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Euthanasia and Assisted Suicide: The Law in Selected Countries

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(Background Paper)

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EUTHANASIA AND ASSISTED SUICIDE: THE LAW IN SELECTED COUNTRIES

1 INTRODUCTION

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

- “Euthanasia” is the “intentional termination of the life of a person, by another person, in order to relieve the first person’s suffering.” “Voluntary euthanasia” is euthanasia performed in accordance with the wishes of a competent person, expressed personally or by advance directive. “Non-voluntary euthanasia” refers to euthanasia performed when the wishes of the person are not known, and “involuntary euthanasia” is euthanasia performed against the wishes of the person in question.¹ The focus of this paper is on legislation permitting voluntary euthanasia.
- “Assisted suicide” is the act of intentionally killing oneself with the assistance of another person who provides the knowledge, means, or both, of doing so.²

This paper reviews developments in jurisdictions that already permit physician-assisted suicide or euthanasia (or both) in certain contexts, as well as what is happening in the United Kingdom, where there have been a number of developments in this area of the law in recent years.³ An appendix at the end of this paper provides an overview, in table format, of the current legal status of euthanasia and assisted suicide in jurisdictions that have relevant legislation in place. Note that other Library of Parliament publications discuss the situation in Canada.⁴

2 THE UNITED STATES

To date, Oregon, Washington, Vermont and California are the only states that have passed laws explicitly permitting some form of physician-assisted suicide. In addition, Montana’s Supreme Court concluded that doctors could use the defence of consent to protect themselves, if certain conditions are met, should they be prosecuted for assisting a suicide.⁵ Euthanasia is not permitted in any state.

2.1 OREGON’S *DEATH WITH DIGNITY ACT*

2.1.1 REQUIREMENTS UNDER THE *DEATH WITH DIGNITY ACT*

In November 1994, Oregon voters approved a ballot initiative, Measure 16,⁶ which was a legislative proposal to allow terminally ill adult residents of Oregon with a

prognosis of less than six months to live to obtain a prescription for medication for the purpose of committing suicide. Because of a legal challenge, the Act did not come into effect until November 1997.⁷

Before a physician can issue such a prescription, certain conditions have to be met. For example:

- The patient must make two oral requests at least 15 days apart and one written request for the medication. The written request must be signed before two witnesses; criteria outlined in the law regulate who may be witnesses. Forty-eight hours must elapse between the written request and the provision of the prescription.
- A second medical opinion is required.
- The patient must be capable, meaning that:
 - in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, psychiatrist or psychologist, a patient has the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available.⁸

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

- The physician must verify that the patient is making an informed decision, which is defined in the statute as a decision based on an appreciation of the relevant facts and made after the patient has been fully informed by the attending physician of:
 - his or her medical diagnosis and prognosis;
 - the potential risks associated with taking the medication to be prescribed;
 - the probable result of taking the medication to be prescribed; and
 - the feasible alternatives, including, but not limited to, comfort care, hospice care and pain control.⁹
- The physician must request that the patient inform his or her next of kin of his or her request for a prescription, although the physician cannot obligate an individual to do so.

Details must be included in the patient's medical record concerning the requests, diagnosis, prognosis, any counselling that occurred and the doctor's offers to rescind the request. Doctors also have reporting obligations to Oregon's Department of Human Services once a prescription is written.¹⁰ Doctors are not obligated to participate in assisting a suicide.¹¹

2.1.2 ANNUAL REPORTS

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

Table 1 – Annual Statistics Relating to Oregon's *Death with Dignity Act*, 1998–2014

Year	Reported Prescriptions Written for Medication to Commit Suicide	Reported Deaths by Ingestion of the Prescribed Medication ^a	Reported Deaths by Physician-Assisted Suicide per 1,000 Deaths
1998	24	16	0.55
1999	33	27	0.92
2000	39	27	0.91
2001	44	21	0.71
2002	58	38	1.22
2003	68	42	1.36
2004	60	37	1.23
2005	65	38	1.2 ^b
2006	65	46	1.47
2007	85	49	1.56
2008	88	60	1.94
2009	95	59	1.93
2010	97	65	2.09
2011	114	71	2.25
2012	116	85	2.35
2013	121	73	2.19
2014	155	105	3.10

Notes: a. The Oregon Department of Human Services reports also note cases in which the status of individuals who received a prescription is unknown.
 b. The figure of 1.2 deaths by physician-assisted suicide for every 1,000 deaths in 2005 is an estimate only, although the annual report for 2005 does not explain why. See Oregon Department of Human Services, Office of Disease Prevention and Epidemiology, [Eighth Annual Report on Oregon's Death with Dignity Act](#), Portland, Oregon, 9 March 2006.

Sources: Oregon Health Authority, "[Death with Dignity Act Annual Reports](#)" (1998–2014).

Although the number of prescriptions written and deaths resulting from ingestion of the prescribed medication have increased almost every year since the law was passed, relatively few prescriptions have been written, considering that almost four million people live in Oregon. In 2014, slightly more than 3 per 1,000 deaths in Oregon were by physician-assisted suicide.

The annual reports provide aggregate statistics about patients who choose assisted suicide. For 2014:

- 52% were men;
- 68% were 65 or older;

- 95% were white;
- 48% had a baccalaureate degree or higher;
- 93% were enrolled in hospice care and 90% died at home;
- 40% had private health insurance, and 60% had some form of government health insurance;¹² and
- 69% had cancer, and 16% had amyotrophic lateral sclerosis (ALS).

The three most common reasons for choosing assisted suicide were concerns about losing autonomy (91%), being less able to engage in activities that make life enjoyable (87%) and loss of dignity (71%). Being a burden on family, friends and caregivers was a concern for 40% of patients.¹³ Despite concerns expressed in the media and in a recent California judgment, the financial costs of treatment do not appear to be a concern in the great majority of cases; 5% of those dying from assisted suicide in Oregon expressed such concerns in 2014.¹⁴

In recent years, the annual reports have published the number of cases per year in which a referral to the Oregon Medical Board was made for failure to comply with the requirements. From 2011 to 2014, the period for which information is available, no cases were referred to the board.¹⁵

2.1.3 BILL TO AMEND OREGON'S LAW

In February 2015, a bill was introduced that would amend the definition of “terminal disease” so that a patient with an incurable disease that is expected to result in death within one year, instead of within six months, would be able to obtain a prescription for medication to end his or her life. House Bill 3337 was in committee when the House of Representatives adjourned for the summer, and no committee hearings had been scheduled at the time of writing.¹⁶

2.2 THE STATE OF WASHINGTON'S *DEATH WITH DIGNITY ACT*

The State of Washington's *Death with Dignity Act* was passed by ballot initiative on 4 November 2008 and came into force on 5 March 2009.¹⁷ The law is based on the law in Oregon and includes reporting requirements by which the Washington State Department of Health plays a collection and monitoring role similar to that of Oregon's Department of Human Services.

2.2.1 ANNUAL REPORTS

Table 2 highlights some statistics that reports have provided since the legislation came into force. In 2014, the State of Washington had a population of more than 7 million, with just over 52,000 total deaths.

