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Euthanasia and Assisted Suicide: International Experiences

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(Background Paper)

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EUTHANASIA AND ASSISTED SUICIDE: INTERNATIONAL EXPERIENCES*

1 INTRODUCTION

Over the last few decades, movements have arisen in a number of jurisdictions in favour of the legalization of physician-assisted suicide and, in some cases, euthanasia.[1] 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. This paper reviews developments in jurisdictions that already permit physician-assisted suicide or euthanasia (or both) in certain contexts, as well as developments in some jurisdictions that appear to be moving toward greater acceptance of these practices. It also summarizes some of the events that have contributed to the debate on this issue. An appendix at the end of this paper provides an overview, in chart format, of the current legal status of euthanasia and assisted suicide in various jurisdictions.

The topic of withholding or withdrawing of 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 on this topic in Canada and it is contentious in some other countries. However, that issue is beyond the realm of this paper.

2 THE UNITED STATES

To date, Oregon and Washington State are the only states that have passed laws explicitly permitting some form of physician-assisted suicide, and no American state has legalized euthanasia.[2] As a result, there is little case law in the United States relating to state laws that permit physician-assisted suicide; most case law relating to this issue addresses state laws that explicitly prohibit the practice.

2.1 CHALLENGES TO STATE LAWS THAT PROHIBIT PHYSICIAN-ASSISTED SUICIDE

The majority of American states have laws explicitly prohibiting physician-assisted suicide, while some rely on common law crimes, which are developed through judicial decision-making to prohibit the practice (euthanasia is addressed through regular homicide laws).[3]

On 1 October 1996, the Supreme Court of the United States agreed to hear an appeal of two Court of Appeals 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 (it 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 Court of Appeals decisions and upheld the Washington and New York statutes prohibiting assisted suicide. Since

that decision, the appeal courts of other states such as Alaska and Colorado have also upheld laws criminalizing assisted suicide, concluding that they do not violate the states' respective constitutions.[4] However, the courts' finding that these statutes are constitutional does not mean that a law permitting assisted suicide would automatically be found unconstitutional. Both Oregon and Washington State have passed such laws. Oregon's laws were challenged but eventually upheld in the courts (see section 2.2.2, "Legal Challenges to the *Death with Dignity Act*").

In October 2007, in another challenge to laws against assisted suicide, two terminally ill patients, four doctors and a patients' rights organization in Montana brought a lawsuit before the District Court claiming the "right to die with dignity." They alleged that the "application of Montana homicide statutes to physicians who provide aid in dying to mentally competent, terminally ill patients" contravened Article 2 of the state constitution, which protects the right to privacy and human dignity. The District Court, the court of "first instance" (where the trial originally took place), 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.[5]

The Montana state government appealed the decision to the Supreme Court of the State of Montana, 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 patient to commit suicide.[6] The consent defence allows a defendant to argue that the victim has consented to the act that the defendant committed, and that the defendant should thus not be convicted. As such, physicians have a defence against charges of assisted suicide in Montana, though non-physicians may not benefit from the same protections since the December 2009 decision only addressed the situation of doctors.[7]

A similar lawsuit in Connecticut was launched by two doctors, but not in relation to any specific patients. The Superior Court, in its June 2010 decision, dismissed the case, finding, among other conclusions, that determining whether the doctors should be allowed to assist patients to commit suicide is an issue for the Connecticut legislature rather than the courts.[8]

2.2 OREGON'S *DEATH WITH DIGNITY ACT*

2.2.1 REQUIREMENTS UNDER THE *DEATH WITH DIGNITY ACT*

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

- The patient has to make two oral requests at least 15 days apart and one written request for medication. Forty-eight hours must elapse between the written request and the provision of a prescription.

- A second medical opinion is required.
- The patient has to be capable, meaning that "in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, psychiatrist or psychologist, a patient has the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available."[9]
- If the physician 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:[10]
  - his or her medical diagnosis;
  - 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.

Details must be included in the patient's medical record concerning the requests, diagnosis, prognosis, any counselling that occurred and offers to rescind the request. Doctors also have reporting obligations to Oregon's Human Services.[11]

