options available to the patient. Perhaps limiting assisted death to PAS provides the greater expression of autonomy — PAS retains the decision for death as a future decision of the patient whereas euthanasia directly militates against the patient’s exercise of the right to choose by ending autonomy.

d. Statistics and Trends

Consistent with its legal mandate, the OHD only gathers and reports information concerning the use of the law, meaning, circumstances where a prescription for lethal medication has been written. Thus the data available from the OHD does not consider the possibility or extent of physician under-reporting (although failure to report is a legal violation) or indeed the overall frequency or nature of PAS requests. A 1999 survey of Oregon doctors however reported that only one in six requests for a prescription for a lethal medication are granted and that one in ten requests result in suicide.531

Data from the OHD annual reports532 indicates that the number of physician-assisted deaths under the 1994 Oregon Law has gradually increased over the years from 15 (five out of every 10,000 deaths or 0.05%) during 1998 to 59 (20.9 out of every 10,000 deaths or 0.21%) during 2010. As of the end of 2010, a total of 821 prescriptions have been written and 525 patients533 have died from medication prescribed under the law.534

The profile of patients who have died under the law has remained fairly consistent over the years: the majority had a cancer diagnosis (e.g., 87% in 1998; 78.5% in 2010); there was a slightly higher rate of men to women (e.g., 53% male in 1998; 58.5% in 2010); the median age was approximately 71 (69 in 1998; 72 in 2010); and the majority of patients had a high school education or higher (e.g., 80% in 1998; 93.7% in 2010).

Of the 525 cases to date, the most frequently mentioned end-of-life concerns for Oregon patients, were: loss of autonomy (91.2%), decreasing ability to participate in activities that made life enjoyable (88.1%) and loss of dignity (84.1%).535 These concerns have been trending upward since 1998.536 Inadequate pain control or concern about pain was significantly less concern (21.3% in 2010). These statistics have been interpreted to mean that for Oregon patients, the issue of main concern is the desire to control the manner in which they die and that the use of PAS is not about a lack of good end of life care. Indeed, the vast majority of PAS patients die at home and the vast majority are enrolled in hospice care — the most comprehensive form of end-of-life care available.537 That said, these concerns also suggest that prospective or anticipatory suffering could be playing a fairly significant role in the Oregon patient’s wish to die, which, given the difficulty in accurately predicting death to within six months, in the author’s opinion warrants deeper examination.

Patients with ALS have the second highest rate of requests granted, which has been slowly increasing over the years (10.8% in 2010 compared with 7.6% for years 1998-2009).538 This has led to some concern regarding the ability of the Oregon AD scheme to accommodate these patients particularly if they have difficulty swallowing. To date, only oral medications have been prescribed under the legislation and some commentators question whether the legislation as written could allow for self-administration of a medication using an intravenous line.539 At face value, however, as long as the patient controls every aspect of the decision, timing and the final act causing death, it should be permissible. Current studies on the other hand indicate that many Oregon physicians do not wish to be present when the patient takes the lethal medication,540 suggesting that the trend of prescribing oral medications will likely continue into the future.

The non-compulsory attendance of physicians when a patient is ingesting the lethal medication has raised the further issue of responsibility for addressing possible complications upon ingestion, such as vomiting, seizures or the regaining of consciousness. To date, complications have occurred in at least 4.4% of the 525 Oregon cases.541

Another ongoing area of concern is the possibility that, contrary to the 1994 Oregon Law, patients with depression are receiving prescriptions for lethal medication.542 As discussed, a referral for psychological evaluation only becomes necessary if the prescribing or consulting physician forms the opinion that the patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment. A 2008 study of 58 Oregonians with terminal illness who requested PAS or contacted an aid-in-dying advocacy organization found that out of the 18 patients who had received a lethal prescription, three met the criteria for depression and died from lethal ingestion.543 The suspicion has intensified as the number of patients referred for a psychological evaluation has continued to decrease over time from 43.5% in 1999 to 1.5% (one out of 65) patients in 2010544 notwithstanding that the primary condition associated with PAS
requests is a terminal cancer diagnosis — known to have a strong correlation with depression disorders.545

Currently, House Bill 2016 is before the Oregon legislature.546 The bill seeks to impose mandatory counseling of all individuals requesting a prescription for medication to end their lives. Proponents of PAS in Oregon see the bill as an attempt to create barriers to “death with dignity”, designed to burden patients and physicians with needless procedures and paperwork.547 What makes this critique particularly interesting is that it implicitly suggests that there should be a presumption that depression is not present in those suffering from terminal illness unlike the Dutch AD scheme, which makes every attempt to rule out depression.548 This contrast illustrates how the limits to autonomy for AD can be drawn: in addition to potentially being drawn to respond to undesirable consequences that have or have not played out (i.e., safeguards), limits are also drawn in the first instance in relation to the perceived foundations or underpinnings of the particular assisted death law at issue. In the case of Oregon, the idea of “death with dignity” pushes the limits that might be imposed by mandatory depression filters outwards while in the case of The Netherlands, the idea of physician-conflict willingly incorporates them. This in turn provides a glimpse into the subsequent task, to determine whether the heterogenous foundations of the respective AD laws are being diluted in such a way as to minimize the limits to AD and maximize AD to its fullest potential based on the expression of autonomy.

6. Washington

a. Historic Overview


Washington’s first attempt at legalization of assisted death came in November 1991 with an Initiative advanced by the Hemlock Society of Washington State — Initiative 119 (“I-119”).550 In addition to collecting 223,000 signatures (50% more than required for a referendum), surveys of the Washington public indicated that approximately two out of three voters were in favour of euthanasia.551

I-119, among other things, would have allowed both PAS and euthanasia for competent adults with a terminal medical condition (i.e., death anticipated within six months).552 Proponents of I-119, emphasized autonomy as the primary value, the right to choose and the importance of quality of life.553 Opponents emphasized the sanctity of life as the primary value.554 I-119 was also opposed by a number of Washington State physicians and the medical association who in response to I-119, mailed out thousands of brochures urging physicians to “vote no”.555

I-119 only garnered 46% of the 1.5 million votes cast.556 The lack of voter support was attributed to the initiative’s failure to provide adequate safeguards against misuse such as the absence of psychological evaluations and waiting periods as well as the inclusion of the more controversial practice of euthanasia.557 Others have attributed the failure to external circumstances including the wealth of the Catholic Church and the negative impact from the “excesses” of Dr. Kevorkian.558

Notwithstanding the failure of I-119, the position taken by the Washington Medical Association (“WMA”) and AD’s illegality, some Washington physicians were providing PAS and euthanasia. A 1996 study of 1,453 Washington physicians (828 responded) reported that 12% of physicians received one or more requests for PAS (156 requests) and 4% received one or more requests for euthanasia (58 requests).559 Twenty-four per cent of patients who requested PAS received prescriptions, twenty-one of whom died, and 24% of patients who requested euthanasia received medication by injection and died.560 The report concluded that the most common patient concern at the time of the requests was non-physical (loss of control, being a burden, loss of dignity) but that physicians were more inclined to grant the requests of patients who had physical symptoms.561

Between the years 1996 and 2006, the path towards a state regime for PAS was carved out: it was appropriate for states to create PAS legislation (Washington v. Glucksberg and Quill v. Vacco), Oregon had developed a scheme that could withstand constitutional scrutiny (Lee v. Oregon), and the federal right to control restricted substances utilized in PAS did not extend to regulating state medical practices (Gonzales v. Oregon). With this and the benefit of Oregon’s ten years of experience, in January 2008, Booth Gardener (a former Washington Governor)562 filed Initiative Measure No. 1000 (“I-1000”)563 which was modeled on the Oregon law.
The I-1000 debate centred on arguments similar to those heard throughout the years of debate in Oregon: for proponents — the issues of pain that cannot be alleviated, the limitations of end-of-life practices such as terminal sedation, and the ability to control the time, place and manner of one’s death; for opponents — the destruction of doctor-patient trust relationship; financial and insurance pressures to choose a “cheaper” death; and the slippery slope leading to euthanasia of society’s most vulnerable members such as those with disabilities and the elderly.564

I-1000 (the “2008 Washington Law”) was passed by voters on November 4, 2008 by a margin of 58% (1,715,219 votes in favour) to 42% (1,251,255 votes against)565 and went into effect on March 5, 2009.566

The WMA continues to oppose the 2008 Washington Law but not to the extent of taking repeal efforts.567

b. Legislative Framework

In Washington, assisted suicide is prohibited under Washington’s Criminal Code provisions whereby a person is guilty of “promoting a suicide attempt” when he or she knowingly causes or aids another person to attempt suicide.568 Like the 1994 Oregon Law, the 2008 Washington Law identifies that actions taken in accordance with the AD law will not constitute suicide, assisted suicide, mercy killing or homicide under the law and protects physicians and others from criminal and civil liability as well as professional disciplinary action.569 As with the Oregon law, the Washington law is not to be construed as authorizing the practice of euthanasia.570

i. Due Care Requirements

The substantive due care requirements mirror those stipulated under the 1994 Oregon law. In order to qualify for PAS, the patient must be a competent571 adult suffering from a terminal disease (death within six months) who has voluntarily expressed his or her wish to die.572 The patient must also be a Washington resident.573

The procedural safeguards are also virtually identical to the Oregon safeguards: two oral requests, one witnessed written request, initial determination by prescribing physician of terminal illness, competency and voluntariness, confirmation by consulting physician, possible counseling referral, waiting periods, the right to rescind, record keeping and so forth.574

It should be noted that the 2008 Washington Law goes a little farther than the 1994 Oregon Law by expressly including in the definition of “qualified” patient, that the patient self-administer the medication which in turn is defined as the act of “ingesting” the medication.575 Thus the Washington law provides physicians with a much clearer image in terms of which patients are qualified under the law as well as a more distinct threshold between the practice of PAS and the practice of euthanasia.

ii. Reporting and Review

The reporting requirements under the 2008 Washington Law are again virtually identical to the 1994 Oregon Law. The Washington Department of Health (“WDH”) is charged with the annual review of all records, the collection of information and the publishing of an annual report.576 The law does, however, provide slightly longer time periods under which Washington physicians and pharmacists are to file the required documentation.577

Additional administrative rules have been adopted to further facilitate the implementation of the law particularly with respect to the form of reporting and confidentiality.578

c. Compassion and Suffering, Autonomy and Self-Determination

Like Oregon, the Washington Law only creates a right to request PAS. Participation by health care providers is not mandatory, and if a health care provider is unwilling to participate he or she is only obligated to transfer a copy of the patient’s medical records to the new health care provider upon the patient’s request.579

While the same can be said of Washington with respect to the issues of suffering and self-determination as described for the Oregon PAS scheme above, it might be argued that the Washington legislation has taken a slightly more expansive view of autonomy.

Under both schemes as described, actions taken in compliance with the law are not to be construed as “suicide” or “assisted suicide” under the law.580 However, the 2008 Washington Law also requires that state reports refrain from utilizing suicide terminology and instead refer to the “obtaining and self-administering life-ending medication”.581 While this shift away from what tends to be provocative value-laden language (particularly from the North American perspective) might be viewed as advancing the principle of autonomy to a certain extent, it is likely more accurate to perceive the
terminology shift as advancing a more accurate descriptor for the ending of life through PAS — many authorities have pointed out that there are fundamental differences in the reasoning underlying the PAS act of a competent terminally ill person and the reasoning underlying the “suicide” act of a clinically depressed person.582

What is more significant, however, to the advancement of the autonomy concept in the 2008 Washington Law is the provision: “The attending physician may sign the patient’s death certificate which shall list the underlying terminal disease as the cause of death”.583 This is particularly compelling because in reality, it would be very difficult to assert an argument that the actual cause of death was anything other than poisoning from the ingestion of a lethal compound. What it does demonstrate, however, is an importation of the law’s perspective on autonomy from the angle of a patient’s right to refuse life-sustaining treatment — that it may not be properly viewed as a form of suicide,584 rather it is the underlying illness that ends the patient’s life.585

d. Statistics and Trends

According to the WDH 2010 Annual Report, from January 1 to December 31, 2010, 87 people requested and received lethal doses of medication.586 This is an increase from 2009, where 65 prescriptions were reported.587 However, it is not possible to conclude whether participation increased as the 2009 year only covered a ten-month period, the law having been implemented on March 5, 2009. The number of deaths under the Washington law is approximately one/tenth of 1% of all deaths in Washington.588

Of the 87 prescriptions dispensed, 51 people died after ingesting the medication and 15 died without having ingested the medication (ingestion status of one was unknown and pending for the other five).589 Of the 72 participants who died, their ages ranged between 52 and 99 years and like Oregon, the majority of patients (78%) were suffering from cancer, with neuro-degenerative diseases (including ALS) and heart disease or “other” at 10% and 12% respectively. Referrals for psychological evaluation occurred 3% of the cases.590

Similar to Oregon, the primary end-of-life concerns of the 72 participants were recorded as loss of autonomy (90%), loss of ability to participate in enjoyable activities (87%) and loss of dignity (64%). Inadequate pain control or concern about it was a significantly less concern at 36%. Of the 51 people who ingested the medicine and died, 90% were at home and 84 were enrolled in hospice care.591

The duration of the patient-physician relationship ranged from three weeks to ten years, with 51% of cases ranging from a three to 24 week relationship and 36% of cases with a relationship of one year or more.592 The prescribing physician was present only 4% of the time and other providers 53% of the time when the medicine was ingested.593 No complications related to the ingestion of medicine were reported.