Table 2 – Annual Statistics Relating to Washington State’s *Death with Dignity Act, 2009–2014*^a

Year	Reported Prescriptions Written for Medication to Commit Suicide	Reported Deaths by Ingestion of the Prescribed Medication
2009 ^b	63	36
2010	87	51
2011	103	70
2012	121	83
2013	173	119
2014	176	126

Notes: a. The Washington State Department of Health reports also note cases in which the status of individuals who received a prescription is unknown.
 b. The numbers for 2009 represent the period beginning 5 March 2009 with the entry into force of the law.

Sources: Washington State Department of Health, [Death with Dignity Act](#) (annual reports, 2009–2014).

The annual reports provide aggregate statistics about patients who choose assisted suicide. For 2014:

- 43% were men;
- 72% were 65 or older;
- 92% were white;
- 50% had a baccalaureate degree or higher;
- 69% were enrolled in hospice care and 92% died at home;
- 23% had private health insurance, 57% had some form of government health insurance and 13% had a combination of both; and
- over 70% had cancer,¹⁸ and 13% had neurodegenerative diseases including ALS.

The three most common reasons for choosing assisted suicide were the same as those in Oregon: loss of the ability to participate in activities that make life enjoyable (94%), loss of autonomy (89%) and loss of dignity (79%). Being a burden on family, friends and caregivers was also a concern for 59% of patients. Eight percent mentioned concerns about the cost of treatment.¹⁹

2.2.2 BILL TO AMEND THE STATE OF WASHINGTON’S LAW

A bill was introduced in February 2015 to clarify that the doctor *must* discuss treatment for the purpose of cure and extending the patient’s life. The law currently

requires the provision of information about “feasible alternatives” and lists comfort care, hospice care and pain control as examples. At the time of writing, Senate Bill 5919 was before the state legislature.²⁰

2.3 VERMONT’S ACT RELATING TO PATIENT CHOICE AND CONTROL AT END OF LIFE

On 20 May 2013, Vermont’s Governor Peter Shumlin signed the Patient Choice at End of Life Bill into law. This is the first law permitting physician-assisted suicide to be passed by a legislature in the United States; the Oregon and Washington laws were passed by ballot initiative. This law is modelled on Oregon’s law. A May 2015 amendment repealed a sunset clause and now requires the collection of information about compliance with the law and the publishing of reports by the Department of Health every two years, starting in 2018. As such, statistics are not currently available for Vermont.²¹

2.4 CALIFORNIA’S END OF LIFE ACTION ACT AND OTHER DEVELOPMENTS

In September 2015, California’s legislature passed Bill AB 15, which allows assisted suicide; the law should come into force sometime in 2016.²² The process by which the bill passed has been criticized, including by the state governor. A similar bill did not have the votes required to pass the committee stage earlier in 2015. Bill AB 15 was then introduced during a special session on health care financing; according to media reports, this means that it was not subjected to the same committee review as it would have received, had it been introduced during a regular session of the legislature.²³

The law is very similar to the Oregon legislation, but expires in ten years unless legislators decide to renew it. Also, unlike the Oregon law, California’s new law requires that the doctor meet privately with the person seeking to die to ensure that he or she is not being coerced or unduly influenced. The law also prohibits an insurance carrier from communicating information about the availability of an aid-in-dying drug unless requested to do so. In addition, insurers cannot include denial of coverage for other forms of treatment along with information about aid-in-dying coverage in the same communications.

This last element with respect to communications with insurance companies may have been included to address some commentators’ fears that assisted suicide will be seen by insurers as an economically attractive alternative, in contrast to costly life-sustaining care for the terminally ill. Media have reported that, for reasons of cost, Oregon’s Medicaid has refused to cover patients’ access to life-sustaining but non-curative cancer treatment because it would not cure their cancer – even though the treatment could prolong and improve the quality of the patients’ lives.²⁴ However, the patients were reportedly told at the same time that the program would cover comfort care, including the cost of the prescription for medication to commit suicide, if they wanted assistance in ending their lives.²⁵

2.5 LEGISLATIVE INITIATIVES IN OTHER STATES

According to the Patients Rights Council, a non-profit organization focused on euthanasia, assisted suicide and end-of-life issues, five proposals to legalize euthanasia and/or assisted suicide by ballot initiative (including an earlier one in Washington State) have been defeated since 1991. Since 1994, more than 175 bills have been proposed on the topic in 35 states, but only the Vermont and California laws have been passed (some others are still pending).²⁶ Massachusetts held a vote in 2012 in which voters rejected an attempt to legalize physician-assisted suicide in that state by a very small margin.²⁷ In addition to the legislature of Montana, which is mentioned below in more detail, many state legislatures dealt with assisted suicide bills in 2015.

2.6 CHALLENGES TO STATE LAWS THAT PROHIBIT PHYSICIAN-ASSISTED SUICIDE

The majority of American states have laws explicitly prohibiting assisted suicide, while some rely on crimes established in common law through judicial decision-making to prohibit the practice. No American state has legalized euthanasia. The prosecution of cases of euthanasia is addressed through regular homicide laws.²⁸

A number of cases that have reached the appellate level, either as criminal prosecutions or constitutional challenges to legislation, are outlined below.

2.6.1 LAWS IN THE STATES OF WASHINGTON AND NEW YORK PROHIBITING ASSISTED SUICIDE UPHELD

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

On 26 June 1997, the Supreme Court reversed both decisions and upheld the Washington and New York statutes prohibiting assisted suicide.²⁹ Since that decision, the appellate courts of other states such as Alaska, Colorado and New Mexico have also upheld laws criminalizing assisted suicide, concluding that they do not violate the states' respective constitutions.³⁰ Although the courts have found that these statutes are constitutional, this does not mean that a law permitting assisted suicide would automatically be found unconstitutional. As noted above, Oregon, Washington State, Vermont and California have passed such laws. Oregon's laws were challenged but eventually upheld in the courts.³¹

2.6.2 DEFENCE OF CONSENT FOR DOCTORS IN MONTANA

In October 2007, in another challenge to laws preventing assisted suicide, two terminally ill patients, four doctors and a patients' rights organization in Montana brought a lawsuit before the District Court claiming the "right to die with dignity."

They alleged that the “application of Montana homicide statutes to physicians who provide aid in dying to mentally competent, terminally ill patients” contravened Article 2 of the state constitution, which protects the right to privacy and human dignity. The District Court, where the lawsuit was initiated, concluded that the constitutional protection of these rights included the right for competent, terminally ill patients to die with dignity. In turn, this right was found to include protection from prosecution for a physician who might assist such a patient.³²

The Montana government appealed the decision to the Montana Supreme Court, which decided the case without addressing the constitutional question. The majority of the Court concluded in its December 2009 judgment that doctors could use the existing defence of consent, if charged with homicide for assisting a mentally competent, terminally ill patient to commit suicide.³³ The consent defence allows a defendant to argue that the victim consented to the act that the defendant committed, and that the defendant should thus not be convicted. In this way, physicians who prescribe medication for a mentally competent, terminally ill patient so that he or she may commit suicide have a defence against homicide charges in Montana. Non-physicians may not benefit from the same protections, since the December 2009 decision addressed only the situation of doctors.³⁴