2.2.2 Legal Challenges to the *Death with Dignity Act*

A legal challenge to the legislation prevented the proclamation of Measure 16 in 1995, but on appeal, the plaintiffs were deemed to have not had a sufficient stake in the outcome to justify being allowed to launch a lawsuit. The Oregon legislature then voted to have another referendum on the law, in which Oregon voters reaffirmed their support by a 60% majority and the Act came into effect in November 1997. Opponents of the *Death with Dignity Act* quickly began lobbying for federal intervention against the state initiative. They initially appeared unsuccessful, but with a change in government at the federal level in 2001, an Interpretive Rule was issued to clarify the legal situation at the federal level 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 suicide would be violating the federal *Controlled Substances Act*.[12] However, in January 2006, the Supreme Court of the United States in *Gonzales* v. *Oregon* ruled that the *Controlled Substances Act* could not be enforced against physicians who prescribed drugs for the purpose of assisted suicide as permitted by Oregon law. The Supreme Court also affirmed the decision of the Court of Appeals for the Ninth Circuit that the Interpretive Rule was invalid because it went beyond the federal Attorney General's authority under the *Controlled Substances Act*.[13]

2.2.3 *Death with Dignity Act* Annual Report

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. Among the statistics that reports have provided in recent years are the following:[14]

Table 1 – Annual Statistics Relating to Oregon's *Death with Dignity Act*, 2006–2010

Actions reported	2006	2007	2008	2009	2010
Prescriptions written	65	85	88	95	96
Deaths by ingestion of the prescribed medication	46	49	60	59	65
Deaths by physician-assisted suicide per 1,000 deaths	1.47	1.56	1.94	1.93	2.09

Source: Oregon Department of Human Services, annual reports on *Death with Dignity Act*, 2006–2010.

Though the number of prescriptions written has increased every year since the law was passed, considering that almost four million people live in Oregon, relatively few prescriptions are written. In addition, the number of deaths by physician-assisted suicide remains quite low at a little over two of every 1,000 deaths in Oregon in 2010.

2.3 Washington State's *Death with Dignity Act*

The State of Washington passed its *Death with Dignity Act* by referendum on 4 November 2008 and it came into force on 5 March 2009.[15] The law is based on the law in Oregon and includes reporting requirements, with the Washington State Department of Health playing a collection and monitoring role similar to Oregon's Department of Human Services.[16] According to the Washington State Department of Health's first report, 63 individuals received prescriptions from the date the Act became law until the end of 2009. Of those, at least 36 died after taking the medication that was prescribed. In 2010, 87 prescriptions were written and at least 51 individuals died after ingesting the medication.[17]

2.4 Other State Initiatives

There has been a renewed focus on the issue of assisted suicide and euthanasia in recent years, likely in part due to the decision of the Supreme Court of the United States in *Gonzales* v. *Oregon*. Since 1991, four referendums on euthanasia and/or assisted suicide (including an earlier one in Washington State) have been defeated. In addition to the laws enacted in Oregon and Washington State, 122 bills have been proposed on the topic in 25 states since 1994.[18]

3 UNITED KINGDOM

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

The case of Diane Pretty was heard by the European Court of Human Rights on 19 March 2002. Ms. Pretty, who was paralyzed from the neck down as a result of a

motor neurone disease (a neurological disorder), had unsuccessfully sought assurances from the Director of Public Prosecutions (DPP) that her husband would not be prosecuted if he assisted her suicide. The House of Lords had dismissed her subsequent appeal of a Divisional Court decision that refused her application for judicial review of the Director's decision. She alleged that the refusal of her request to the DPP and the U.K. prohibition on assisted suicide infringed her rights under articles 2, 3, 8, 9 and 14 of the Council of Europe's *Convention for the Protection of Human Rights and Fundamental Freedoms*.[19] The Court found no violation of any of the articles.[20]

In March 2004, Lord Joffe introduced the Assisted Dying for the Terminally Ill Bill in the House of Lords, and a Select Committee was established to review the bill in November of the same year. The bill was similar to the Oregon *Death with Dignity Act* in many ways: for example, it stipulated that the patient must be terminally ill; the physician must have no reason to believe that the patient is not competent; the physician must refer the patient to a second consulting physician; and the physician must inform the patient of his or her medical diagnosis and prognosis, the process involved in an assisted death, and alternatives to assisted death, such as palliative care. Lord Joffe's bill differed, however, in one major respect from the Oregon model, in that it not only allowed a physician to provide a patient with the means to end his or her life, but also allowed the physician to end the life of a patient who was physically unable to do so himself or herself. The bill also differed from the *Death with Dignity Act* in its requirement that a patient who makes a declaration seeking assisted suicide do so in front of a solicitor who, in order to witness the declaration, must find the patient to be of sound mind and be satisfied that the patient understands the effect of the declaration. The Assisted Dying for the Terminally Ill Bill also contained a clause preventing a physician with a conscientious objection from being obligated to participate in an assisted death.