Thirty-one days after the passage of the Washington Law, in the case Baxter v. Montana, a Montana District Court held that “The Montana constitutional rights of individual privacy and human dignity, taken together, encompass the right of a competent terminally ill patient to die with dignity”.594 The court found that the right included the protection of the patient’s physician who prescribes life-ending medication from liability under the homicide statues.595 In December 2009 the Montana Supreme Court upheld the result but declined to decide the issue on constitutional grounds, preferring instead to decide on the basis of statutory interpretation, i.e., a terminally ill patient’s consent to physician aid in dying will constitute a statutory defense to the charge of homicide against the aiding physician.596 The Baxter v. Montana decision was followed by the tabling of two bills in the Montana Senate — Bill SB 167597 which aimed at regulating PAS in the same manner as Oregon and Washington and Bill SB 116598 which sought to ban PAS altogether (Bill SB 116). Both bills were defeated in February 2011.

PART III. SUMMARY

A. CONSTRUCTION OF AUTONOMY IN THE NETHERLANDS AND THE AMERICAN AD MODELS

In The Netherlands as discussed, AD regulation originally evolved in response to a perceived conflict in physician duties — the duty to protect life and the duty to relieve suffering (Figure 1). This conflict of professional duties in turn was resolved by allowing physicians to provide AD pursuant to a defense of necessity. Thus the essence of AD law in The Netherlands is the regulation of a medical activity. This formulation produces distinct policy constraints on AD — legalized AD must connect to a medical condition, and it can only be implemented by the physician as a measure of last resort.
Thus in order to “qualify” for AD in The Netherlands, suffering has to be grounded in a medical condition and it must be lasting and unbearable as determined by, that is “palpable”, to the doctor within the doctor-patient relationship. Furthermore, in keeping with the professional duty ideology, once a decision to proceed with AD has been made, the doctor must remain with the patient until his or her death. Implicitly, within this particular construction, the expression of autonomy and self-determination is fairly narrow, operating only as a necessary pre-condition to the doctor’s activities as described above.

One of the most significant outcomes of the physician conflict-of-duties underpinning is the broad scope of The Netherlands AD scheme, justifying euthanasia or PAS and justifying medical conditions beyond those strictly considered “terminal”. That said, it should be reiterated that the catalyst for what appears to be an expansive approach to AD was not rooted in a similarly expansive version of self-determination being instead grounded in a medical-professional judgment of suffering.

On the other hand, because a patient can legally refuse treatment that might otherwise address a condition and/or its symptoms, the notion of an operative “necessity” defence could be considered somewhat misleading as it is arguably the patient — the autonomous individual — who controls whether or not the conditions of necessity have been met. Granted, even where conditions of necessity do exist, the physician cannot legally be compelled to provide AD. However, the point is, that without a necessity defence, logically speaking, there seems to be little basis for filtering the suffering criteria through a medical lens (apart from the gate-keeping role regarding patient voluntariness and competency). When combined with the inherent subjectivity of suffering and the expansive “remedies” (i.e., euthanasia and PAS) available in the Netherlands, it is not much of a stretch to contemplate a demand for euthanasia or PAS for any form of suffering, particularly when elderly individuals, who are closer to the death event temporally speaking, are involved, a demand that is already being heard in The Netherlands (Figure 2).

Even with this weakness in the transparency of the necessity defence underpinning (which in the author’s opinion warrants further exploration), what is essential here, is that it is the necessity defence underlying the development of AD in The Netherlands that has served to justify the act of euthanasia, that is, lethal injection. Without this association, the continued practice of euthanasia would have to be grounded in an alternative principle such as autonomy or self-determination. We can, however, also observe that the American (Oregon and Washington) AD model, the model which is arguably the most overtly associated with the principles of autonomy and self-determination, does not permit euthanasia, only allowing PAS in the case of patients with six months or less to live (Figure 8). Indeed, the American AD laws not only streamline the physician’s legal obligations regarding the assessment of a patient’s suffering (the “six months or less to live” bright line) but also direct the primary responsibility for the AD act towards the patient.

This shift in the locus of responsibility is reflected in a number of other provisions under the American model including the non-compulsory attendance of physicians when the patient ingests the lethal dosage. Thus the interpretation of autonomy and self-determination within the American AD schemes informs limits different than those of the Netherlands: it does not extend to incorporating the practice of euthanasia, nor does it extend beyond a diagnosis of terminal illness.

This particular interpretation of the scope of the expression of autonomy in the American AD schemes appears to connect with the particular way in which AD practice has evolved in the United States. As described earlier, the American AD schemes have evolved under the influence of legal arguments seeking to extend the legal right to refuse life-saving treatment (even if resulting in the death of the patient) to include an analogous medicalized result for all “dying” patients on a basis loosely related to the rights to liberty, privacy and/or equality. Given these influences, the suitability of citing the cause of death as the underlying terminal disease, as is the case under the 2008 Washington Law, is perhaps not as dubious as it may first seem.

The progression of American AD law on this foundation, that is, autonomy construed through the concepts of rights to liberty, privacy and/or equality in turn serve to confine AD development to a negative, as opposed to a positive, right. That is, the opportunity to request assisted death if viewed as a right to choose or a right to be free of unwarranted interference or perceived as a right to equal treatment for those who are dying does not compel any particular right to assisted death. Such foundations do not oblige a physician to perform AD; participation in AD remains the physician’s choice. At best, it seems that AD advanced on these principles only warrants the provision of immunity
to the physicians who voluntarily agree to assist. Thus, we see the result in the more recent case of Baxter v. Montana where the Montana District Court’s view that a right to die with dignity was established on the basis of a right to privacy and human dignity was constrained by the Montana Supreme Court which limited legal AD to a less complex statutory defense to homicide.599

Under these two models — The Netherlands and the American — autonomy has been constructed in two very discrete ways leading to two very distinct approaches to the accessibility and methods of assisted death. The former, which evolved from the perspective of the physician facing a dilemma in carrying out conflicting professional duties, expresses the idea of autonomy more narrowly in the sense that it is not autonomy or self-determination that justifies the practice of AD. Rather, autonomy acts to constrain the options available to the physician in resolving that dilemma. The latter, which evolved more from the patient’s perspective, expresses the idea of autonomy more broadly in the sense that it stems from the right to self-govern and the right to direct medical treatment. The “dying with dignity” lexicon contributed to the expansion of this form of self-determination via concepts of equality, liberty and privacy and increased the scope of medical options available to the dying patient. This more expansive construction of autonomy, however, translates into an overall reduced legal expectation and obligation regarding physician involvement in a patient’s decision to die.

Regardless of these different constructions of autonomy, both models lead to the regulation of assisted death as a form of physician immunity.

B. CONSTRUCTION OF AUTONOMY IN THE BELGIUM AND LUXEMBOURG SCHEMES

As described, the AD schemes of Belgium and Luxembourg are quite similar to that of The Netherlands. However, it also appears that through the process of bringing the respective laws to fruition, both jurisdictions shed the “necessity” underpinning (and so too associated policy constraints) in favor of a human-rights approach, with both euthanasia and PAS being justified primarily on the basis of the patient’s free and informed request. From this rights perspective, the physician duty to protect life (as imposed by the right to life) is to be interpreted pursuant to the right to self-determination and reflect the will of the patient (as imposed through the right to privacy) (See Figure 4). In other words, the patient’s right to control treatment supersedes the doctor’s obligation to protect life.

The activities of the physician as circumscribed by the right of the patient to self-determine, again does not logically lead to any positive right to AD, indeed no such right is established in either the Belgium or Luxembourg AD laws. However, the importance of a right to privacy more visibly underpins the genesis of these laws. As a result, the Belgium and Luxembourg AD laws can be viewed as constructing AD as a type of negotiation between physician and patient.

The rules of this negotiation require recourse to individual personal convictions and conscience, not only of the patient, but also of the physician as the individual tasked with carrying out the practice of AD. Thus what emerges is the regulation of AD based on a construction of autonomy again located within the patient-physician nexus, whereby it is legal for a patient to request AD and legal for a physician to respond to that request in the affirmative or the negative (Figure 5). Furthermore, the patient-physician nexus necessarily imposes a medical dialogue, again positioning suffering as the element common to both parties (Figure 3). The result is the inclusion of unbearable and hopeless/constant medical suffering as pre-requisite for AD but understood first and foremost from the patient’s perspective.

It might thus be argued that pursuant to these underpinnings, the Belgium and Luxembourg AD laws envision a more expansive view of autonomy than the Netherlands Law of 2002. This is particularly so given that physician obligations under the Belgium and Luxembourg AD laws are increasingly oriented towards ensuring the voluntariness, capacity and/or competency of the requesting patient. Reflections of this orientation can be seen in the added safeguards imposed on the physician when the patient is “not expected to die in the near future” under the Belgian Law of 2002 and the provisions related to “dispositions de vie” under the Luxembourg Law of 2009. On the other hand it could also be argued that the net effect of these additional procedural obligations is an increased burden on the patient which in turn serves to create additional barriers to self-determination, an argument similar to that described earlier with respect to proposed mandatory counseling under the Oregon AD scheme.

Regardless, the formulation of autonomy as a type of negotiation based on the freedom of choice of the patient and the freedom of conscience of the doctor does not provide a ready basis upon which to
expand AD into a positive right, an expansion contemplated by the KNMG, the Dutch Medical Association as discussed earlier.600

As discussed, unlike the KNMG, the Belgian and Luxembourgish medical associations had little input into the development of AD laws in their respective jurisdictions, taking a position that AD had been imposed upon the medical profession and represented an intrusion into the trust relationship between doctor and patient. Indeed, it was not until the Belgian Law of 2002 was passed when the Belgian Deontological Code was amended to permit physicians to inform the patient of all possible end-of-life options. Under the current Luxembourg Code of Medical Ethics, euthanasia is still prohibited.601

Thus the Belgium Law of 2002 and the Luxembourg Law of 2009 demonstrate a greater disconnect with the respective medical professional associations than their Dutch counterpart, despite the fact that these laws have been structured in the same manner as the Dutch Law of 2002. Accordingly, the view of autonomy under the Belgium and Luxembourg schemes is different than the Dutch construction. On one hand, this construction of autonomy might be seen as less expansive than the Netherlands in the sense that AD did not have the extensive support from the medical community in these jurisdictions. This in turn augurs against the further expansion of AD as a medicalized activity from a negative to a positive right as discussed above.

Paradoxically, the construction of autonomy in Belgium and Luxembourg might be viewed as being more expansive than the Netherlands for the very same reason. AD laws were introduced without requiring significant support from the respective medical associations. As described earlier, the idea of the freedom to choose, was advanced largely as an appreciation and outgrowth of the right to privacy. As a result, the dilemma involving physician conflict of duty was subordinated to the concept of physician freedom of conscience to facilitate a response to a patient’s request for AD. Euthanasia or PAS are both permissible responses, justified not by a conflict of professional duties but by the patient’s freedom to choose. From this perspective, the scope of autonomy under the Belgium and Luxembourg schemes is broader than the Dutch Law of 2002. Accordingly, the AD conflict has been framed in a number of different ways. For example, the Swiss AD scheme was infused with medicalized contours despite general reluctance to AD from factions of the Swiss medical profession and opposition by certain individuals in right-to-die organizations. Thus while AD is technically legal for any “condition”, whether physical or mental, fatal or non-fatal, AD has been restricted through policies and agreements between right-to-die organizations and the government to, for example: (i) prohibit assisted suicide to younger persons who are not experiencing severe physical suffering; and (ii) impose the use of specific barbiturates to trigger narcotics regulations which in turn increase physician involvement. Physician guidelines impose further restrictions on physicians specifically, for example, by requiring the existence of a terminal or “fatal” condition, that is, one that will lead to death within a few days or weeks.

Because the Swiss experience with AD is one associated with the narrowing of an expansive scheme as opposed to the expansion of a narrow scheme, the AD conflict has been framed in a number of different ways. For example, the Swiss National Advisory Commission on Biomedical Ethics, the NEK-CNE, described the “twin poles” of the conflict as one between providing care for the...
person at risk for suicide on the one hand, and respecting the autonomy of that same person on the other. The conflict is thus appreciated at the level of the individual him- or herself and that particular individual’s interaction with the state. The NEK-CNE, however, also described a second clash akin to a slippery slope concern, that in the provision of care of the individual desirous of AD, the state must ensure that the freedom of choice of other individuals to not opt for assisted suicide is not restricted or impinged upon (Figure 6). In other words, in permitting AD, the state must not (and must not be seen to) impose AD on those who would not otherwise be inclined to consider it as an option.