Although the decision provided a defence for doctors in the state, it did not outline any procedures, standards or safeguards. Because of this, in Montana, the practice of assisting a suicide is not regulated in any way, unlike in Washington, Oregon, Vermont and California, where safeguards are outlined in the legislation on assisted suicide. Bills have been brought before the Montana Legislature both to overturn the state Supreme Court decision to make assisted suicide illegal in Montana, and to provide a framework to regulate the practice, but none has passed to date.³⁵

2.6.3 EXAMPLES OF RECENT CONSTITUTIONAL CHALLENGES

2.6.3.1 GEORGIA

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

To convict someone of the crime of assisting a suicide, Georgia’s statute required that public advertising of assisted suicide, or a public offer to assist in the act, be an element of the crime. Assisted suicide was legal as long as it remained a private matter.³⁶ The accused challenged the constitutionality of the law on the basis of both the federal and state constitutions, arguing a number of issues; for example, the accused maintained that the inclusion of public advertising as an element of the crime violated the right to free speech. On 6 February 2012, the Supreme Court of Georgia (the state’s highest appellate court) found that the statute restricted free speech and was unconstitutional under both the United States and Georgia constitutions. The charges against all of the accused were dismissed. In response,

the state legislature passed legislation on 29 March 2012 criminalizing assisted suicide. The new legislation eliminates the advertising element of the offence but also narrows the scope of the assisted suicide provisions.³⁷

2.6.3.2 MINNESOTA

As a result of the investigation in Georgia, information came to light that a woman in Minnesota, Doreen Dunn, may also have been assisted by FEN members in committing suicide in 2007. FEN and four of its members, including two of the accused in the Georgia case (Mr. Goodwin and Dr. Egbert), were charged with various offences, including assisting a suicide.³⁸

The accused challenged Minnesota's law on assisted suicide on grounds similar to those of the Georgia challenge. The law criminalizes "advise[ing], encourage[ing], or assist[ing] another in taking the other's own life." In September 2013, in an unpublished decision that is not binding in future cases, the State of Minnesota Court of Appeals found that the prohibitions on advising and encouraging unjustifiably infringed on free speech and were overly broad.³⁹

In March 2014, Minnesota's Supreme Court decided a case with repercussions for the FEN case. A former nurse, William Melchert-Dinkel, had used the Internet to encourage two individuals, a Briton and a Canadian, to kill themselves. His motivation appears to have been entirely different from that of the individuals in FEN. The Supreme Court decided that the prohibitions on advising and encouraging a person to commit suicide violated constitutional free speech rights and struck "advising" and "encouraging" suicide from the statute. As the trial court in the Melchert-Dinkel case had not decided whether the accused's actions constituted "assisting" the victim, the case was remanded to the district court to decide that matter.⁴⁰

The majority's judgment at the Supreme Court in the Melchert-Dinkel case states that "assisting" a person to commit suicide is not limited to physical assistance and could include speech alone, such as by providing instruction on how to commit suicide. The majority stated that instructing someone on methods of suicide is not constitutionally protected speech (the dissent disagreed).⁴¹ According to news reports, Mr. Melchert-Dinkel was found guilty of one count of assisting a suicide and one count of attempting to assist a suicide.⁴² He is appealing that decision.⁴³

After the Melchert-Dinkel Supreme Court decision, the FEN case was sent back to the trial court on the charge of assisting a suicide but, for various reasons, the case proceeded only against FEN and not the individual accused. FEN was convicted in May 2015 of assisting in the suicide of Ms. Dunn, was given the maximum fine of \$30,000; a restitution payment to the family of nearly \$3,000 was also ordered. At the time of writing, FEN intended to appeal.⁴⁴

2.6.4 NEW MEXICO

In March 2012, two doctors and a woman with advanced ovarian cancer launched a challenge of New Mexico's law prohibiting physicians from assisting terminally ill patients to commit suicide. In contrast to the FEN proceedings, which were criminal

in nature, this was a civil case. The plaintiffs argued that the state's law against assisted suicide does not encompass a situation in which a physician provides a prescription to a mentally competent, terminally ill person. They also made constitutional arguments. At trial, the District Court judge concluded that the state's law against assisted suicide *did* encompass such a scenario, but that this violated liberty interests protected by the State constitution. In August 2015, the New Mexico Court of Appeals published its decision, which included majority, concurring and dissenting opinions. In a 2-to-1 decision, the court agreed that the current law did encompass physician-assisted suicide but concluded that such assistance is not protected as a fundamental liberty interest by the New Mexico Constitution. The case was heard by the state's Supreme Court in October 2015, but no judgment had been published at the time of writing.⁴⁵

2.6.5 OTHER CASES

Suits to challenge laws on assisted suicide are ongoing in at least two other states. The plaintiffs in cases heard in New York and Tennessee lost at trial in the fall of 2015 but are planning to appeal.⁴⁶

3 THE NETHERLANDS

3.1 DEVELOPMENT OF THE LAW

Traditionally, euthanasia was prohibited under the Dutch penal code, which states that anyone who terminates the life of another person at that person's explicit request is guilty of a criminal offence. Nonetheless, physicians who practised euthanasia in the Netherlands were not prosecuted as long as they followed certain guidelines. The guidelines were developed through a series of court decisions in which physicians who had been charged with practising euthanasia were found not to be criminally liable. In February 1993, the Netherlands passed legislation on the reporting procedure for euthanasia. Although it did not legalize euthanasia, the legislation provided a defence to physicians who followed certain guidelines. In effect, this provided doctors with concrete protection from prosecution.

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

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

With respect to infants, in 1995, Dutch courts dealt with two separate but similar cases in which doctors had ended the lives of severely disabled infants, both of whom were in pain and were not expected to survive their first year. In each case, the doctor had acted at the explicit request of the child's parents. The courts concluded that the doctors had met the requirements of good medical practice in those cases.⁴⁷ In 2004, some doctors and the district attorney in Groningen, the Netherlands, developed a protocol to identify when euthanasia of infants is appropriate. The Groningen Protocol has been ratified by the Paediatric Association of the Netherlands, and doctors who respect the protocol's requirements appear not to be prosecuted in the Netherlands, although the protocol is not an actual law.⁴⁸

3.2 CURRENT STATE OF THE LAW

In August 1999, the Dutch Minister of Justice and the Minister of Health tabled a legislative proposal in the House of Representatives – the lower house of Parliament – to exempt physicians from criminal liability in situations of euthanasia and assisted suicide as long as certain conditions are met. The bill passed the legislature in 2001.⁴⁹

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

- be satisfied that the patient's request is voluntary and well considered;
- be satisfied that the patient's suffering is unbearable and that there is no prospect of improvement (not necessarily a terminal illness or *physical* suffering);
- inform the patient of his or her situation and further prognosis;
- discuss the situation with the patient and come to the joint conclusion that there is no other reasonable solution;
- consult at least one other physician with no connection to the case, who must then see the patient and state in writing that the attending physician has satisfied the criteria for due care; and
- exercise due medical care and attention in terminating the patient's life or assisting in his or her suicide.⁵⁰

There is no requirement that the request be made in writing, and there is no mention of a need for repeated requests in the legislation, although this appears to be the general practice. Although the law has no explicit residency requirement, the patient must have a "medical relationship" with a physician; in practical terms, this limits the law's application to residents of the Netherlands.⁵¹ As in other jurisdictions, physicians are not obligated to assist a suicide or provide euthanasia if asked. Unlike the American jurisdictions where assisted suicide is legal, the physician must stay with the patient in cases of assisted suicide until the patient has died. Individuals may write an advance directive outlining the circumstances in which they would want euthanasia to be performed, meaning that they need not have the capacity to make the decision at the time of their death.