The Select Committee released its report on the bill in April 2005 and, while noting that there was insufficient time to proceed with the bill in that session, made a number of recommendations with respect to any similar bills that might be introduced at a later date. For example, a new bill should draw a clear distinction between assisted suicide and euthanasia. Also, such legislation should spell out what actions a physician may or may not take in assisting with a suicide or in administering voluntary euthanasia. The committee report was debated in the House of Lords in October 2005. A subsequent bill introduced by Lord Joffe was effectively defeated by the Lords on 12 May 2006.

A few years ago, 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 find out the DPP's official policy in this regard, and clarify whether it was legal under British law for a British citizen to assist someone to commit suicide in a country like Switzerland where assisted suicide is legal.

In June 2008, two High Court judges agreed to a judicial review of the DPP's refusal to publish the official policy. The House of Lords concluded that the DPP should be

required to make the policy public.[21] The DPP published an interim policy and then held public consultations, receiving nearly 5,000 submissions, which led to some adjustments in the policy before it was finalized in February 2010.[22] The policy is clear that assisted suicide has not been decriminalized. However, it outlines a two-stage process to determine whether charges will be brought: first, it must be determined if there is sufficient evidence 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.[23]

The DPP's jurisdiction is limited to England and Wales, but Northern Ireland has a similar policy, developed in collaboration with the DPP.[24] The DPP policy does not apply in Scotland. Last year, the Scottish Parliament considered a bill that would have legalized assisted suicide; the bill was introduced by an independent member of Parliament with Parkinson's disease, Margo MacDonald. According to the website of the Scottish Parliament, "Parliament disagreed to the general principles of the Bill," so the bill fell on 1 December 2010.[25]

4 THE NETHERLANDS

4.1 DEVELOPMENT OF THE LAW

In the Netherlands, the term "euthanasia" has one clear meaning and is normally not qualified by adjectives such as voluntary or involuntary. The practice is the deliberate termination of a patient's life by a physician acting on the patient's request and according to strict guidelines.

Traditionally, euthanasia was prohibited under the Dutch penal code, which states that anyone who terminates the life of another person at that person's explicit request is guilty of a criminal offence. Nonetheless, those who practised euthanasia in the Netherlands were not prosecuted as long as certain guidelines were followed. 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 for their action. Under the guidelines, all the following requirements had to be met:

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

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

In 1994, the Supreme Court of the Netherlands decided the controversial Chabot case, finding Dr. Boudewijn Chabot technically guilty of assisted 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 suffering from depression for 20 years. After working with the patient for some time, considering the situation 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, and, the issue of assisting suicide as a relief from non-somatic (non-physical) suffering remains a contentious one.

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.[26] In 2004, some doctors and the district attorney in Groningen, Netherlands developed a protocol to identify when euthanasia of infants is appropriate. The Groningen Protocol has been ratified by the National Association of Pediatricians and doctors that respect the protocol's requirements appear not to be prosecuted in the Netherlands, though the protocol is not an actual law.[27]

4.2 CURRENT STATE OF THE LAW

In August 1999, the minister of Justice and the minister of Health tabled a legislative proposal in the House of Representatives – the lower house of Parliament – legalizing euthanasia and assisted suicide as long as certain conditions are met. The bill was passed by the House of Representatives on 28 November 2000 by a vote of 104 to 50 and by the Senate on 10 April 2001 by a vote of 46 to 28. The *Termination of Life on Request and Assisted Suicide (Review Procedures) Act* came into effect on 1 April 2002.

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. 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;

- 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.

Physicians must report cases to a regional review committee. That committee decides whether the criteria were respected by majority decision and reports its findings to the Board of Procurators General and the regional health care inspector.[28]

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 Netherlands' *Medical Treatment Contracts Act*, and parental consent is required for persons under age 16. In principle, 16- and 17-year-olds can decide for themselves, but their parents must always be involved in the discussion.

In June 2004, an article in the medical journal *The Lancet* suggested that the strict regulations governing euthanasia in the Netherlands might be loosened, in part because of a concern that they might be causing under-reporting. The situation with respect to persons with Alzheimer's disease or other non-terminal illnesses remains somewhat ambiguous. There has also been some discussion in the Netherlands of allowing euthanasia and/or assisted suicide for people who are simply "tired of life."[29] In 1998 (before the current law was in place), an 86-year-old former senator who had no physical or psychiatric illness or disorder was assisted to die by a doctor because he no longer wanted to live. At the appeal level, the doctor was found guilty of assisting suicide since he had not respected the requirements set out in the caselaw, 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."[30]

5 AUSTRALIA

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

The bill created considerable controversy, both within Australia and internationally. There were calls for its repeal, and for the Governor-General of Australia to disallow it under the *Northern Territory (Self-Government) Act, 1978*; however, the

administrator of the Northern Territory assented to the Act in June 1995, and to regulations under the Act in June 1996. These came into effect, with the Act itself, on 1 July 1996. The Northern Territory thus became the first jurisdiction in the world to legalize physician-assisted suicide and euthanasia.