Thus while the state perceives an obligation to protect the individual in the sense of ensuring that an individual’s decision is truly autonomous (via physician assessment), AD has been rationalized in Switzerland in such a way as to presuppose assisted suicide as a form of inherent right.

On the other hand, the 2004 SAMW Guidelines, frame the AD conflict as a conflict between the aims of medicine and the wishes of the patient. Where such a conflict exists, these medical guidelines identify that the doctor must make a decision of conscience. The 2004 SAMW Guidelines approach is stricter than what would generally be permissible under Swiss AD law and under current government policy discussed above. This particular view of the patient-physician interface, intensifies the medicalization of the activity and accordingly engages additional professional considerations, such as the specific nature of the illness. It is interesting to note that while the 2004 SAMW Guidelines incorporate the Luxembourg government’s perspective on AD, that is, recourse to physician conscience to settle the negotiation between patient and physician, to date, the Luxembourg medical code itself has not yet incorporated the same view.

When the above perspectives are added to the varied guidelines of the right-to-die organizations as discussed as well as the lessons from the Haas case (which expressed the wide margin of appreciation available to states when balancing the right to life with the right to respect for privacy), the Swiss perspective describes the scope and function of autonomy in a variety of different ways. Indeed, it demonstrates commonalities with the other AD schemes. For example, from the Swiss perspective there is a general acceptance that autonomy and self-determination underpin the practice of AD. There is also a sense that AD might be in contradiction to the aim of medicine but it stands that a physician must take a patient’s wishes into account. Thus physician conscience and suffering both have roles to play in the negotiation involving patient autonomy and physician assistance in death. And finally, while autonomy may support or justify assisted suicide or PAS, it does not necessarily support the practice of euthanasia.

PART IV. CONCLUSION

The drivers and justifications underlying the current assisted death liberalization movement are widely thought to be connected to the principles of autonomy and self-determination. However, the foregoing review demonstrates that the practical application and translation of these principles into assisted death regulation is far from straightforward and is certainly not homogenous. Furthermore, while best practices in carrying out assisted death are becoming better understood, for example, in terms of preferred medications and anticipation of potential complications and so forth, what is precisely being regulated and the philosophical and moral bases for this regulation in the overall global picture are perhaps a little less clear.

This lack of clarity becomes quite evident when examining the role of the respective medical communities in the development of legalized AD and in the varied participation of medical doctors in the practice of AD. It is only in the case of the Netherlands where there was both (i) historic support from the medical profession, and (ii) where AD emerged as a legalized medical practice connected to years of evaluation and discussion within and beyond the medical community. In all other cases as discussed, assisted death was met with degrees of opposition from the medical profession and within respective professional codes. What emerges then is a variety of regulatory approaches to AD. In three jurisdictions both assisted suicide and euthanasia are permitted, while in three others, only assisted suicide is allowed. Under certain regimes, a particular level and quality of suffering is required while in others, access to AD hinges on a diagnosis of six months or less to live. In some jurisdictions, the legal role of physician appears more clearly linked to the role of gatekeeper with respect to competency and voluntariness of the patient, while in others it appears more deeply connected to the physician’s duty to relieve suffering. Furthermore, in some cases assisted death can be legally described as “natural” while in others, it is legally construed as “unnatural”.

In every case, however, the expression of autonomy as it pertains to AD has been largely defined through its interface with medicine. Thus it
can be generally observed that the limits to autonomy are reached if the request for assisted death falls outside of a medical construct. Elements that can exceed the medical construct of assisted death include:

1. Suffering that does not connect in some way to physician duties, such as suffering that has no medical basis or suffering arising from a curable or treatable medical condition;
2. Lack of competency or capacity such that the patient is unable to direct medical treatment; and
3. A method of bringing about death other than by way of a controlled narcotic.

Each jurisdiction, however, interprets, incorporates and applies these elements differently which in turn generates inimitable territorial boundaries on the individual seeking assisted death. Two of the primary examples here are the complex boundaries related to AD for non-residents and the shifting boundaries related to the medical evaluation of suffering. Furthermore, all medicalized limits are not equal. For example, in the case of Switzerland, it is recourse to a controlled drug that is the principal trigger for physician involvement. While the physician must still address issues related to the nature of the individual’s suffering or competency, this application limits the individual’s autonomous decision for death to a lesser extent than do limits imposed in other jurisdictions.

Perhaps one of the most interesting results of the heterogeneous foundations of the AD schemes is the demonstration of a potentially inverse relationship between autonomy and the mode of assisted death. For example, when autonomy is given its most expansive interpretation, the remedies available to the patient appear to contract; only assisted suicide is made available in Oregon, Washington and Switzerland. Similarly when autonomy is given a much narrower interpretation, as was the case of the Netherlands pursuant to the defence of necessity, a broader range of options for the patient became justified, that is, PAS or euthanasia.

On the other hand, the Belgian and Luxembourg schemes challenge this construct by justifying euthanasia and PAS on the basis of autonomy and a perceived right to die following from a right to privacy. But as discussed earlier, the AD laws of Belgium and Luxembourg emerged after what is considered to be a brief political and public discussion and without the same level of support from their respective medical communities. Thus the introduction of AD laws in Belgium and Luxembourg demonstrate that while there may be limits that arise in association with the heterogeneous foundations of the respective AD laws, these limits are not impenetrable. Additionally, as the lexicon of “self-determination” and “dying with dignity” intensifies globally — along with increased transparency in the physician practice of AD regardless of legality, the reality of “suicide tourism” and the emergence of comprehensive PAS and euthanasia statistics — there is increasing domestic pressure to consider the introduction of AD schemes comparable to those already in place.

It is difficult to say whether these and other pressures will lead to the proliferation of AD laws based principally on the ideas of autonomy and self-determination. However, it is important to recall that the processes, players and systems that have led to the emergence of the AD laws currently in existence have been peculiar to the respective jurisdictions at issue. The lesson to be gained from this observation merits against taking a streamlined approach to AD and particularly bodes against the importing or mimicking of these schemes. There are already many examples of failed attempts to import blended AD regulatory frameworks into new jurisdictions. These failures make evident the critical nature of unique domestic perspectives in AD discussions. As can be observed from the overall discussion herein, the shape and the integrity of any end of life regulation is dependent on the players involved and the particular systems in which they operate.

Indeed, recent developments in the United Kingdom point to an entirely different formulation of assisted death, one that does not stem primarily from the perspective of medicine nor primarily from the perspective of autonomy. Following the Purdy case, the Department of Public Prosecutions issued prosecutorial guidelines identifying the criteria to be taken into account when deciding whether or not to prosecute individuals for encouraging or assisting suicide (DPP Guidelines). Under the DPP Guidelines, a public interest factor that warrants against prosecution is that the assistor was wholly motivated by compassion. Assistance by a medical doctor, nurse or other healthcare professional on the other hand are factors that merit in favour of prosecution. While the DPP Guidelines cannot be interpreted as legalizing AD in the United Kingdom (as they pertain only to whether it is in the public interest to proceed with a prosecution), the guidelines do identify possible de facto immunity for those who
assist others to die. The major distinction between the U.K. approach and the approach taken under most of the AD laws is that this immunity does not belong to the medical profession. Additionally, apart from capacity and voluntariness requirements, autonomy has little to do with justifying the non-prosecution of an assistor. Instead, the justification connects back to the motivations of the assistor.

Whether or not one perceives the current U.K. approach as an echo of the necessity defence at the origin of Dutch AD law, this approach in conjunction with all AD schemes canvassed throughout this discussion raise the question as to what extent is, or should, the art of dying be a function of medical practice. Despite the apparent momentum for an expansion of legalized AD, it seems obvious that a one-size-fits-all approach to the development of assisted death legislation will not be sufficient to address the moral confusion associated with the complex and immense dimensions of assisted death.

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1 Swiss Penal Code (SR 311.0) Art. 115.
2 See discussion on defining autonomy in Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics* (6th ed., OUP 2009) 99. Note: this definition is provided notwithstanding that precise definition is the subject of ongoing dispute and discussion.
5 The legitimacy of this practice is based on the doctrine of double-effect which posits that as long as the primary intention of the physician is to relieve suffering, the act of increasing medication to the extent that it might hasten death is not culpable. This practice in early discussion has also been described as “indirect” euthanasia. See discussion in Leon R. Kass, “I Will Give No Deadly Drug” in *The Case Against Assisted Suicide* (Baltimore, MA: The Johns Hopkins University Press, 2002) at 37. See also Keown, *ibid.*, at 20-22.
6 Deep, sustained sedation along with the withholding of artificial nutrition and hydration particularly at the terminal phases of a patient’s life. Note that there is ongoing discussion as to the appropriate scope of this practice, its terminology (“palliative” versus “terminal” sedation) and possible improvements to the practice so that it does not become an unregulated alternative to the legal AD practices. For further discussion see Agnes van der Heide, *et al.* (2007) “End-of-Life Practices in The Netherlands under the Euthanasia Act” 356 New Eng. J. Med. 1957, 1961-64 [Van der Heide, Netherlands]. See also B. Gordijin and R. Janssens, “Euthanasia and Palliative Care in The Netherlands: An Analysis of the Latest Developments” (2004) 12 Health Care Analysis 195 at 195-207.
10 Definition expanded from Jansen-van der Weide 2004 study, *supra*, note 8 at 366.
12 See discussion in Keown, *supra*, note 4 at 9-10, 84.
13 Euthanasia in The Netherlands excludes other life-shortening medical practices that are generally considered to be within the bounds of “normal” medical practice namely: withholding or withdrawing life prolonging treatment either on the basis of futility or in order to honour the patient’s refusal of treatment; the administration of medically-indicated doses of pain relief with life shortening effect. Griffiths, Weyers and Adams, *supra*, note 11 at 76.
Supreme Court, November 27, 1984, Note: Killing a person without an individual’s express request, while possibly justifiable, is not ‘euthanasia’ but rather, in Dutch discussion is called, ‘termination of life without an explicit request’. Such activity will generally be prosecuted as murder.


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Griffiths, Weyers and Adams, supra, note 11 at 76.

Supreme Court, November 27, 1984, Nederlandse Jurisprudentie 1985, no 106 [Schoonheim]. In this case, Dr. Schoonheim gave a lethal injection to his patient, Mrs. Barendregt, upon her repeated requests. Mrs. Barendregt was 95 years old and although not suffering from a terminal illness, she was bedridden, experienced dizziness and had great difficulty seeing and hearing. A full English translation of the case can be found in J. Griffiths, A. Bood and H. Weyers, Euthanasia and Law in The Netherlands (Amsterdam: Amsterdam University Press, 1998) at 322-28 [Griffiths, Bood and Weyers].

Schoonheim, ibid., at 459.

Netherlands Ministry of Security and Justice, Euthanasia and assisted suicide control act takes effect on 1 April 2002 (Press release, 26 March 2002).

Nederlandse Jurisprudentie 1973, no. 183 [Postma]. The 1973 case of Dr. Geertruud Postma is considered to be the genesis of the Dutch debate on Euthanasia.

E. Vermeersch, “The Historical and Ethical Background: The Belgian Law on Euthanasia” (2002) 102 Acta chir belg 394 at 394 [Vermeersch]; See also B. Sneiderman and M. Verhoef, “Patient Autonomy and the Defence of Medical Necessity” (1996) 34 Alta. L. Rev. 374 at 385 [Sneiderman and Verhoef]. Dr. Postma, injected her 78-year-old mother with a lethal dose of morphine upon her mother’s repeated requests. Her mother was suffering from partial paralysis, deafness and incontinence. Dr. Postma was guilty of killing on request, a violation under the Penal Code. The Leewarden District Court acknowledged that in certain situations, doctors are not required to prolong a patient’s life and that it may be permissible to administer pain relief at the risk that death might be hastened, provided certain conditions were met, i.e., incurable illness; unbearable suffering; and request by the patient. The court did not find Dr. Postma’s decision to be reasonable, sentencing her to a suspended sentence of one week’s imprisonment and one year of probation.

In the Wertheim case, Mrs. Wertheim, an euthanasia activist and volunteer assisted the suicide of a 67-year-old woman suffering from physical and mental conditions. The district court articulated that in certain situations, assistance with suicide might be justified. These included: unbearable suffering; enduring desire to die; and no alternatives for relief. The court also identified procedural safeguards that should be met: assistance by physician and consultation. Mrs. Wertheim was not a doctor and was, therefore, found guilty of assisted suicide and given a six-month conditional sentence subject to one year of probation and two weeks house arrest.

Nederlandse Jurisprudentie 1982, no. 63:223 [Wertheim]. See also discussion of additional Dutch cases in Griffiths, Bood and Weyers, supra, note 17 at 63-65 and in Sneiderman and Verhoef at 388-392. Because of cases such as Postma and Wertheim, ibid., the College of Procurators-General (the highest authority in the prosecutorial system) made a policy decision that the determination of whether to prosecute cases of euthanasia were only to be made by the College based on the guidelines and criteria emerging from the courts. See discussion in Griffiths, Bood and Weyers, supra, note 17 at 58-60. See also discussion in Griffiths, Weyers and Adams, supra, note 11 at 30. See also the Admiraal case where Dr. Admiraal, an anesthetist performed euthanasia to a patient with multiple sclerosis suffering from a state of total physical dependency. The court found that Dr. Admiraal had made a justifiable choice and was in compliance with the requirements of careful practice.