Physicians must report cases to a regional review committee (this requirement predates the law and was introduced in 1998), which refers cases in which one of the criteria is not met to the Board of Procurators General (prosecution service) and the Health Care Inspectorate.⁵²

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

The situation with respect to persons with Alzheimer's disease or other non-terminal illnesses remains contentious. There has also been some discussion in the Netherlands of allowing euthanasia and/or assisted suicide for people who are simply "tired of life."⁵³ In 1998 (before the current law was in place), a doctor assisted an 86-year-old former senator who had no physical or psychiatric illness or disorder to die because he no longer wanted to live. At the appellate level, the doctor was found guilty of assisting a suicide since he had not respected the requirements set out in the case law, though he received no punishment because, as was reported in a January 2003 *British Medical Journal* article, "he had acted out of great concern for his patient."⁵⁴

3.3 ANNUAL REPORTS AND REVIEWS OF THE SYSTEM

As in other jurisdictions, most cases of reported deaths by euthanasia and assisted suicide involve individuals suffering from cancer. There have been significant increases in reported deaths by euthanasia and assisted suicide in recent years in the Netherlands (as high as 19% between 2009 and 2010). Although regional review committees have been examining the reasons for these increases, they do not appear to have come to any clear conclusions as to whether they reflect an actual trend, or simply more frequent reporting, given that reporting had not been universal in the past. Multiple reviews and studies of the system, both official and independent, have been undertaken in recent years.⁵⁵ The law has been officially reviewed twice, most recently in 2012.

Research on the situation in the Netherlands shows that the majority of requests do not result in euthanasia or assisted suicide. Among the various reasons for this, the most common are that the patient died before the procedure was performed or his or her situation did not meet the statutory criteria.⁵⁶ Failure to meet the statutory standard of due care is found in very few cases: in 2013, only five out of 4,829 cases failed to meet that standard.⁵⁷ The 2012 review mentioned above found that physicians have become more comfortable over time considering requests from patients with mental illness or dementia. It found that this is because the meaning and scope of the requirements has become clearer with more years of experience.⁵⁸ The majority of cases of assisted suicide or euthanasia over the period addressed by the report (2007–2011) involving a patient with dementia related to individuals in the early stages of the disease who were still able to understand the illness and its symptoms.⁵⁹ Nonetheless, when the report was written, more than half of doctors were unwilling to be involved in such cases, although most of these doctors were willing to refer the patient to another physician.⁶⁰

Tables 3 and 4 highlight some statistics from annual reports in recent years. The Netherlands had a population of almost 17 million people and almost 140,000 deaths in 2014.

Table 3 – Annual Statistics Regarding the Netherlands’ Law Relating to Euthanasia and Assisted Suicide, 2003–2013

Year	Reported Deaths by Euthanasia	Reported Deaths by Assisted Suicide	Reported Deaths by a Combination of Euthanasia and Assisted Suicide	Total
2003	1,626	148	41	1,815
2004	1,714	141	31	1,886
2005	1,765	143	25	1,933
2006	1,765	132	26	1,923
2007	1,923	167	30	2,120
2008	2,146	152	33	2,331
2009	2,443	156	37	2,636
2010	2,910	182	44	3,136
2011	3,446	196	53	3,695
2012	3,965	185	38	4,188
2013	4,501	286	42	4,829

Sources: Annual reports published by regional euthanasia review committees, including the following: [Annual Report 2013](#), The Hague, September 2014; [Annual Report 2012](#), The Hague, July 2013; [Annual Report 2011](#), The Hague, August 2012; [Annual Report 2010](#), The Hague, August 2011; [Annual Report 2009](#), The Hague, May 2010; [2008 Annual Report](#), The Hague, April 2009; [2007 Annual Report](#), The Hague, April 2008; [2006 Annual Report](#), Arnhem (The Netherlands), May 2007; [2005 Annual Report](#), Arnhem, April 2006; [2004 Annual Report](#), Arnhem, March 2005; and [2003 Annual Report](#), Arnhem, September 2004.

Table 4 – Disorders or Illnesses of Patients Who Died in the Netherlands by Euthanasia or Assisted Suicide in 2013⁶¹

Disorder or Illness	Number of Patients	Percentage of Reported Deaths
Cancer	3,588	74.3
Neurological disorders	294	6.1
Multiple geriatric syndromes	251	5.2
Cardiovascular disease	223	4.6
Pulmonary disorders	174	3.6
Other disorders	160	3.3
Dementia	97	2.0
Mental disorders	42	0.9
TOTAL	4,829	100.0

Source: Regional Euthanasia Review Committees, [Annual Report 2013](#), The Hague, September 2014, p. 39.

3.4 RECENT ASSISTED SUICIDE CASE

A May 2015 Dutch appeal court decision absolved a Dutch man of criminal responsibility for assisting his mother to commit suicide in 2008. The lower level court had convicted the man but given him no punishment. It appears that the appeal court based its decision on the son's argument that he was faced with a decision to obey the law or his "unwritten moral duty" to help his mother to die as she wished and had chosen the latter. Before this case, involvement in euthanasia and assisted suicide was illegal for non-physicians. The implications of this decision remain to be seen.⁶²

4 BELGIUM

Belgium "conditionally decriminalis[ed]"⁶³ euthanasia in 2002.⁶⁴ Unlike the law in the Netherlands, the Belgian Act does not specifically mention assisted suicide. Nonetheless, the Belgian oversight body for euthanasia has determined that euthanasia, as defined in the Act, encompasses assisted suicide.⁶⁵ The law defines euthanasia as an act of a third party that intentionally ends the life of another person at that person's request.

Anyone who has reached the age of majority (18 years) or is an emancipated minor (by marriage or court order), is mentally capable and is conscious may make a request if they have an incurable condition that results in constant and unbearable physical or psychological suffering. As in the Netherlands, the patient does not need to have a terminal illness or *physical* suffering, and must reside in the country.⁶⁶

In 2014, the legislation was amended to permit a person of any age with the "capacity for discernment," and who is conscious at the time of the request, to ask for euthanasia, although the conditions are narrower for minors who are not emancipated. They must experience constant and intolerable *physical* pain, have a serious and incurable condition, be close to death and have their parents' or legal guardians' permission. In addition, a child psychiatrist or psychologist must be consulted to verify the minor's capacity for discernment in relation to the decision to request euthanasia.⁶⁷

This change to the law was challenged before the Constitutional Court in October 2015. The court upheld the constitutionality of the law and provided some clarifications. Since a capacity for discernment is required, newborns and young children are excluded from the provisions of the law (i.e., they do not have access to euthanasia). Also, in the case of unemancipated minors, the view of the independent child psychiatrist or psychologist about the patient's capacity for discernment, which must be in writing, is binding on the treating physician (i.e., he or she cannot practise the euthanasia where such capacity is lacking in the opinion of the psychiatrist or psychologist).⁶⁸

The legislation establishes conditions that must be met by both the person seeking euthanasia and the physician who performs it. The doctor must meet the patient several times with a reasonable delay between visits. The doctor must also seek the opinion of at least one independent doctor, and two doctors if the patient is not expected to die in the near future. There is a waiting period of at least one month between the

written request and the performance of euthanasia in situations where death is not imminent. As in other jurisdictions, no one is obligated to practise euthanasia.