Between May 1995, when the bill was passed, and July 1996, when it came into effect, the Northern Territory Legislative Assembly had passed further amendments to the legislation whereby the number of doctors to be involved was increased from two to three, one of whom must be a qualified psychiatrist and another a specialist in the patient's illness. The *Rights of the Terminally Ill Act 1995* (NT) included many administrative safeguards as well as numerous references to treatment and levels of suffering "acceptable to the patient."

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

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

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

Senator Bob Brown has introduced a number of bills in the Commonwealth Senate (national level) since 2007 to repeal the *Euthanasia Laws Act 1997*, the law that overturned the Northern Territory euthanasia law. To date, of Senator Brown's bills have passed, but the senator currently has one such bill before the Senate, the *Restoring Territory Rights (Voluntary Euthanasia Legislation) Bill 2010*.[31]

In recent years, there have been numerous legislative proposals relating to euthanasia at the state level, with all states except Queensland considering the issue.[32] For example, in June 2008, Member of Parliament Colleen Hartland introduced a bill permitting medically assisted suicide in the Parliament of the State of Victoria but it was defeated 10 September 2008.[33] In Western Australia, a euthanasia bill was introduced 20 May 2010 but did not pass second reading.[34] Two private members' bills were also introduced in South Australia's lower house, the House of Assembly, in 2010 and were adjourned at second reading, while an exact duplicate of one of those bills was introduced in the state's upper house, the Legislative Council, but was negatived (i.e., did not pass).[35] Initiatives in other legislatures have occurred but, as of April 2011, none had yet been passed.

6 BELGIUM

Belgium legalized euthanasia in 2002.[36] Unlike the law in the Netherlands, the Belgian act does not regulate assisted suicide;[37] it regulates only euthanasia, which it defines as an act of a third party that intentionally ends the life of another person at that person's request. Anyone who has reached the age of majority (18 years) or is an emancipated minor, is mentally capable and is conscious may make a request if they have an incurable condition that results in constant and unbearable physical or psychiatric suffering.[38] The legislation established conditions that must be met by both the person seeking euthanasia and the physician who performs it. The physician is required to fill out a registration form each time he or she performs euthanasia; this form is then reviewed by a commission whose role it is to determine whether the euthanasia was performed in accordance with the conditions and procedures of the legislation. If two thirds of the commission members are of the opinion that the conditions were not fulfilled, the case is referred to the public prosecutor.

In March 2008, the media reported that some parliamentarians wanted to extend the right to euthanasia to teenagers, and to give parents the right to opt for euthanasia in the case of terminally ill younger children, though no such change to the law appears to have been made to date.[39]

7 SWITZERLAND

Article 114 of the *Swiss Penal Code* prohibits voluntary euthanasia (ending a person's life at his or her request), although it has a lesser sentence than other acts deemed homicide; murder carries a mandatory minimum sentence of five years' imprisonment, for example, while Article 114 provides only 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.[40]

Assisted suicide is also not limited to those with a terminal illness or to Swiss residents. As such, Switzerland has become a popular destination for foreigners, predominantly Europeans, seeking assistance in committing suicide.[41] 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.[42]

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. It remains to be seen what will be decided at the national level.[43]

In January 2011, the European Court of Human Rights held that no violation of the *European Convention on Human Rights'* protections of private life occurred when a Swiss man was unable to obtain a lethal substance that was available only by prescription. Ernst G. Haas, who suffers from serious bipolar affective disorder, had attempted suicide twice and had been unsuccessful in getting a psychiatrist to prescribe a lethal dose of a drug for him. He had also unsuccessfully sought permission from federal and cantonal authorities to receive such a dose without a prescription and had appealed those decisions in the Swiss courts before turning to the European Court. The Court recognized his right to decide to end his own life, 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 did not accept to hear an appeal.[44]

8 FRANCE

In France, the health minister reopened the euthanasia debate in an interview published in the newspaper *Le Figaro* in August 2004. Philippe Douste-Blazy called for a law that would ensure the right to die in dignity, but ruled out the legalization of euthanasia. He suggested that a draft law defining the legal options for terminally ill patients would be placed before the National Assembly before the end of the year. In April 2005, amendments to France's *Public Health Code* relating to end-of-life care were approved by the French Senate.[45] The legislation does not address either assisted suicide or euthanasia: rather, it addresses cessation of treatment and the prescribing of pain medication in circumstances where such action might shorten a patient's life.