Nederlandse Jurisprudentie 1985, no. 709 [Admiraal]. Following the Admiraal case, the Ministry of Justice advised that doctors who were in
compliance with the “requirements of careful practice” would be exempt from prosecution for euthanasia. For full discussion see Griffiths, Bood and Weyers, supra, note 17, at 66-67 and Keown, supra, note 4 at 83-86.

For example, following the Postma case, the Royal Dutch Medical Association (“KNMG”) issued a report in 1973 accepting Euthanasia in cases where there was no other relief for extreme suffering. Royal Dutch Medical Association, “The Problem of Euthanasia” (1973) 28 Medisch Contact 857. For a discussion see Guenter Lewy, Assisted Death in Europe and America (New York: Oxford University Press, 2011) at 19 [Lewy]. See also KNMG, Vision on Euthanasia, supra, note 13. See also discussion in Sneiderman and Verhoef, supra, note 20 at 385.


Griffiths, Weyers and Adams, supra, note 11 at 32; Lewy, ibid., at 25.


English Translation of Dutch Penal Code provisions from Sneideman and Verhoef, supra, note 75.

Griffiths, Weyers and Adams, supra, note 11 at 77. For further discussion on the interplay between the courts’ treatment of the Schoonheim case and political discussion and emerging policy statements and guidelines from professional bodies such as the KNMG and the Association of Nurses see Lewy, supra, note 22 at 21-22.

Griffiths, Weyers and Adams, supra, note 11 at 33, 41. For full discussion of the evolution of the defence of necessity in Dutch case law with respect to euthanasia, see Sneideman and Verhoef, supra, note 20.

For critique of necessity defence see Keown, supra, note 4 at 84 et seq.

Griffiths, Weyers and Adams, supra, note 11 at 49.


For further discussion on the impact of this failure to distinguish, see Griffiths, Weyers and Adams, supra, note 11 at 82-84.

Barney Sneiderman, “Euthanasia Safeguards: Legal and Socio-Political” in Barney Sneiderman and Joe Kaufert, eds. Euthanasia in The Netherlands: A Model for Canada? (Winnipeg, MB: Legal Research Institute, 1994) at 100 [Sneiderman, Safeguards].

Griffiths, Weyers and Adams, supra, note 11 at 78.

Implementation of the request criteria over the years has demonstrated that requests must be: specific, directly made and timely; well-informed (full and open discussion between physician and patient); and internally and externally voluntary, i.e., mental capacity and free from external pressures or influence, respectively. In the case of psychiatric illness or disorder, great caution must be taken in assessing voluntariness and competence and consultation with a psychiatric expert is required. A patient suffering from depression may not have decisional competence and if there is any doubt, consultation with a psychiatrist in addition to an independent physician is advisable. Similar caution is to be exercised in cases of dementia. See also discussion in Compassion and Suffering, Autonomy and Self-Determination in Part II.B.1.c below.

Advance written directives are also permissible in the case of a patient who is no longer competent as well as for those who are competent. In the case of a competent patient, while a written directive may be helpful, it is not required. The physician should, however, record in detail, discussions with patient regarding the patient’s wish for termination of life and the decision-making process. See 2009 RRC Report, supra, note 26 at 9-12.


Sneiderman, Safeguards, supra, note 35 at 100. This is interpreted as including consultation with an independent physician (independent of physician and patient) who will give an expert opinion on whether the due care criteria have been fulfilled in a timely
manner and will see the patient to determine if the consulting physician has overlooked anything regarding due care criteria. 2009 RRC Annual Report, supra, note 26 at 29. See also discussion on suffering criteria below in Part II.B.1.c below.

The 2009 RRC Annual Report, supra, at Art. 23.


The Dutch Law of 2002, supra, note 26 at 44.


The Dutch Law of 2002, supra, at Art. 3.

Ibid., at Arts. 3 and 8.

Ibid., at Art. 9.

Ibid., at Arts. 8-10.

Ibid., at Art. 17.


The Brongersma Case, Nederlandse Jurisprudentie 2003, no. 167 [Brongersma].

The Chabot Case, Nederlandse Jurisprudentie 1994, no 320 [Chabot]. In this case the Supreme Court ruled that a physician could lawfully assist a patient who was suffering from a non-somatic medical condition, but only in exceptional circumstances. Dr. Boudewijjn Chabot was found guilty of assisted suicide for assisting the death of his patient, 50-year-old Hilly Bosscher who was suffering from inconsolable grief after the successive deaths of her two sons. After numerous consultations with other doctors (none of whom though had actually examined the patient), Dr. Chabot determined that Mrs. Bosscher was experiencing intense, psychic suffering with no prospect of improvement and provided the means for her to commit suicide. Lewy, supra, note 22 at 48. See also extensive discussion of the case in Sneideman and Verhoeff, supra, note 20 at 398 et seq. The 2009 RRC Annual Report, supra, note 26 at 6.

Extra precautions must be taken in these situations in order to ensure that patient voluntariness in these circumstances. See note 37 and the 2009 RRC Annual Report, supra, note 26 at 7, 11. See also Chabot, supra, note 55.

Griffiths, Weyers and Adams, supra, note 11 at 107 and 113.

The Dutch Law of 2002, supra, note 15 at Arts. 2.1.b and 2.1.d.

See discussion in Griffiths, Weyers and Adams, supra, note 11 at 90.

“The question here is not whether people in general or the physician himself would find suffering such as the patient’s unbearable, but whether it is unbearable to this specific patient”. The 2009 RRC Annual Report, supra, note 26 at 22.


The 2009 RRC Annual Report, supra, note 26 at 24 and Cases 4, 5 and 6.

Aanwijzing vervolgingsbeslissing inzake actieve levensbeëindiging op verzoek (euthanasie en hulp bij zelfdoding) [Note prosecution decision on euthanasia on request (euthanasia and assisted suicide)] 23 December 2003 Staatscourant No. 248 at 19. See also Griffiths, Weyers and Adams, supra, note 11 at 89, 92. The Dutch Law of 2002, supra, note 15 at Art. 2.2.

For further discussion on assessing unbearable suffering in comatose patients and where euthanasia may be justified see the 2009 RRC Annual Report, supra, note 26 at 24-25.

Ibid., at 22.

Ibid.

This will be the case for non-somatic as well as somatic-based suffering despite the Supreme Court’s earlier decision in Chabot, supra, note 55; that in principle, suffering will not be legally considered to be lacking any prospect for improvement when the person has refused a realistic therapeutic alternative. The 2009 RRC Annual Report, supra, note 26 at 26 and case 10. A recent 2005 study of 158 reported cases indicated that in 35% of the cases there had been alternatives to relieve the patient’s suffering but were not applied. In 81% of the cases where alternatives were available the patients had refused them.
Additionally, the review committees relatively often scrutinized the consultation (41%) and suffering (32%); they rarely scrutinized possible alternatives (1%). H. Buiting, J. Van Delden, B. Onwuteaka-Philipsen, J. Rietjens, M. Rurup, D. van Tol, J. Gevers, P. Van der Maas and A. Van der Heide, “Reporting of euthanasia and physician-assisted suicide in The Netherlands: descriptive study (2009) 10(18) BMC Medical Ethics 2, 9, 12, 13 [Buiting].

The Dutch Law of 2002, supra, note 15 at Arts. 2.1.c and 2.1.d.

Griffiths, Weyers and Adams, supra, note 11 at 49.

Ibid., at 37-38. See also the Chabot case, supra, note 55.

Griffiths, Weyers and Adams, supra, note 11 at 36 citing Trouw, November 2, 2000.

Brongersma, supra, note 54. Although the District Court acquitted Dr. Sutorius, he was later found guilty by the Court of Appeals in 2001 which was upheld by the Supreme Court in 2002 (though no punishment was imposed).


For further discussion see Griffith, Weyers and Adams, supra, note 11 at 107-108 regarding statements by the Royal Medical College regarding obligations to the patient and that Euthanasia should be available to all eligible patients.

Sneiderman and Verheof, supra, note 20 at 414.


The 2009 RRC Annual Report, ibid. A similar assessment conducted in 2005, indicated that the increase in reported euthanasia from 2001 to 2005, was attributable to an increase in reporting compliance — from 54% of cases in 2001 being reported to 80% in 2005. See Ministry of Health Welfare and Sport, ‘Less Cases of Euthanasia’ (Press Release, 5 October 2007) <http://www.rijksoverheid.nl/onderwerpen/euthanasie>.

The 2009 RRC Annual Report, ibid., at 48, Annexe I. Ibid.

The remainder of patients died in hospital (17), nursing home (77), care home (111), hospice (124) and elsewhere, for example, a relative’s home (37). Ibid., at 48, Annexe I.

The nine cases reported were reported to Public Prosecutions and involved: four cases where physicians did not use the correct medication; one case where physician was not present; one case where physician allowed the patient’s partner to administer the drug; and two cases where consultation with a second independent physician did not take place. Ibid., at 48, Annexe I. See also discussion, ibid., at 9.

See discussion in Griffith, Weyers and Adams, supra, note 11 at 33-49. Additionally some commentators observe the extension of euthanasia to non-somatic suffering as notably addressed in the Chabot case, supra, note 55 is also an indicator of movement away from the doctor-centred approach towards individual-centred with greater weight on principle of autonomy. See discussion generally in G. Bosshard, B. Broeckaert, D. Clark, L.J. Materstvedt, B. Gordijn, H.C. Müller-Busch, “A role for doctors in assisted dying? An analysis of legal regulations and medical professional positions in six European countries” (2008) 34(1) J. Med. Ethics 28 at 28-32 [Bosshard]. See also Sheldon, Suffering through Living, supra, note 76.


‘Tired of Life. Group calls for assisted suicide’ Dutch News (Netherlands, 31 January 2011). See discussion on “Drion’s Pill” in Lewy, supra, note 22 where a former chairman of the Dutch Supreme Court published an article in 1991 advocating a pill be available to all those over the age of 75.

Life-shortening medical practices by physicians such as withholding or withdrawing life prolonging treatment on the basis of futility, proportionality or at the patient’s direction and the administration of appropriate pain relief with life shortening effect are considered to be within the realm of “normal medical practice” and therefore, not subject to criminal sanction. Advice of the Council of State, Parliamentary Proceedings (Senate 2000-01, 2-244/21:1D); See also Article 97 Deontological Code (Code of Medical Ethics) of the Belgian Order of Physicians and the avoidance of “therapeutic obstinacy”. Nationale raad van de orde der geneesheren, Geneesheerpatiënt verhouding [Physician-patient relationship] (2000), in Dutch: <http://www.ordomedic.be/nl/code/inhoud/> [Belgian Deontological Code].

Bosshard, supra, note 89 at 29; R. Vander Stichele et al., “Drugs used for Euthanasia in Flanders Belgium” (2004) 13 Pharmacoepidemiology and Drug Safety 89 at 90: “the legal debate on euthanasia was not accompanied by internal preparation of guidelines among the medical profession”.

For example the establishment of two right-to-die organizations: Association belge pour le droit de mourir dans la dignité (Belgian Association for the Right to Die with Dignity) (1981) and its Flemish counterpart Vereniging voor het recht op waardig sterven (Association for the Right to Die with Dignity) (1983). E. Vermeersch, “The Historical and Ethical Background, The Belgian Law on Euthanasia” (2002) 102 Acta chir belg 394 at 394 [Vermeersch]; Commencing in 1984, a variety of bills regarding discontinuation of futile treatment, right to refuse treatment, euthanasia and assisted suicide were introduced into parliament by independent members. For further discussion see Vermeersch, at 394.

Griffiths, Weyers and Adams, supra, note 11 at 275-276.

Under Art. 95 of the earlier Deontological code, a doctor could not intentionally cause the death of one of his patients or help him to take his own life and under Article 96, the doctor was limited to provision of palliative care in the case of a dying patient. For further discussion, see Bosshard, supra, note 89 at 29. After the Belgian Law of 2002 was passed, the Code of conduct was changed to incorporate legalization of euthanasia. Articles 95-98 of the Belgian Deontological Code, supra, note 94 now states that when a physician receives a question regarding the end of life, the physician is to inform the patient of all possible options and provide any medical and moral assistance required. Bosshard, supra, note 89 at 29. See also discussion in Lewy, supra, note 22 at 82. See also in discussion in E. Michiels, R. Deschepper, J. Bilsen, “Information disclosure to terminally ill patients and their relatives: self-reported practice of Belgian clinical specialists and general practitioners” (2009) 23 Palliative Medicine 345 at 345.