The physician is required to fill out a registration form each time he or she performs euthanasia; this form is then reviewed by a commission whose role it is to determine whether the euthanasia was performed in accordance with the conditions and procedures established by the legislation. If two thirds of the commission members are of the opinion that the conditions were not fulfilled, the case is referred to the public prosecutor. It appears that the first case was referred to the prosecutor's office in the fall of 2015. The case involved an 85-year-old woman whose daughter had died recently and who was depressed.⁶⁹ It remains to be seen whether the doctor will face charges. Prior to that, where issues have been identified, they have generally been procedural (information missing from a form, etc.).⁷⁰ The commission is also responsible for producing biannual reports.

Individuals who are 18 or above or emancipated minors can make an advance directive expressing their desire to be euthanized as long as certain conditions are met when the procedure actually takes place. Unlike in the Netherlands, an advance directive is valid only for persons who are unconscious at the time of the euthanasia. This means that individuals with conditions affecting decision-making capacity, such as dementia, are not able to use an advance directive to request euthanasia for a future date when they are no longer capable of making decisions. Also, the directive may be taken into account only if it was written within five years of the date at which the individual can no longer express his or her will.

Various amendments to the law continue to be proposed by parliamentarians. Topics of recent bills include expanding euthanasia to individuals with illnesses affecting their capacity, such as dementia, if an advance directive is in place; introducing a requirement for a doctor unwilling to perform euthanasia to refer a patient to one who will do so; and the explicit regulation of assisted suicide.⁷¹

A few euthanasia cases in Belgium have made international headlines in recent years, including the case of deaf twins who were going to lose their sight and requested to die together.⁷² According to media reports, Tom Mortier, a Belgian man whose mother received euthanasia at her request because of long-standing depression is challenging the Belgian law at the European Court of Human Rights, but no information confirming this is available on the court's website.⁷³

4.1 ANNUAL REPORTS

Belgium's Commission fédérale de contrôle et d'évaluation de l'euthanasie (Federal Commission for the Control and Evaluation of Euthanasia) publishes biannual reports that aggregate statistics about those who choose euthanasia. For 2013:

- 52% were men;
- 84% were aged 60 or older;⁷⁴ and
- 44% died at home.

Tables 5 and 6 highlight some statistics from biannual reports in recent years.

Table 5 – Annual Statistics Concerning Belgium’s Law Relating to Euthanasia, 2002–2013

Year	Reported Deaths by Euthanasia	Deaths by Euthanasia per 1,000 Deaths
22 Sept. 2002–31 Dec. 2003 (approximately 15 months)	259	2.0
2004	349	3.6 (2004–2005 average)
2005	393	3.6 (2004–2005 average)
2006	429	4.4 (2006–2007 average)
2007	495	4.4 (2006–2007 average)
2008	704	7.0 (2008–2009 average)
2009	822	7.0 (2008–2009 average)
2010	953	10.0 (2010–2011 average)
2011	1,133	10.0 (2010–2011 average)
2012	1,432	13.0
2013	1,807	17.0

Sources: Belgium, Santé publique, Sécurité de la chaîne alimentaire et Environnement, [Biannual reports](#) on the *Loi relative à l’euthanasie*, 2004–2013.

Table 6 – Disorder or Illness of Patients in Belgium Who Died by Euthanasia or Assisted Suicide in 2013⁷⁵

Disorder or Illness	Number of Patients	Percentage of Reported Deaths
Cancer	1,242	68.7
Progressive neuromuscular disease	114	6.3
Multiple illnesses	109	6.0
Cardiovascular disease	107	5.9
Non-cancerous pulmonary disease	70	3.9
Neuropsychiatric illness (including dementia)	67	3.7
Kidney disease	12	0.7
Non-cancerous gastrointestinal disorder	11	0.6
Non-progressive neuromuscular disease	7	0.4
AIDS	1	0.1
Other	67	3.7
TOTAL	1,807	100.0

Source: Belgium, Santé publique, Sécurité de la chaîne alimentaire et Environnement, [Biannual report](#) on the *Loi relative à l’euthanasie*, 2012–2013.

5 LUXEMBOURG

In 2008, Luxembourg became the most recent country to pass a law decriminalizing doctors' involvement in euthanasia and assisted suicide where certain conditions are met. As in the Netherlands and Belgium, there is no explicit legal requirement for the patient to be a resident, but since a close relationship with a doctor is required, patients must, in practice, be residents.⁷⁶ Conditions similar to those in Belgium are set out in the legislation, the *Loi du 16 mars 2009 sur l'euthanasie et l'assistance au suicide*.⁷⁷ There are some differences, including the age at which a person may request euthanasia or assisted suicide. In Luxembourg, an individual must be at least 18, the age of majority. Unlike in Belgium, advance directives have no limitation on their validity period, although they are registered with a government body that verifies every five years whether they continue to reflect the wishes of the person in question.

5.1 ANNUAL REPORTS

Luxembourg's Commission Nationale de Contrôle et d'Évaluation de la loi du 16 mars 2009 sur l'euthanasie et l'assistance au suicide (National Commission for the Control and Evaluation of the law of 16 March 2009 on euthanasia and assisted suicide) provides reports to the public every two years. The reports indicate that there has never been a case of euthanasia or assisted suicide that was sent to the prosecutor for charges to be considered. The annual reports provide aggregate statistics about those who choose euthanasia (only one assisted suicide has been reported to date). For 2014:

- 71% were men;
- 100% were over the age of 60;
- 14% died at home;
- 86% had cancer; and
- 14% had a neurodegenerative disease.

Table 7 provides information on the number of reported deaths by euthanasia per year. The country has a population of over 500,000 and had 3,841 deaths in 2014.

**Table 7 – Reported Deaths by Euthanasia
in Luxembourg, 2009–2014**

Year	Reported Deaths by Euthanasia
2009	1
2010	4
2011	5
2012	9
2013	8
2014	7

Source: Luxembourg, Commission Nationale de Contrôle et d'Évaluation de la loi du 16 mars 2009 sur l'euthanasie et l'assistance au suicide, [Troisième rapport à l'attention de la Chambre des Députés \(Années 2013 et 2014\)](#).

6 SWITZERLAND

Article 114 of the Swiss Criminal Code prohibits euthanasia, although the crime has a lesser sentence than other acts deemed homicide. Murder carries a mandatory minimum sentence of five years' imprisonment, while Article 114 provides that an individual who kills a person for compassionate reasons on the basis of that person's serious request will be fined or sentenced to a maximum term of imprisonment of three years. Assisted suicide is addressed in Article 115, which provides that someone who, for selfish reasons, incites someone to commit suicide or assists a suicide will be fined or sentenced to a maximum term of imprisonment of five years. Thus, it is implicit that assisted suicide is permitted if the person assisting the suicide does so for unselfish reasons.

Since Article 115 does not explicitly regulate assisted suicide for unselfish reasons, the Penal Code does not require that a physician be the person to assist a suicide, nor does it require the involvement of any physician whatsoever, which is a significant departure from legislation in other countries where assisted suicide is permitted.⁷⁸ Nonetheless, at least one canton (region) has approved, by referendum, legislation to regulate the provision of assisted suicide in hospitals and other "socio-medical establishments."⁷⁹

Assisted suicide is also not limited to those with a terminal illness or to Swiss residents. Because of the lack of residency requirements, Switzerland has become a destination for foreigners, predominantly Europeans, seeking assistance in committing suicide.⁸⁰ For example, on 1 March 2011, Nan Maitland, an 84-year-old British advocate for assisted suicide, went to a Swiss clinic to receive assistance in committing suicide. Ms. Maitland had arthritis but was not terminally ill and simply wanted to avoid a long decline as she got older.⁸¹ Canadian Kathleen ("Kay") Carter went to Switzerland in 2010 with her daughter, Lee Carter, and son-in-law, Hollis Johnson, to end her life. She suffered from spinal stenosis, a compression of the spinal cord or spinal nerve roots that was painful but not fatal. Lee Carter and Hollis Johnson were plaintiffs in litigation that successfully challenged Canada's laws on assisted suicide.⁸²

In July 2008, the Swiss government called on the Department of Justice and the federal police to prepare a report on the necessity of updating the rules on assisted suicide. That report, as well as consultations undertaken in 2009 and 2010, concentrated primarily on two options: either to provide a more detailed legislative framework to regulate assisted suicide or to prohibit organizations that provide assistance to commit suicide altogether.⁸³ In the end, there was no consensus on the best course of action, and the Swiss Federal Council (the Swiss cabinet) decided not to make any changes to the law.⁸⁴ Referendums in Zurich to ban assisted suicide or at least to impose a residency requirement also failed to pass.⁸⁵

6.1 CASES

In January 2011, the European Court of Human Rights held that no violation of the *European Convention on Human Rights'* protections of private life occurred when a Swiss man was unable to obtain a lethal substance that was available only by prescription. Ernst G. Haas, who suffers from bipolar disorder, had attempted suicide

twice and had been unsuccessful in getting a psychiatrist to prescribe a lethal dose of a drug for him. He had also unsuccessfully sought permission from federal and cantonal authorities to receive such a dose without a prescription and had appealed those decisions in the Swiss courts before turning to the European Court. The Court recognized his right to decide to end his own life as protected under the right to privacy in section 8 of the Convention, but concluded that the state has no obligation to assist someone to access such a drug without a prescription. The Grand Chamber of the European Court of Human Rights refused to hear an appeal.⁸⁶

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

The Court left it up to the Swiss authorities to develop the necessary guidelines to remedy the violation of section 8. However, the Swiss government requested the case be referred to the Grand Chamber of the European Court of Human Rights as a serious question to be decided. It was then discovered that Ms. Gross had died in 2011 and that her death had been hidden from the court so that her case would go ahead.⁸⁷ The Grand Chamber found Ms. Gross's application to be inadmissible in a nine-to-eight decision in 2014, meaning that the earlier decision requiring clarification of the prosecution policy is not binding on Switzerland.⁸⁸

7 COLOMBIA⁸⁹

In Colombia, euthanasia is a criminal offence for which the maximum sentence is less than that for homicide. In a 1997 case, an individual initiated a constitutional challenge to this sentencing distinction on the grounds of the right to life and to equality. One argument was that individuals convicted of euthanasia should not benefit from a lower maximum sentence. Colombia's highest court, the Constitutional Court, rejected the constitutional challenge, concluding that a doctor could not be prosecuted for euthanasia for assisting an individual in ending his or her life if the person had a terminal illness, severe pain and suffering and had consented. Nonetheless, "mercy killing" remains a crime in Colombia if those conditions are not met.⁹⁰ The judgment also urged legislative action in this area, but it seems that legislative efforts have not been successful to date, as the issue is quite contentious in this predominantly Catholic country.⁹¹ Given the uncertainty created by a lack of legislation responding to the Constitutional Court decision, few physicians appear to have practised euthanasia openly.⁹²

In December 2014, the Constitutional Court again addressed the issue of euthanasia, concluding that the fundamental rights of the claimant, who had terminal cancer, had been violated when she was refused euthanasia. She died of natural causes before the proceedings were complete, but the court nonetheless ordered the Ministry of Health to regulate “dying with dignity,” which it did in April 2015.⁹³ The first person to have a legally assisted death after the regulations were put in place, a man with cancer, died in July 2015.⁹⁴

The 2014 Constitutional Court decision also urged Congress to legislate on this issue. As such, a bill to regulate euthanasia and assisted suicide was tabled in July 2015.⁹⁵

8 UNITED KINGDOM

8.1 ENGLAND AND WALES

8.1.1 COURT CASES

End-of-life decisions have caused considerable controversy in the United Kingdom (U.K.). Euthanasia is unlawful throughout the U.K. Although assisted suicide also remains illegal, because of the developments discussed in this section, a person who assists the suicide of another person will not necessarily be prosecuted.⁹⁶

In a 2002 European Court of Human Rights case, Diane Pretty unsuccessfully challenged the law prohibiting assisted suicide and sought assurances from the Director of Public Prosecutions (DPP) that her husband would not be prosecuted if he assisted her suicide. The Court found that the DPP’s refusal of her request and the U.K.’s prohibition of assisted suicide did not infringe on any of her rights under the Council of Europe’s *European Convention on Human Rights*.⁹⁷

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

The House of Lords concluded that the DPP should be required to clarify its policy in dealing with such cases for the public.⁹⁸ The resulting updated policy, published in February 2010, stated clearly that assisted suicide remains a criminal offence. However, it outlined a two-stage process to determine whether charges will be brought: first, it must be determined whether there is sufficient evidence of an offence having been committed and, second, it must be decided whether a prosecution is in the public interest. Specific factors, such as whether the person who committed suicide clearly stated the intention to do so, and the motivation of the person who assisted, are to be considered.

In 2014, the policy was clarified again with respect to the risk of prosecution for health care workers. This was done to make it clear that it is the relationship with the patient that matters in assessing whether prosecution is more likely to be required (that is, whether the victim was in the health professional's care and at risk of undue influence). The intent is not for the listed types of professionals to be at greater risk of prosecution simply because of their profession.⁹⁹ This clarification arose from the Nicklinson case, in which Tony Nicklinson and another person known as AM or Martin, both of whom had locked-in syndrome,¹⁰⁰ challenged the law on assisted suicide and euthanasia in England and Wales. Paul Lamb, another plaintiff with the same syndrome, joined the challenge later. None of the men appears to have had a terminal illness. When Mr. Nicklinson died shortly after a lower level court decision was released, his wife also became a plaintiff. As part of that case, the Supreme Court concluded that the policy lacked clarity with respect to the likelihood of prosecution of health care professionals, but left the DPP to clarify the policy.