Lewy, supra, note 22 at 82. See also observation by Vice President of the Belgian Order of Physicians during hearings in 2000 who expressed the unease felt by doctors concerning their new role as “bringer of death” as well as scepticism from one of the chairperson’s of a private doctor’s organization, that softening the law on euthanasia will alter abuse already in existence. Parliamentary Proceedings (Senate 2000-2001, 2-244/24:108) reported in Griffiths, Weyers and Adams, supra, note 11 at 287-288 [Belgian Parliamentary Proceedings 2000]. See also L. Deliens and G. van der Wal, “The Euthanasia Law in Belgium and The Netherlands” (2003) 362 (9391) The Lancet 1239. “[N]o medical association supported the process in Belgium”.

Unlike Netherlands, there were no specific provisions on Euthanasia or assisted suicide in the Belgium Penal Code. 8 Juin 1867 — Code Penal [The Belgium Penal Code]. Euthanasia was treated in the same manner as intentionally causing death under criminal law. See The Belgium Penal Code, Arts. 393 and 394, voluntary homicide and murder respectively. Article 397 regarding poisoning might also have been relevant. Suicide was not prohibited and, therefore, the legal status of providing assistance with suicide was unclear. Assisted suicide may have been addressed by Art. 422b which addresses failure to provide assistance to a person in grave danger. Belgian Parliamentary Proceedings 2000, supra, note 98.
The Belgian Advisory Committee on Bioethics was established by a co-operation agreement between the federal Government, the French-speaking Community, the Dutch-speaking Community, the German-speaking Community and the Joint Consultativebodies/Commitees/Bioethics/index.htm>

In January 2000, the public prosecutor arrested two physicians on suspicion of administering a lethal drug to a man suffering from a chronic lung condition. Ultimately, the physicians were not prosecuted. Griffiths, Weyers and Adams, supra, note 11 at 305, fn 42.

Three studies were conducted in Flanders in the years of 1996, 1998 and 2001. Flanders is the Dutch speaking part of Belgium where 60% of the population of Belgium resides. The 1996 pilot study was conducted only in the city of Hasselt, Flanders while the 1998 and 2001 studies were conducted throughout Flanders. These three studies are: F. Mortier L. Deliens, J. Bilsen, M. Cosyns, K. Ingels, R. Vander Stichele, “End-of-life decisions of physicians in the city of Hasselt (Flanders, Belgium)” (2000) 14(3) Bioethics 254-67 <http://onlinelibrary.wiley.com/doi/10.1111/1467-8519.00195/pdf> [the 1996 Mortier Study]; Luc Deliens et al., “End-of-life decisions in medical practice in Flanders, Belgium: a nationwide survey” (2000) 356 (9244) The Lancet 1806-1811 <http://www.thelancet.com/journals/lancet/article/PI IS0140-6736(00)03233-5/fulltext> [the 2000 Deliens study]; and A. Van der Heide, L. Deliens, K. Faisst, T. Nilstun, M. Norup, E. Paci, G. van der Wal, P.J. van der Maas, “End-of-life decision-making in six European countries: Descriptive study” (2003) 362 (9381) The Lancet 345-350 [the EURELD Study]. As will be later described, the results from the 2000 Deliens Study were released during senate debate of proposed euthanasia legislation. For a succinct overview of scope and variation of Euthanasia, PAS and pharmacological practices in Belgium prior to legalization see Lewy, supra, note 22 at 71.

Vermeeersch, supra, note 96 at 394; Cohen-Almagor, supra, note 101 at 436.

Griffith Weyers and Adams, supra, note 11 at 277.

The Belgian Advisory Committee on Bioethics was established by a co-operation agreement between the federal Government, the French-speaking Community, the Dutch-speaking Community, the German-speaking Community and the Joint Commission for Community Matters. The Advisory Committee is to be comprised of 35 voting members from both languages and varied disciplines (academics, doctors, philosophers, legal experts, sociologists, etc.) in order to establish ideological, philosophical and linguistic balance. Belgium Advisory Committee on Bioethics, ‘Belgium Advisory Committee on Bioethics’ <http://www.health.belgium.be/portal/Healthcare/ Consultativebodies/Commitees/Bioethics/index.htm> [Belgium Advisory Committee on Bioethics].

Belgium Advisory Committee on Bioethics, ibid., at Art. 1.

The phrase “particularly from the angle of the respect for human rights”, has also been interpreted as “in particular the rights of the individual”. Lewy, supra, note 22 at 72, fn 12.


Ibid., at 1. The Advisory Committee left issues related to other medical acts (such as the administration of drugs which can shorten life and the withdrawal and withholding of futile medical treatment) and cases involving patients unable to express their wishes for future discussion. Ibid.


Advisory Committee Opinion no. 1, supra, note 109 at Part III.

“The law must guarantee the right of every individual to do as he wishes, and according to own convictions, with respect for others”. Ibid.

Griffiths, Weyers and Adams, supra, note 11 at 282.

Griffiths, Weyers and Adams, supra, note 11 at 282-283.


Griffiths, Weyers and Adams, supra, note 11 at 283.
118 Regeerakkoord [Coalition Agreement] (July 1999), para. 11. See also Griffiths, Weyers and Adams, supra, note 11 at 283.

119 The 2000 Deliens study, supra, note 103 at 1806.

120 Pain relief with life shortening effect (18% of total deaths examined) and withdrawal or withholding of treatment (16% of total deaths examined). Ibid., at 1806. Ibid., at 1806; One possible explanation for the high rate of termination of life without a request (pre-legalization) in competent patients was physician fear of legal complications if discussed in an open manner. See discussion in Johan Bilsen, Robert Vander Stichele, Freddy Mortier, Jan Bernheim and Luc Deliens, “The Incidence and Characteristics of End-of-Life Decisions by GPs in Belgium” (2004) 21 Family Practice 282, 286. See also discussion in M. Otlowski, “The effectiveness of legal control of euthanasia. Lessons from comparative law” in A. Klijn, M. Otlowski, M. Trappenburg, eds., Regulating Physician-negotiated Death. (Elsevier, 2001) 137–155.

121 Griffiths, Weyers and Adams, supra, note 11 at 321. Main difference is that unlike the Dutch Law of 2002, supra, note 15, the Belgian Law of 2002 expressly address the issue of euthanasia via advance directives and additional safeguards for non-terminal patients. See text to fn 133-136 below.

122 Federale Controle en Evaluation Commissie Euthanasie [the Federal Control and Evaluation Commission] is the evaluation body established under the Belgian Law of 2002, supra, note 92 at Art. 6 §1.


124 The Belgian Law of 2002, supra, note 92 at Art. 3 §1. Notwithstanding the use of the term “emancipated minor” in the Belgian Law of 2002, euthanasia for minors is a contested issue in Belgium. An emancipated minor for the most part appears to be limited to exceptional cases for persons aged 16 years or over and requires decision by a judge. For further discussion see Cohen-Almagor, supra, note 101 at 437 and Vermeersch, supra, note 96 at 396. Contrast with Loi du 22 août 2002 relative aux droits du patient [Law on Patient’s Rights] (M.B. du 26/09/2002, p. 43719) [Law on Patients Rights] Art. 12 §2 which provides that minors can exercise patient rights in keeping with age and level of maturity. If they can reasonably appreciate their circumstances, they may exercise rights on their own behalf.


126 See the Belgian Law of 2002, supra, note 92 at Art. 4.

127 If the patient is unable to write due to physical disability for example, the request can be written by another person chosen by the patient and who has no material interest in the patient’s death. Belgium Law 2002, supra, note 92 at Art. 3 §4.

128 Ibid., at Art. 3 §2.

129 Ibid., at Art. 3 §3.

130 Cohen-Almagor, supra, note 101 at 37.

131 The Belgium Law 2002, supra, note 92 at Art. 3 §3.

132 Ibid., at Art. 3§3.

133 See also Ibid., at Art. 15 where euthanasia is classified as “natural” for the purposes of insurance contracts for example.

134 Ibid., at Art. 6 §2. There are also linguistic and gender diversity requirements. Art 6 §2.

135 Ibid., at Art. 5.

136 Ibid., at Art. 7.

137 Ibid., at Art. 8.


139 The Belgium Law 2002, supra, note 92 at Art. 3 §1.

140 Ibid., at Art. 3 §1.

141 Cohen-Almagor, supra, note 101 at 438.

Law on Patients Rights, supra, note 127 at Art. 8(4) describes the patient’s right to refuse or withdraw consent for medical intervention. See also the Belgian Law of 2002, supra, note 92 at Art. 3 §2 whereby a doctor is only required to discuss the options with the patient.

The Belgian Law 2002, supra, note 92 at Chapter III.

Ibid., at Art. 4 §1.

Ibid., at Art. 4 §1.

Ibid., at Art. 4 §2.

Proposition de loi sur le droit de mourir en dignité (1) Exposé des motifs, (2) Texte de la proposition de loi, (3) Commentaire des articles (J-2001-O-0277) 4909/00 (19 February 2002) at 3 [Huss and Err Proposal].


“... for the Dutch, Belgian and Luxembourg Acts, addressing the patient’s suffering is the most important principle underlying the Act”. Buiting, supra, note 70 at 4.

Griffiths, et al. argue that this omission leaves no statutory basis to impose standards for additional activities such as remaining with the patient until death, the drugs selected and the division of responsibilities between doctor and nurse. See Griffiths, Weyers and Adams, supra, note 11 at 322. Note, however, that there is legislation in place to shield pharmacists from liability. Wet van 10 November 2005 tot aanvulling van de wet van 28 mei 2002 betreffende de euthanasie met bepalingen over de rol van de apotheker en het gebruik en de beschikbaarheid van euthanatica [The Law supplementing the Law on Euthanasia with provisions on the role of the pharmacist and the availability of euthanatica of November 10, 2005] Belgisch Staatsblad (13 December 2005) <http://www.lachambre.be/FLWB/pdf/51/1832/51K1832001.pdf>.


The number of reported cases of PAS is small, representing no more than 1% of all cases of reported assisted deaths. The FCEC Reports, supra, note 156.


FCEC 2010 Report, supra, note 126 at 21.


The FCEC data is consistent with results from the EURELD Study, supra, note 103. See discussion in Griffiths, Weyers and Adams, supra, note 11 at 331-334. 83% (2002-2003); 86% (2004-2005); 81% (2006-2007); 80% (2008-2009). The FCEC reports, supra, note 156. Only 60% of the Belgium population is...
Dutch speaking, thus this figure appears disproportionate. For discussion as to possible explanations for this difference see Lieve Van den Block, *End-of-Life Care and Medical Decision-Making in the last Phase of Life* (Brussels: Brussels University Press, 2008) at 151. See also discussion in Lewy, *supra*, note 22 at 80.


48% in 2002-2003; 49% in 2004-2005; and 55% in 2006-2007. For 2008-2009, 52% of cases were from ages 60-79 and 73% cases occur in ages 40-79. FCEC Reports, *supra*, note 156.


99.5% (2002-2003); 98% (2004-2005); and 96% (2006-2007); FCEC 2010 Report, *supra*, note 126 at 15. Note, however, the 2007 Smets Study found that “Unreported cases were generally dealt with less carefully than reported cases: a written request for euthanasia was more often absent (87.7% vs. 17.6% verbal request only). The 2007 Smets Study, *supra*, note 161 at 341. Additionally, a second study regarding nurse involvement in euthanasia (also carried out in 2007) found that of the nurses surveyed in the Flanders area (1,678 with 76% response rate), in the case of euthanasia, 12% of nurses administered the drug “and in almost half of the cases without an explicit request from the patient”. Els Ingelbrecht, Johan Bilsen Freddy Mortier and Luc Deliens, “The role of nurses in physician-assisted deaths in Belgium” (2010) 182(9) CMAJ [Ingelbrecht study]. See also Chambære, CMAJ, *supra*, note 161.


The FCEC Reports, *supra*, note 156.

See for example, Association of General Practitioners, *Policy Statement on End of Life Decisions and Euthanasia* (4 December 2003) Art. 2: “Euthanasia is one of the possible choices in terminal care and must be framed by and embedded in total palliative care that transcends individual care”.


“The rate of intensified alleviation of pain increased from 18.4% in 1998 and 22.0% in 2001 to 26.7% in 2007, and the rate of withholding or withdrawing life-prolonging treatment increased from 14.6% in 2001 to 17.4% in 2007. In the case of 14.5% of all deaths, physicians reported using continuous and deep sedation until death, a rate that was substantially higher than that in 2001 (8.2%)”. Bilsen, Cohen, Chambære and Pousset, *supra*, note 161 at 1119-1121. See also 2007 Smets Study, *supra*, note 161. See also Tinne Smets, Joachim Cohen, Johan Bilsen, Yanna Van Wesemael, Mette L Rurup, Luc Deliens “The labelling and reporting of euthanasia by Belgian physicians: a study of hypothetical cases” (2010) Eur. J. Public Health online: <http://eurpub.oxfordjournals.org/content/early/2010/12/03/eurpub.ckq180.abstract>.


The Belgian Law of Palliative Care, *ibid*., at Art. 2. See also The Law on Patient’s Rights, *supra*, note 127 at Art. 5, the right to high-quality care. Note: The right to palliative care does not import any obligation; palliative care need not be performed before a patient can demand euthanasia.