The Supreme Court (previously the House of Lords) handed down a divided decision on 25 June 2014 in which each justice wrote a judgment. The appellants (Mr. Nicklinson and others) lost the appeal, seven of nine judges dismissing their claims. Four judges concluded that the court should defer to Parliament on this topic. Five of the justices concluded that the "court has the constitutional authority to make a declaration that the general prohibition on assisted suicide in Section 2 is incompatible with Article 8" (article 8 relates to the right to privacy and family life). However, three of those justices found that Parliament should be given the opportunity to address the issue first. Only two justices concluded that such a declaration should be issued at the time of judgment.¹⁰¹ An application to the European Court of Human Rights by Mrs. Nicklinson and Mr. Lamb challenging the decision was deemed inadmissible.¹⁰²

AM also unsuccessfully challenged the General Medical Council's (the regulatory body for doctors in the U.K.) guidance for doctors with respect to assisted suicide.¹⁰³ AM is appealing that decision.¹⁰⁴

8.1.2 LEGISLATIVE PROPOSALS

In March 2004, a bill was introduced in the U.K. House of Commons that would have permitted assisted suicide and euthanasia but it did not pass.¹⁰⁵ Bills have also been introduced in the House of Lords three times in the past three years to legalize "assisted dying" in England and Wales, all of them very similar. The most recent bill was introduced in June 2015. A bill very similar to the ones considered in the House of Lords failed to pass second reading in the House of Commons in September 2015.¹⁰⁶

The bills introduced in the U.K. Parliament are similar to the laws in the United States, requiring a person seeking assistance with dying to have a terminal illness with less than six months to live, to be 18 years or older, to have the capacity to make the decision and to be a resident of England and Wales, for example. One key difference is that participants would need the authorization of the High Court (Family Division), whereas judicial involvement is not required in the American states where assisted suicide is legal. The bills would allow a doctor or a nurse to "assist [the] person to

ingest or otherwise self-administer the medicine; but the decision to self-administer the medicine and the final act of doing so must be taken by the person for whom the medicine has been prescribed.”¹⁰⁷ The assisting health professional would also need to remain near the patient until he or she either dies or decides not to administer the medicine.

8.2 NORTHERN IRELAND

The DPP’s jurisdiction is limited to England and Wales, but Northern Ireland has a similar policy, developed in collaboration with the DPP. Unlike the policy in England and Wales, this policy does not appear to have been updated to clarify the situation with respect to health care workers.¹⁰⁸

8.3 SCOTLAND

Unlike England, Wales and Northern Ireland, Scotland does not have a statutory offence of assisted suicide. Depending on the facts, a case of assisted suicide could be addressed through homicide laws.¹⁰⁹ In an attempt to eliminate this risk, Margo MacDonald, an independent Member of Parliament living with Parkinson’s disease, introduced a bill in the Scottish Parliament in 2010 that would have legalized assisted suicide. The bill was defeated later that year.¹¹⁰

Ms. MacDonald introduced a bill on the same topic in November 2013. When she died in 2014, another Scottish Member of Parliament took responsibility for the bill. In May 2015, the bill failed to pass the Stage 1 debate in the Scottish Parliament and died on the Order Paper. That bill would have allowed individuals who were at least 16 years old with a terminal illness or a life-shortening condition to request assistance in committing suicide. It would have introduced a role for “licensed facilitators” in giving practical assistance to the patient and would have provided for a licensing scheme for such facilitators. Unlike the assisted suicide legislation in the U.S., the bill did not require the prognosis to be six months or less.¹¹¹

The Scottish courts have also addressed the issue of assisted suicide recently. A September 2015 trial level decision addressed the petition of Gordon Ross. Similar to the earlier *Purdy* decision, Mr. Ross sought judicial review of the failure of the Lord Advocate (the Scottish minister responsible for the public prosecution service) to adopt and publish a policy on prosecutions in cases of assisted suicide. The court dismissed the petition. Among other conclusions, the court found that section 8 of the *European Convention on Human Rights* (right to privacy and family life) was engaged, but distinguished *Purdy* because of the difference in the laws and prosecutorial practice between Scotland and England and Wales. The court concluded that the Scottish policy was in accordance with the law and that section 8 of the European Convention was not violated.¹¹² Mr. Ross is quoted in media reports as intending to appeal.¹¹³

NOTES

1. [Carter v. Canada \(Attorney General\)](#), 2012 BCSC 886, para. 38.
2. *Ibid.*, para. 37. Definitions found in this paper follow those used in the judgment in the *Carter* case. Also of note, the terminology used for assisted suicide can be controversial, and some supporters of the practice prefer terms such as “death with dignity” or “aid in dying.”
3. The Northern Territory of Australia was the first jurisdiction to make euthanasia and assisted suicide legal in 1996, but because the law was overturned by federal legislation after only a short time it is not discussed here. The law in a number of countries is silent with respect to assisted suicide, meaning that the practice is technically legal in those jurisdictions. Countries in such situations are not discussed in this paper, as the focus here is on legislative initiatives and court rulings. Not all countries where bills have been proposed but have not yet passed, such as New Zealand, are discussed. Germany passed a law in November 2015 allowing assisted suicide in some cases, but a copy of the legislation was not available in French or English for analysis at the time of writing. Media reports state that assisted suicide will be allowed in cases of “altruistic motives” but will not be allowed on a “business ‘basis’.” Before this legislation was passed, Germany’s law was silent with respect to assisted suicide. (Associated Press, “Germany Passes Law Allowing Some Types of Assisted Suicide,” *The New York Times*, 6 November 2015.) In addition, the policies of medical associations that regulate professions such as medical practice and nursing have not been examined. Finally, the topic of withholding or withdrawing treatment appears to be less controversial in Canada than euthanasia or assisted suicide, although there are some outstanding challenges to the application of the law in Canada. Withholding or withdrawing treatment is contentious in some other countries. However, that issue is beyond the scope of this paper.
4. Martha Butler and Marlisa Tiedemann, [Carter v. Canada: The Supreme Court of Canada’s Decision on Assisted Dying](#), Publication no. 2015-47-E, Parliamentary Information and Research Service, Library of Parliament, Ottawa, 7 October 2015; and Martha Butler, Julia Nicol and Marlisa Tiedemann, *Euthanasia and Assisted Suicide in Canada*, Publication no. 2015-139-E, Parliamentary Information and Research Service, Library of Parliament, Ottawa (forthcoming).
5. Mary J. Shariff, “Immortal Beloved and Beleaguered: Towards the Integration of the Law on Assisted Death and the Scientific Pursuit of Life Extension,” *Health Law in Canada*, Vol. 31, No. 1, 2010, p. 6.
6. A ballot initiative is “a form of [direct democracy](#) ... by which citizens exercise the power to place measures otherwise considered by state legislatures or local governments on statewide and local ballots for a public vote.” See Robert Longley, [“The Ballot Initiative Process: Empowering Citizen Lawmakers with Direct Democracy,”](#) *About.com*.