Should the physician refuse, however, the physician must inform the patient in a timely manner his/her reasons for refusal and must provide the patient’s medical record to the any new physician designated by the patient. The Belgian Law of 2002, *supra*, note 92 at Art. 14.


*ibid*. This issue has been recognized in the latest 2010 report of the FCEC although no reforms have been suggested. FCEC 2010 Report, *supra*, note 146.


The Chamber of Deputies, Luxembourg’s parliament,
The Luxembourg Penal Code, Code Pénal (Loi du 16 juin 1879) Mém. 1879, 589

The Luxembourg Penal Code, ibid., at Art. 410-1: failure to assist a person in danger.


The Luxembourg Ethics Commission opinion serves a fourfold function: (1) to provide information to bodies responsible for the public; (2) to conduct ethical debate and determine legal consequences; (3) to make recommendations to public bodies; (4) initiate ethical and legal debate. Commission Consultative Nationale d’Ethique pour les Sciences de la Vie et de la Santé, Les Avis de la C.N.E. L’aide au suicide et l’euthanasie (Avis 1/1998, May 2008) 1

Association pour le droit de mourir dans la dignité – Lëtzebuerg a.s.b.l. [Association for the right to die with dignity] was established in 1989

Huss, supra, note 189.


Notice of State Council (13 July 2007).

See Huss Letter, supra, note 200.

Huss and Err Proposal, supra, note 152 at 3.

Ibid., at 4.


2002 College Opinion, ibid., at para. 2.

Ibid., at para. 4.

Arrêté ministériel du 21 mai 1991 approuvant le code de déontologie des professions de médecin et de médecin-dentiste édicté par le Collège Médical (Mémorial A-N°36, 21 May 1991) Art. 45: doctors have no right to cause the deliberate death of their patients.


Ibid., at para. 8.


De la proposition de loi no.5584 sur le droit relative aux soins palliatifs, à la directive anticipée et à l’accompagnement en fin de vie Doc. parl. No. 5584, Sess. Ord. 2005-2006 [Palliative Care Bill].

The bill also obligated doctors to effectively relieve pain (physical or psychological), described treatment decision-making via advance directives and special leave provisions for family member’s providing care. Ibid.


Arrete ministeriel du 7 juillet 2005 approuvant le code de deontologie des professions de medecin et de medecin-dentiste edict par le College Medical <http://www.collegemedical.lu/Codededeontologiemedecale.pdf> [2005 Luxembourg Code of Medical Ethics].

Ibid., at Art. 40.


Laws must be passed by an absolute majority of the Chamber of Deputies in two separate votes held at least three months apart. This two-vote requirement can be waived by the Council of State. Chambre Travail, supra, note 188.


Ibid., EAPC, supra, note 207.

McCabe, supra, note 206 at 1.

Chambre des Deputes Session ordinaire 2007-2008 No 4909(10) Amendements adoptés par la Commission de la Santé et de la Sécurité social (10
If the patient is physically unable to draft and sign the request it may be transcribed and signed by an adult person chosen by the patient, in the presence of a doctor as witness. Luxembourg Law of 2009, *ibid.*, at Arts. 2.1.4 and 2.2.7. See also interpretation in Luxembourg Euthanasia Guide, *supra*, note 189 at 14.


*ibid.*, at Art. 2.2.

*ibid.*, at Art. 8.

*ibid.*, at Art. 8.

A close doctor-patient relationship is inferred because the doctor must know the patient well enough to be able to confirm that the request is made freely and direct because of the obligation to have several interviews and so forth. See Luxembourg Euthanasia Guide, *supra*, note 189 at 26.

Le Commission Nationale de Contrôle et d’Evaluation (“the CNCE”) is established under Chapter 5 and is to be comprised of nine members from medicine, law and patient rights representatives. The Luxembourg Law of 2009, *supra*, note 183 at Chapter V.

Substantive conditions include: severe and incurable accidental or pathological disorder; state of unconsciousness; and an irreversible situation according to science at the time. As with the Belgian Law of 2002, suffering is not a requirement. Procedural conditions include; consultation with a colleague in respect of the patient’s condition; discussion with the care team; and discussion with the family and appointed person of trust. The Luxembourg Law of 2009, *ibid.*, at Art. 4.


*ibid.*, at Arts. 7 and 8.

*ibid.*, at Art. 9.


*ibid.*, at 13.


*ibid.*, at 10.


Euthanasia was not used in German-speaking Europe including Switzerland because of its association with Nazi Germany’s “Euthanasie” programme. The term “Sterbehilfe” (literally, “assisted dying”) is preferred and relates to any medical act or omission that foreseeably or intentionally hastens death. Euthanasia as it is understood in this paper, is described as “direct active” Sterbehilfe in Switzerland. Georg Bosshard, “Switzerland” in John Griffiths, Heleen Weyers and Maurice Adams, eds., Euthanasia and Law in Europe (Portland OR.: Hart Publishing, 2008) at 463, 468 [Bosshard, Switzerland]. Article 114, Penal Code: A person who, for decent reasons, especially compassion, kills a person on the basis of his or her serious and consistent request, will be sentenced to a term of imprisonment. Swiss Penal Code, supra, note 275. Under Swiss law, the intentional killing of a person will result in a charge of “intentional killing” under Art. 111 of the Penal Code but can be elevated to murder (Art. 112, Mord) if it is shown that the accused acted with a “reprehensible motive”. Mitigating circumstances on the other hand will lead to charges of manslaughter (Art. 113, Totschlag), killing on request (Art. 114, Tötung auf Verlangen) or infanticide (Art. 116, Kinderstötung). Another provision of potential relevance is Art. 117, Negligent Killing (fahrlässige Tötung). Christian Schwarzenegger and Sarah J. Summers, Criminal Law and Assisted Suicide in Switzerland (Hearing with the Select Committee on the Assisted Dying for the Terminally Ill Bill, House of Lords, February 3, 2005) at 2-3, <http://www.rwi.uzh.ch/lehrforschung/alphabetisch/schwarzenegger/publikationen/assisted-suicide-Switzerland.pdf> [Schwarzenegger and Summers]. Also known as “indirect active sterbehilfe” whereby a person acts with a view to relieve suffering, not to kill. Thus, would also therefore include palliative/terminal sedation. Death is considered ‘natural’. Oliver Guillod and Aline Schmidt, “Assisted Suicide under Swiss Law” (2005) 12 Euro. J. of Health L. 25, at 26 [Guillod and Schmidt]. See also Bosshard, Switzerland, supra, note 278 at 466-468. Also known as “Passive sterbehilfe” whereby death is caused by the underlying illness. Guillod and Schmidt, ibid., at 26. Passive sterbehilfe is not restricted to end-of-life decisions — a competent patient can refuse treatment at any stage of disease. Death is considered ‘natural’. Bosshard, Switzerland, supra, note 278 at 466. See also court decision, Arbeitsgruppe Sterbehilfe 1999:15.

These acts are deemed permissible from the criminal, civil and constitutional law perspectives, civil law perspective and constitutional perspective. For full discussion see Guillod and Schmidt, supra, note 280, at 26, fn 6.

See discussion in Bosshard, Switzerland, supra, note 278 at 466-467.
Guilod and Schmidt, *supra*, note 280 at 29. See also discussion in NEK-CNE Opinion No. 9, *supra*, note 276 at 28-30, 32.

During the 19th century (in Switzerland and other jurisdictions) suicide was examined from a sociological (rather than religious) perspective which called for sympathy and prevention measures rather than criminal punishment. Suicide was thus not included in the criminal codes of individual Swiss cantons nor in the articulation of the Swiss Penal Code commencing the last decade of the 19th century. Assistance with suicide, however, was considered a crime in a number of Swiss cantons and continued to be so considered as the Swiss Penal Code was elaborated, except under particular altruistic circumstances in order to prevent the over-extension of the criminal offence. For further discussion see discussion in NEK-CNE Opinion No. 9, *ibid.*, at 28. See also Guilod and Schmidt, *supra*, note 280 at 28-29. See also NEK-CNE Opinion No. 9, *ibid.*, at 28-30, 32.


Bosshard, Switzerland, *supra*, note 278 at 463.


812.21 Loi fédérale du 15 décembre 2000 sur les médicaments et les dispositifs médicaux (Loi sur les produits thérapeutiques, LPTh) (Etat le 1er octobre 2010) [Federal Law on Medicinal Products and Medical Devices] (Law on Therapeutic Products) of December 15, 2000 (as at October 1, 2010) at Art. 26: Basic principle relating to prescribing and dispensing (Principe de la prescription et de la remise) [the Pharmaceuticals Law].

In German, Schweizerische Akademie der MweizinischencWissenschaften.


Lewy, *supra*, note 22 at 89.


Lewy, *supra*, note 22 at 110; Dignitas – Menschewürdig leben – Menschenwürdig sterben [“Dignitas – Live with dignity – Die with dignity”] <http://www.dignitas.ch/> [Dignitas Website].

Suizidhilfe, <http://Suizidhilfe.ch> [Suizidhilfe Website].


Lewy, *ibid.*, at 89.

EXIT, ‘Patientenverfügung – Was ist ein PV?’ <http://www.exit.ch/wDeutsch/2110006/was_i_eine_pv.php?navanchor=2110030>. Note: an advance directive cannot be used to request suicide assistance. Lewy, *ibid.*, at 93.

Lewy, *ibid.*, at 93.

Exit DS Website, *supra*, note 292.


Bosshard, Switzerland, *supra*, note 278 at 472.

Fischer, *ibid.* at 810.


Where foreign patient has a close relationship to Swiss members of the organization. Lewy, *supra,* note 22 at 93.

See for example, the Basel case – Dr. Meinrad Schär, professor of preventative medicine at Zurich University and member of Exit DS was investigated in 1998 for prescribing lethal medication based on a questionable diagnosis of a 29-year-old woman suffering from a mental illness. Exit DS subsequently issued a moratorium on assisted suicide for individuals with a mental illness and stimulated discussions on types of precautions required. The moratorium was apparently relaxed in 2004. NEK-CNE Opinion No. 9, *supra,* note 276 at 9; cf. Baezner-Sailer, *supra,* note 305 at 146.

For full discussion see Lewy, *supra,* note 22 at 89-100. *Vereinbarung über die organisierte Suizidhilfe* between Ober staats anwalt schaft des Kantons Zurich and Exit Deutsch Schweiz <http://www.sterbehilfedeutschland.de/shgl/files/Medien/PDF%20neu/Vereinbarung%20Zuerich%20Brunner-Exit.pdf> [Exit DS Agreement]. Rules include: a ban on profit — charge for assisted suicide must not exceed 500 Swiss francs (£280; €330; $470USD); assisted suicide to be provided only in certain conditions (severe suffering due to disease, accident or disability; discussion of alternative treatments with patient including palliative care; counselling over several weeks; examination by physician; in case of psychiatric illness, psychiatrist examination and confirmation that desire for death is not a result of the psychiatric disorder; exclusive use of the medical substance sodium-pentobarbital (NaP); written certificates from involved physicians confirming all required procedures have been followed, etc. For interpretation of provisions, see Deutsches Referenzzentrum für Ethik in den Biowissenschaften [The German Reference Centre for Ethics in the Life Sciences] (DRZE), *Discussion in the Canton Zurich Concerning Euthanasia* (Module) <http://www.drze.de/in-focus/euthanasia/modules> [DRZE Module]. See also discussion in Lewy, *supra,* note 22 at 100-101.

Exit DS Agreement, *supra,* note 311 at Arts. 2 and 4.4.4.


Ibid. These figures are consistent with figures issued by the Zurich City Police for years 2001, 2002 and 2003. NEK-CNE Opinion No. 9, supra, note 276 at 9.

Membership breakdown is fairly consistent with number of assisted suicides actually carried out, although the U.K. appears slightly overrepresented. For example, from 2002-2009, the percentage of total asssisted suicides is: Germany (59.14%), Switzerland (11.76%) and United Kingdom (14.08%). Guardian Datablog, supra, note 331. In September 2005, Dignitas opened a branch in Germany (Hanover) under the name DIGNITATE. This move has attracted fierce controversy and protests from a variety of doctors, church representatives and German politicians. Annette Tuffs, “Assisted suicide organisation opens branch in Germany” (2005) 331 Brit. Med. J. 984 <http://www.bmj.com/content/331/7523/984.4.full>. See also Die Zeit (27 October 2005, No. 44).

Fischer, supra, note 305 at 813.


A 2001-2004 study has shown that Exit DS had a higher rate of assisted suicide for non-fatal diagnosis (32%) than dignitas (21%). Fischer, supra, note 305 at table 1; a study of 200 Exit ADM cases in years 2001-2005, revealed a rate of 13.5% for non-fatal conditions. Brukhardt, supra, note 322 at 42.

Ibid., note 328 at 3.

Fischer, supra, note 305 at 810; Lewy, supra, note 22 at 110. To date, Ex-International has not published any data on its activities and practices.

Fischer, supra, note 305 at 810; Lewy, supra, note 22 at 110. To date, Ex-International has not published any data on its activities and practices.

Ibid., at 22.

Ibid., at 22.