7. Although the legislation was not struck down as a result of the legal challenge, the Oregon legislature then voted to have another citizen vote on the law. Oregon voters reaffirmed their support by a 60% majority, and the Act came into effect in November 1997. Opponents of the *Death with Dignity Act* quickly began to lobby for federal intervention against the state initiative. They initially appeared unsuccessful, but with a change in government at the federal level in 2001, an Interpretive Rule was issued to clarify the legal situation in federal law for doctors who might assist a patient to commit suicide. The Interpretive Rule stated that physicians who prescribed, dispensed or administered federally controlled substances to assist a suicide would be violating the federal *Controlled Substances Act*. However, in January 2006, the Supreme Court of the United States ruled in *Gonzales v. Oregon* that the Interpretive Rule was invalid because it went beyond the federal Attorney General's authority under the *Controlled Substances Act* (*Gonzales, Attorney General, et al. v. Oregon et al.*, [2006] (04-623) 368 F.3d 1118, 17 January 2006).
8. United States, Oregon, State Legislature, [The Oregon Death with Dignity Act](#), Oregon Revised Statutes, c. 127, 127.800, s. 1.01(3).
9. *Ibid.*, s. 1.01(7).
10. *Ibid.*, 127.855 s. 3.09, "Medical record documentation requirements"; 127.865 s. 3.11, "Reporting requirements."
11. *Ibid.*, 127.855, s. 4.01(4).
12. The report for 2014 notes that the number of patients who had private insurance was lower in that year than in previous years (39.8% instead of 62.9%), and that the number of patients with only Medicare or Medicaid insurance was higher (60.2% compared to 35.5%).
13. United States, Oregon, Public Health Division, [Oregon's Death with Dignity Act – 2014](#), 12 February 2015, pp. 2 and 5.
14. *Ibid.*, p. 5; ["SF Judge Upholds Law Prohibiting Physician-Assisted Suicide," NBC Bay Area](#), 14 August 2015 [SF Judge].
15. United States, Oregon Public Health Division, [Annual Reports](#). See annual reports for 2011–2014.
16. United States, Oregon State Legislature, ["2015 Regular Session – HB 3337."](#)
17. United States, Washington State, Department of Health, ["Death with Dignity Act."](#) For information about the ballot initiative, see Washington Secretary of State, ["Initiatives to the People," Elections & Voting](#), "Initiative Measure No. 1000."
18. The annual report provides two different numbers for the percentage with cancer in different places, 73% and 76%. See United States, [Washington State Department of Health 2014 Death with Dignity Act Report](#), DOH 422-109, 2014, pp. 1 and 5.
19. *Ibid.*, pp. 1 and 7.
20. United States, Washington State Legislature, [SB 5919-2015-16](#); State of Washington, [Senate Bill 5919](#), 64th Legislature, 2015 Regular Session.
21. United States, Vermont, Legislature, [No. 39. An act relating to patient choice and control at end of life](#), (Bill S.77), 14 May 2013; and Vermont General Assembly, [An act relating to repealing the sunset on provisions pertaining to patient choice at end of life](#), S.108 (Act 27).
22. United States, California Legislative Information, [AB-15 End of Life](#) (2015–2016).
23. April Dembosky, ["California Approves Physician-Assisted Suicide; Bill Heads to Governor's Desk," NPR](#), 12 September 2015; and Alexei Koseff, ["Which bills will Jerry Brown sign?" The Sacramento Bee](#), 17 September 2015.

24. Medicaid is state-funded health care for low income residents.
25. Susan Harding and KATU Web staff, "[Letter noting assisted suicide raises questions](#)," *Katu.com* [Portland], 30 July 2008; and Dan Springer, "[Oregon Offers Terminal Patients Doctor-Assisted Suicide Instead of Medical Care](#)," *FoxNews.com*, 28 July 2008.
26. Patients Rights Council, "[Attempts to Legalize Euthanasia/Assisted-Suicide in the United States](#)," 2015.
27. William Galvin, [Return of Votes For Massachusetts State Election, November 6, 2012](#), 28 November 2012, p. 57. Forty-six percent of voters voted to legalize physician-assisted suicide, 48% voted against and 6% of ballots were left blank.
28. Nightingale Alliance, "[Legal Status of Assisted Suicide/Euthanasia in the United States](#)," n.d. Note that this source is not completely up to date. For example, California's recent change to the law on assisted suicide is not reflected.
29. United States, [Washington v. Glucksberg](#), 521 U.S. 702 (1997) [U.S. Supreme Court]; and [Vacco v. Quill](#), 521 U.S. 793 (1997) [US Supreme Court].
30. United States, [Sampson v. Alaska](#), [2001] 31 P.3d 88, Alaska [Supreme Court of Alaska]; and [Sanderson v. People](#), [2000] No. 99CA0203, 8 June 2000 [Colorado Court of Appeals]. For information about the 2015 New Mexico case, see section 2.6.4.
31. See endnote 6.
32. United States, [Baxter v. Montana](#), [2009] MT 449 [Supreme Court of the State of Montana], para. 7.
33. *Ibid.*, para. 13.
34. Nightingale Alliance (n.d.).
35. For a bill seeking to make assisted suicide illegal, see, for example, United States, Montana Legislature, "Detailed Bill Information," [HB 477](#), 2015. For a bill seeking to regulate the practice, see "Detailed Bill Information," [SB 202](#).
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APPENDIX A – THE LAW ON EUTHANASIA AND ASSISTED SUICIDE: COMPARISON OF VARIOUS JURISDICTIONS

Table A.1 – Current Legal Status of Euthanasia and Assisted Suicide in Various Jurisdictions with Legislation on the Topic

	United States	The Netherlands	Belgium	Luxembourg
Euthanasia (E)/assisted suicide (AS) allowed?	AS allowed (Oregon, Washington State, Vermont, California and Montana only)	E and AS allowed	E and AS allowed	E and AS allowed
Terminal illness required?	Yes	No	No	No
Residency required?	Yes	Yes, although not explicitly in the law	Yes, although not explicitly in the law	Yes, although not explicitly in the law
Advance directives permitted?	No	Yes	Yes (only for unconscious persons)	Yes (only for unconscious persons)
Permitted for minors?	No	Yes (12 years and older or newborn)	Yes	No
Permitted for persons with dementia/psychiatric illness not capable of making decisions?	No	Yes, if there is a signed advance directive	Yes, but the person must be competent at time of request	Yes, but the person must be competent at time of request
Psychological suffering sufficient?	No	Yes	Yes	Yes

Note: This table includes a number of elements to highlight the differences between jurisdictions but does not include all criteria that must be met to satisfy the conditions in each jurisdiction. The table does not include Colombia because of a lack of sufficient information in English or French and does not include the U.K. because that country has no legislation regulating euthanasia or assisted suicide. Switzerland is not included in the table because it does not have a detailed regulatory regime.

Sources: United States: Oregon State Legislature, [The Oregon Death with Dignity Act](#), Oregon Revised Statutes, c. 127, 127.800; Washington State Department of Health, "[Death with Dignity Act](#)"; Vermont Legislature, [No. 39. An act relating to patient choice and control at end of life](#), (Bill S.77), 14 May 2013; California Legislature, [An act to add and repeal Part 1.85 \(commencing with Section 443\) of Division 1 of the Health and Safety Code, relating to end of life](#); and The Netherlands: The *Termination of Life on Request and Assisted Suicide (Review Procedures) Act* came into effect on 1 April 2002. An English translation of the law can be found at [Act of 12 April 2001, containing review procedures for the termination of life on request and assisted suicide and amendment of the Criminal Code and the Burial and Cremation Act \(Termination of Life on Request and Assisted Suicide \(Review Procedures\) Act\)](#). Belgium: Belgian Federal Parliament, [Loi relative à l'euthanasie](#), F. 2002-2141 [C-2002/09590], 28 May 2002. Luxembourg: Chamber of Deputies, [Loi du 16 mars 2009 sur l'euthanasie et l'assistance au suicide](#).