Ibid., at 110.

Ibid., at 110.

Sigg has been the subject of criminal investigation, particularly with respect to activities concerning German patients. For example, in contravention of German law, he smuggled NaP into Germany to
provide to persons seeking assisted death. See ibid., at 111.

Ibid., at 110 citing a talk given by Margrit Weibel in Luxembourg in July 2006.


Lewy, supra, note 22 at 109.

Baumann had considered a patient competent, but expert evidence demonstrated that if he had acted with proper care, he would have realised that was not indeed the case. The trial court decision was affirmed by the Court of Appeal. See ibid., at 109.

See discussion in Lewy, ibid., at 110. According however to the NEK-CNE Opinion No. 9, an individual will be deemed selfish under Art. 115 if the offender is pursuing “personal advantage” which may be material in nature (securing an inheritance for example) or non-material or emotional (e.g., gratification of hatred, desire for revenge or spite). NEK-CNE Opinion No. 9, supra, note 276 at 7 and 31.


The Narcotics Law, supra, note 288 at Art. 11.

Schwarzennegger and Sumners, supra, note 279 at 6.


See Schwarzennegger and Sumners, supra, note 279 at 6.

Schweizerisches Bundesgericht [Federal Supreme Court of Switzerland], Entscheid 2A.4812006, 2006 [The Haas case]. See also Bosshard, Switzerland, supra, note 278 at 473. See also decision by the Administrative Court Canton of Zurich, which revoked a gynaecologist’s authority to prescribe lethal medication because he did not have the necessary psychiatric knowledge in order to judge the patient’s wish to die. In doing so, he had violated his duty of care. Verwaltungsgericht des Kantons Zürich [Zurich Administrative Court], Geschäftsnr. VB.2009.00559 Endentscheid vom 11.03.2010.


See Guillod and Schmidt, supra, note 280 at 27.

2004 SAMW Guidelines, supra, note 291.

Ibid., at para. 41.
<http://www.ejpd.admin.ch/content/dam/data/gesellschaft/gesetzgebung/sterbehilfe/bericht-f.pdf> of which a majority recommended that under exceptional circumstances, the court should have the discretion to abstain from imposing criminal punishment under Art. 114. See also 2000 initiative by National Councillor Franco Cavalli submitted to the National Council which sought a similar exceptional circumstances judicial discretion and physician immunity for euthanasia, Cavalli Initiative, 00.441 (27 September 2000)

In 2004, Christoph Blocher, the head of the Federal Department of Justice and Police (“EJPD”) from 2004-2007, stopped a project commenced by previous head of EJP, Ruth Metzler, aimed at overhauling existing regulations on euthanasia and assisted suicide. Blocher took the position that no additional state action was necessary and that in any event, any regulation on the matter was properly under the jurisdiction of the cantons, not the federal government. See NEK-CNE Opinion No. 9, supra, note 276 at 9. See also Federal Department of Justice and Police, Regulations on prescribing and issuing sodium pentobarbital are sufficient (Press Release, 29 August 2007)
<http://www.ejpd.admin.ch/content/dam/data/gesellschaft/gesetzgebung/sterbehilfe/ber-sicherheilf_ergaenzung-d.pdf>. See also discussion in Lewy, supra, note 22 at 120-121.

Ibid.

2000 Cavalli Initiative, supra, note 372; 2000 Initiative by Dorle Vallender submitted to the National Council which sought to, among other things, prohibit doctors and nurses from participating in assisted suicide, Vallender Initiative 01.407 (14 March 2001)
<http://www.parlament.ch/ab/frameset/fn/4611/44739/44740.htm> [2000 Vallender Initiative]. For further discussion see NEK-CNE Opinion No. 9, supra, note 276 at 35.

See 2000 Cavalli Initiative, ibid. See also NEK-CNE Opinion No. 9, ibid., at 36, 69.


NEK-CNE Opinion No. 9, supra, note 276 at 13, 62.

Ibid., at 62.

Ibid., at 61-73.

Swiss National Advisory Commission on Biomedical Ethics, Duty-of-care criteria for the management of assisted suicide (Opinion No. 13/2006)

Incorporating the “twin poles”, NEK-CNE recommendations included: mental capacity assessed over a series of discussions; severe suffering arising out of illness (accident or disease), no assisted suicide when suicidality is a manifestation of mental illness; enduring, consistent and voluntary request; all options to be assessed and exhausted in accordance with the wishes of the person desiring suicide; independent second expert opinion; documentation. NEK-CNE Opinion No. 13, ibid., at 4-6.

Ibid., at 2-3. The due care criteria recommended are not concerned with assistance provided by a close family member or personal relation, single acts within the physician-patient relationship nor with the act of suicide. Ibid., at 3.

Federal Department of Justice and Police, Organised assisted suicide to be regulated (Press Release, 28 October 2009)

“This option rests on the belief that individuals working in assisted suicide organisations are never actually motivated by purely altruistic reasons, and may develop a close relationship with the suicidal person”. Ibid.

Ibid.

Thirty-five in favour of setting strict duties of care, 20 in favour of complete ban, 22 called for special licensing scheme or the creation of a supervisory authority. Federal Department of Justice and Police, “Specific regulations for organised assisted suicide in Switzerland” (Press Release, 17 September 2010)
<http://www.ejpd.admin.ch/content/epjd/en/home/do
For example, in a 1999 EXIT ADMD survey of 1,000 members of the public, 82% agreed that “a person suffering from an incurable disease and who is in intolerable physical and psychological suffering has the right to ask for death and to obtain help for this purpose”. Hurst, supra, note 365 at 272; “A recent study by Zurich University found that most Swiss are in favour of assisted suicide, and would also support direct active euthanasia. However, two-thirds of respondents came out against the practice of “death tourism””. The World Federation of Right to Die Societies, ‘Swiss Government wants rules for assisted suicide’ (17 September 2010) <http://www.worldrtd.net/node/1072>.


Hurst, supra, note 365 at 272.


210 Swiss Civil Code of December 10, 1907 (Status as on January 1, 2011) Art. 18: “A person who lacks legal capacity cannot, unless a statutory exception applies, enter into any legal transactions”. Article 16 is also relevant: “A person who lacks legal capacity cannot, unless a statutory exception applies, enter into any legal transactions”. See discussion in Schwarzenegger and Summers, supra, note 279 at 5.

Note that, a mere omission could amount to criminal responsibility if the individual (such as parents) had a duty to take positive steps to prevent a suicide. Guillod and Schmidt, supra, note 280 at 30. See also Schwarzenegger and Summers, ibid.

See How Dignitas Works, supra, note 328. 

Ibid., at 21.

Exit ADMD, Membership Application Form, supra, note 319.

Baezner-Sailer, supra, note 305 at 142.

See text associated with note 355.

Baezner-Sailer, supra, note 305 at 142; Exit 25 Years, supra, note 320 at fn 39; How Dignitas Works, supra, note 328 at 7-9, 28. See, however, criticisms of practice where assisted suicide has been known to occur within only a very short membership time. Hurst, supra, note 365 at 81. In a 2007 study on Exit DS, the interval between the time between the first visit and the act was 14 days or less in 37% of cases. Lewy, supra, note 22 at 98. See also the 2001-2004 study by Fischer et al. where in 1.5% of Dignitas cases and in 5.4% of Exit DS cases, membership was less than one week. Fischer supra, note 305 at 811. See for example Baezner-Sailer, ibid., at 142.

For Exit DS see Baezner-Sailer, ibid. For Dignitas see How Dignitas Works, supra, note 328 at 17.

The 2004 SAMW Guidelines elaborate the criteria for assessing decision-making capacity in conformance with Art. 16 of the Swiss Civil Code. For example, “the ability to weigh up rationally, information obtained in the context of a coherent system of evaluation” and “the ability to express his own choice”. 2004 SAMW Guidelines, supra, note 291 at 7, ad. 2.

Patients in a terminal phase are to be distinguished from “patients with incurable, progressive diseases that may persist for several months, or even years”. However, the SAMW recognizes that there is a certain vagueness in its definition, given that it often coincides with medical decisions regarding the withdrawal or refusal of treatment. 2004 SAMW Guidelines, ibid., at 7, ad.1.

2004 SAMW Guidelines, ibid., at 6, 4.1.


2004 SAMW Guidelines, supra, note 291 at 7, ad. 4. SAMW Care of Elderly Persons Guidelines, supra, note 406 at 9.

Ibid., at 9.

2004 SAMW Guidelines, supra, note 291 at 78, ad. 4.1.

Ibid., at para. 4.1.

Ibid., at 8, ad. 4.1.

Ibid., at 8, ad. 4.1.

Ibid.

Baezner-Sailer, supra, note 305 at 143.

NEK-CNE Opinion No. 9, supra, note 276 at 8. See also Hurst, supra, note 365 at 271.

Fischer, supra, note 305 at 811-812.

The Haas case, supra, note 355. See also discussion in Bosshard, Switzerland, supra, note 278 at 473.
See for example Exit DS moratorium on mental illness, supra, note 309.

2004 SAMW Guidelines, supra, note 291 at para. 4.1.

Schweizerisches Bundesgericht [Federal Supreme Court of Switzerland], Entscheid 2A.4812006, 2006. See also discussion in Bosshard, Switzerland, supra, note 278 at 473.

ECHR, ‘Switzerland cannot be criticised for not having assisted a suicide’ (Press Release, no. 040, 20 January 2011) 2


NEK-CNE Opinion No. 9, supra, note 305 at 810.

Hurst, supra, note 365 at 810.

NEK-CNE Opinion No. 9, supra, note 276 at 26. See also Guardian Datablog, supra, note 331.

NEK-CNE Opinion No. 9, ibid., at 26. See also Dignitas, How Dignitas Works, supra, note 328 at 2.


NEK-CNE Opinion No. 9, supra, note 276 at 26.

Baezner-Sailer, supra, note 305 at 141. The increase in annual deaths is attributable at least in part to an increase in the Swiss population. The population in Switzerland has increased from approximately seven million in 2005 to 7.8 million at the end of 2009. See Bosshard, Switzerland, supra, note 278 at 477 and Federal Council, ‘Population scenarios of Switzerland 2010-2060’ (1 July 2010) <http://www.bfs.admin.ch/bfs/portal/en/index/themen/01/01/new/nip_detail.html?gnpID=2010-555>.

Exit 2009 Annual Report, supra, note 314.

Exit Bulletins, supra, note 323 at 323.

Guardian Datablog, supra, note 331.

Guardian Datablog, ibid.

A 2011 referendum involving over 278,000 voters in Zurich indicated that 78% of voters were against a ban that would prohibit non-residents from accessing assisted suicide in Switzerland. Additionally, 85% of voters rejected an initiative to ban assisted suicide. ‘Swiss voters reject ban on assisted suicide’, The Guardian (15 May 2011).

Baezner-Sailer, supra, note 305 at 145.

Hurst, supra, note 365 at 272 citing survey by Exit ADMD which surveyed 1,000 people in 1999, Sondage assistance au suicide et euthanasie active <http://www.exit-geneve.ch/Sondage1.htm>.

Nineteen per cent of 90 palliative care physicians surveyed. Hurst, supra, note 365 at 272.

The patient was suffering from amyotrophic lateral sclerosis (ALS) a progressive degenerative condition.


The 1994 Oregon Law, ibid., at Art. 127.805 §2.01.

Ibid., at Art. 3.14.


Nancy Cruzan sustained brain injuries from a car accident leaving her in a persistent vegetative state. When it became apparent that there was no chance of recovery, her parents petitioned the courts to permit the hospital to remove the feeding tubes that were keeping her alive. The U.S. Supreme Court upheld the right to refuse life-sustaining treatment on the constitutionally-protected autonomy-based liberty interest. In the case of an incompetent person, however, their wish to have life-support withdrawn must be proven by clear and convincing evidence. Cruzan v. Director, Mo. Dept’ of Health, 497 U.S. 261, 284 (1990). The Cruzan case was preceded by the 1976 landmark case, In re Quinlan, 355 A.2d 647 (N.J.) 664 [Quinlan] where the New Jersey Supreme Court granted the parents’ request to turn off the respirator that was keeping their daughter Karen Ann (who was in a coma) alive. The court held that a patient’s constitutional right to privacy could outweigh the state’s interest in preserving life particularly as the degree of bodily invasion increases and the prognosis dims.


Previous draft bills allowing PAS introduced in the years, 1987, 1989 and 1991 by Oregon Senator Frank Roberts (with the support of the Hemlock Society) were unsuccessful. Lewy, supra, note 22 at 127.

Pratt, supra, note 454 at 1032.


This group of individuals ultimately formed the Oregon Right to Die political action committee. Pratt, ibid., at 1032.


See also Oregon Legislative Policy & Research Office, Basics on . . . Ballot Measure 51 (Legislative Policy & Research Office, October 1997) 1 [http://www.leg.state.or.us/comm/commsrvs/51final.pdf] [OLPRO].


Lee v. Oregon, 107 F.3d 1382 (9th Cir 1997).

A further petition to the U.S. Supreme Court for certiorari was denied. Lee v. Oregon, 522 U.S. 927 (1997).
Compassion In Dying v. Washington, 850 F. Supp. 1454 (W.D. Wash. 1994), rev’d, 49 F.3d 586 (9th Cir.), reh’g en banc granted, 62 F.3d 299 (9th Cir. 1995), aff’d, 79 F.3d 790 (9th Cir.).


Pratt, supra, note 454 at 1031.

For further discussion see Pratt, ibid., at 1029 et seq.

Washington v. Glucksberg, supra, note 468 at 728.

Ibid., at 785.

Vacco v. Quill, supra, note 469 at 801.


Washington v. Glucksberg, supra, note 468 at 735.

House Bill 2954-Refereed to the Electorate of Oregon by the 1997 Legislature to be voted on at the Special Election, November 4, 1997.


Voters Guide, ibid., at 4. The American Medical Association was also in favor of a repeal and along with the Roman Catholic Church, the Mormon Church and the group Oregon Right to Life, was among the primary funders of the campaign to repeal the legislation. Pratt, supra, note 454 at 1098.


Ibid., at 4.

Ibid., at 4.

Lee, supra, note 451 at 311.

Ibid., at 312.


Controlled Substances Act, 21 U.S.C. §§ 801-971 (1994 & Supp.II 1996). The Controlled Substances Act was enacted to address drug abuse but also served to ensure that legally available drugs could continue to be legally distributed and used.


1999 Pain Relief and Promotion Act (HR 2260 in the House and S1272 in the Senate). While garnering some support by the American Medical Association and the National Hospice Association, there were serious reservations about the ability of federal government to second-guess physicians’ intent and legitimate pain relief and the PRPA failed to reach Senate before its adjournment. Jack P. Freer, “Congress and the Pain Relief Promotion Act” (2000) 172(1) West J. Med. 2000 5, 5-6 <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1070704/#ref1> [Freer]. See also S.H. Johnson, “Disciplinary actions and pain relief: analysis of the Pain Relief Act” (1996) 24 J.L. Med. Ethics 319. See also proposed legislation, the Lethal Drug Abuse Prevention Act of 1998 (HR4006 in the House and S2151 in the Senate) introduced in the 105th Congress.

John Ashcroft, Dispensing of Controlled Substances to Assist Suicide (memorandum, 6 November 2001) a copy available from Cornell Law <http://www.law.cornell.edu/primary_sources/ashcroft_dft_directive.html> [the Ashcroft Directive]. See also discussion in Ganzini 2004, supra, note 486 at 166.


Department of Human Resources, Oregon’s Death with Dignity Act: The First Year’s Experience (Oregon Health Division, 18 February 1999) at 9 [1999 Oregon Annual Report].


Oregon Revised Statutes § 163.117 provides that: It is a defense to a charge of murder that the defendant’s
conduct consisted of causing or aiding, without the use of duress or deception, another person to commit suicide. Nothing contained in this section shall constitute a defense to a prosecution for, or preclude a conviction of manslaughter or any other crime. Oregon Revised Statutes § 163.125 provides that: (1) Criminal homicide constitutes manslaughter in the second degree when: (a) It is committed recklessly; or (b) A person intentionally causes or aids another person to commit suicide. (2) Manslaughter in the second degree is a Class B felony.

498 Ibid., at Arts. 127.885 §4.01(1) and 127.885 §4.01(2).
499 AMA, supra, note 450 at Art. 2.20 and American Medical Association, Opinion 2.211 — Physician-Assisted Suicide (June 1994).

500 The 1994 Oregon Law, supra, note 447 at Arts. 127.805 §2.01 and 127.800 §1.01(3).
501 Residency can be shown by driver’s license, voter registration, property lease or tax return. The 1994 Oregon Law, ibid., at Art. 127.860 §3.10. While the patient must be a resident of Oregon, there is nothing in the law that prevents someone from moving to Oregon to participate in the law provided the individual can demonstrate residency. Oregon Health Authority, ‘Frequently Asked Questions About the Death with Dignity Act’ <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Page/s/FAQs.aspx>.

502 The 1994 Oregon Law, ibid., at Arts. 127.800 §1.01(7), 127.815 §3.01, 127.820 §3.02, 127.825 §3.03, 127.840 §3.06.
503 Cannot be a relative or entitled to a portion of the patient’s estate or be employed by the health care facility where the individual resides or is a patient. If the patient is an inpatient at a health care facility, one of the witnesses shall be an individual designated by the facility. Ibid.

504 The 1994 Oregon Law, ibid., at Art. 127.810 §2.02. See for example, ibid., at Arts. 127.800 §1.01(7)(c) and (d), 127.815 §3.01(g) and §4.01(1), 127.880 §3.14.
505 Ibid., at Art. 127.845 §3.07.
506 Ibid., at Art. 127.815 §3.01(h) and Art. 127.840, s. 3.06.
507 Ibid., at Art. 127.850 §3.08.
508 Ibid., at Art. 127.840 §3.06.
509 Ibid., at Art. 127.885 §3.09.

510 Note that the average duration of physician-patient relationship for PAS ranged from 10-18 weeks.

511 Department of Human Resources, Oregon’s Death with Dignity Act — 2010 (Oregon Health Division, 2011) 1 at Table 1 [2010 Oregon Annual Report]. According to the OHD’s summary report for years 1998-2007, 3.4% of Oregon physicians wrote all prescriptions for the 541 patients total during those years. “It is also no secret that right-to-die organization Compassion & Choices helps patients find doctors who in principle are prepared to write prescriptions”. Lewy, supra, note 22 at 141-142.

512 The 1994 Oregon Law, supra, note 447 at Art. 127.815 §3.01(L)(A).
513 The prescription must, however, be provided directly to the pharmacist by the physician with the patient’s consent. The 1994 Oregon Law, ibid., at Art. 127.815 §3.01(L)(B)(ii).

514 As of 2010, prescribing physicians reported their presence on average only 24.2% of the time when the patient ingested the lethal medication. The 2010 Oregon Annual Report, supra, note 511 at Table 1. A recent news report, however, cites that volunteers of the organization, Compassion and Choices, have been present in about 85% of the cases. John Iwaski, “Oregon assisted suicide at record high”, Seattle Post-Intelligencer (9 January 2009) <http://www.seattlepi.com/local/395517_deathdignity10.html>.

515 The 1994 Oregon Law, supra, note 447 at Art. 127.815 §3.01(g).
516 Ibid., at Art. 127.885 §4.01(4).
517 Ibid., at Arts. 127.800-127.897.

519 The 1994 Oregon Law, ibid., at Art. 127.865 (1)(b) and Oregon Admin Rules, ibid., at Art. 333-009-0010(3).
520 Note under the 1994 Oregon Law, the Oregon Health Division is only required to review a “sample” of records submitted but has developed administrative rules and the practice of reviewing all records submitted – the 1994 Oregon Law, ibid., at Art. 127.865 §3.11(1)(a) and Oregon Admin Rules, ibid., at 333-009-0020(1).

521 The 1999 Oregon Annual Report, supra, note 493 at 3.
522 OHD FAQs, supra, note 450 at 2.
523 The 1994 Oregon Law, supra, note 447 at Arts. 127.800 §1.01 and 127.805 §2.01.
Based on protocols established by the Oregon State Pharmacy Association, the barbituates being prescribed are either secobarbital or pentobarbital. Non-lethal medications are also provided to increase stomach emptying and to prevent nausea and vomiting. The 1999 Oregon Annual Report, supra, note 493 at 5.

The 2010 Oregon Annual Report, supra, note 511 at Table 1.

Oregon Public Health Division, Oregon’s Death with Dignity Act: Thirteen Years (CD Summary, Vol. 60, No. 06, 15 March 2011) 1 [OHD 13-Year Summary].

For example in 2010, 96.9% of patients died at home and 92.6% were enrolled in hospice care. The 2010 Oregon Annual Report, supra, note 511 at 2.

The 2010 Oregon Annual Report, supra, note 511 at Table 1.

Lewy, supra, note 22 at 131.

Lewy, ibid., at 140.

The 2010 Oregon Annual Report, supra, note 511 at Table 1. See generally discussion in Pereira regarding Swiss physicians’ sense of confliction and the non-abandonment on the patient. Pereira, supra, note 368.

Erin Hoover Barnett, ‘Is Mom Capable of Choosing to Die?’ The Oregonian (Oregon, 17 October 1999) G1-2; Hendin and Foley, supra, note 524 at Parts II and III.


OHD 13-Year Summary, supra, note 536 at 2.


Battin, Way, supra, note 527 at 299-300.
Chapter 70.245 RCW, The Washington Death with Dignity Act


Carson, ibid., at 7.


Jacobs, supra, note 459 at 189-94; Carson, supra, note 550 at 7.

Carson, ibid., at 194-199.


Carson, supra, note 550 at 7.


Carson, supra, note 550 at 7.


Ibid., at 919.

Ibid.

Governor Booth Gardner headed up the Washington initiative, announcing his support of legalized assisted suicide shortly after the Supreme Court decision in Gonzales v. Oregon. David Postman, ‘Ex-governor backs initiative to legalize assisted suicide, The Seattle Times (7 February 2006).

Initiative Measure No. 1000, The Washington Death with Dignity Act

Svenson, supra, note 557 at 59.

See Washington Secretary of State, November 4, 2008 General Election

The 2008 Washington Law, supra, note 549 at Art. 70.245.903; Washington State Department of Health, ‘Washington Death with Dignity Act’


Wash. Rev. Code 9A.36.060(1) 1988. Promoting suicide is classified as a Class C felony punishable by imprisonment for up to five years and by a fine of $1,000. Wash. Rev. Code 9A.36.060(2), 9A.20.020(1)(c). Although this prohibition has been in place since 1854 in one form or another, it was rarely enforced. Melvin I. Urofsky, “Justifying Assisted Suicide: Comments on the Ongoing Debate” (2000) 14 Notre Dame J.L. Ethics & Public Pol’y 893, at 903.

The 2008 Washington Law, supra, note 549 at Arts. 70.245.180 and 70.245.190(1)(a).

Ibid., at Art. 70.245.180.

The definition of “competent” is the same definition as “capable” under the 1994 Oregon Law. The 2008 Washington Law, ibid., at Art. 70.245.010(3).

Ibid., at Arts. 70.245.020 and 70.245.010(13).

Ibid., at Art. 70.245.020.

Ibid., at Arts. 70.245.020 et seq.

Ibid., at Arts. 70.245.010(11)-(13).

Ibid., at Art. 70.245.150.

For example, physicians and pharmacists have 30 days after prescribing or dispensing the medication within which to send the required documentation and physicians have 30 days after the death of the patient to send additional required document to the Washington Department of Health. The 2008 Washington Law, ibid., at Art. 70.245.150.

Death with Dignity Act Requirements, Chapter 246-978 WAC.

The 2008 Washington Law, supra, note 549 at Art. 70.245.190.


The 2008 Washington Law, ibid., at Art. 70.245.180. Note: since 2007, the Oregon Department of Health annual reports use the terminology, “death with dignity option”. Svenson, supra, note 557 at 61.

Aid in Dying” (1998) 34(6) Community Mental Health Journal 547; Tucker, supra, note 9 at 1595.  
583  The 2008 Washington Law, supra, note 549 at Art. 70.245.040(2).  
585  The 1994 Oregon Law does not contain a similar mandate although in reporting guidelines from the Oregon Health Division, it is recommended that the prescribing physician complete the death certificate with the underlying terminal condition(s) as the cause of death, and the manner of death as “natural”. The Task Force to Improve the Care of Terminally-Ill Oregonians, The Oregon Death With Dignity Act: A Guidebook for Health Care Professionals (March 1998) Chapter 7 <http://www.wsha.org/files/Death%20with%20dignity%20guidebook.pdf>.  
588  O’Reilly, supra, note 567.  
590  Ibid., at 8.  
591  Ibid., at 9.  
592  Ibid., at 8.  
593  Ibid., at 9.  
595  Ibid.  
599  Baxter v. Montana, supra, note 596.  
600  See note 78 and associated text.  
601  See note 262 and associated text.  
603  See for example, the failure of Bill C-384 in Canada, which would have created an AD scheme incorporating elements from all AD laws discussed herein in the sense that it would have provided physician immunity for euthanasia or PAS for physical or mental suffering or a diagnosis of terminal illness. Bill C-384, An act to amend the Criminal Code (right to die with dignity), 2d Sess., 40th Parl., 2009 (2nd reading 20 April 2010, Ms. Francine Lalonde).  
604  R. (on the application of Purdy) v. D.P.P., [2009] UKHL 45. The Purdy case involved the prohibition against assisted suicide under s. 2 of the Suicide Act, 1961 (U.K.), 9 & 10 Eliz. 2, c. 60, s. 2(1). Prosecution under this section can only take place at the discretion of the Director of Public Prosecutions.  
605  United Kingdom, The Crown Prosecution Service, Policy for Public Prosecutors in Respect of Cases of Encouraging or Assisting Suicide (The Director of Public Prosecutions, February 2010).  
606  Ibid., at s. 45(1).