In March 2008, a court in Dijon turned down a request by Chantal Sébire, who was suffering from a rare form of cancer, to take a lethal dose of barbiturates under the supervision of a doctor. According to the court, such a request was not permitted under the 2005 legislation. Ms. Sébire was found dead in her apartment soon after

the decision, apparently after taking barbiturates. No one has been charged for involvement in her death.[46]

The French Senate's Committee on Social Affairs recently studied three bills proposed by three different parties, from which it proposed the development of a bill to regulate medical assistance to commit suicide. However, on 25 January 2011, the Senate rejected the proposal.[47]

9 LUXEMBOURG

Luxembourg is the most recent country to have passed a law legalizing euthanasia and assisted suicide (in 2009). Conditions similar to those in the Netherlands are set out in the legislation, the *Loi du 16 mars 2009 sur l'euthanasie et l'assistance au suicide*.[48]

The act was passed in December 2008 and came into force in March 2009, though not without some controversy.[49] Luxembourg is a constitutional monarchy, and the country's monarch, the Grand Duke Henri, refused to sign the law for reasons of conscience as a Catholic. In response, the Parliament amended the Constitution to reduce the Grand Duke's powers from approving laws to simply signing them.[50]

10 COLOMBIA

In a 1997 case, Columbia's highest court, the Constitutional Court, concluded that a doctor could not be prosecuted for assisting an individual in ending their life as the person had a terminal illness and had consented. Nonetheless, "mercy killing" remains a crime in Columbia if those conditions are not met.[51] The judgment also urged legislative action in this area, but it seems that legislative efforts have not been successful to date as the issue is quite contentious in the predominantly Catholic country.[52]

NOTES

1. Although there are many possible definitions of euthanasia and assisted suicide, this paper uses the same definitions as provided in Julia Nicol, Marlisa Tiedemann and Dominique Valiquet, *Euthanasia and Assisted Suicide in Canada*, Publication No. 2010-68-E, Parliamentary Information and Research Service, Library of Parliament, Ottawa, 2010. These same definitions are also used in Senate, Special Senate Committee on Euthanasia and Assisted Suicide, *Of Life and Death*, June 1995. "Euthanasia" is the deliberate act undertaken by one person with the intention of ending the life of another person in order to relieve that person's suffering. "Assisted suicide" is the act of intentionally killing oneself with the assistance of another who provides the knowledge, means or both.
2. 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, August 2010, p. 6.
3. Nightingale Alliance, "Legal Status of Assisted Suicide/Euthanasia in the United States."

4. *Sampson* v. *State*, [2001] 31 P.3d 88, Alaska; *Sanderson* v. *People*, [2000] No. 99CA0203, 8 June 2000.
5. *Baxter* v. *Montana*, [2009] MT 449, para. 7.
6. Ibid., para. 13.
7. Nightingale Alliance.
8. Sharriff (2010), p. 6; *Blick* v. *Connecticut*, [2009] HHD-CV-09-5033392-S (Conn. Sup. Ct.).
9. United States, Oregon State Legislature,*The Oregon Death with Dignity Act*, Oregon Revised Statutes, Chapter 127, 127.800 s. 1.01(3).
10. Ibid., s. 1.01(7).
11. Ibid., 127.855 s. 3.09, "Medical record documentation requirements"; 127.865 s. 3.11, "Reporting requirements."
12. The United States Department of Justice, "Statement of Attorney General Reno on Oregon's Death with Dignity Act," News release, 5 June 1998.
13. *Gonzales* v. *Oregon*, [2006] (04-623) 368 F.3d 1118, 17 January 2006.
14. Oregon Health Authority, "Death with Dignity Act."
15. Washington State Department of Health, "Centre for Health Statistics: Death with Dignity Act." For information about the referendum, see Washington Secretary of State Sam Reed, "Initiative Measure No. 1000," *Elections & Voting*.
16. Carol M. Ostrom, "Initiative 1000 would let patients get help ending their lives," *The Seattle Times*, 21 September 2008.
17. Washington State Department of Health, "Centre for Health Statistics: Death with Dignity Act." The reports note a number of cases where it is unclear if the individual ingested the medication. The numbers included here are for established cases only, but the actual number of cases may be higher.
18. Patients Rights Council, "Attempts to Legalize Euthanasia/Assisted Suicide in the United States," 2011.
19. *Convention for the Protection of Human Rights and Fundamental Freedoms*, Council of Europe, 4 November 1950, ETS 5.
20. *Pretty* v. *the United Kingdom*, [2002] 2002-III Eur. Ct. H.R. 155.
21. *R (on the application of Purdy)* v. *Director of Public Prosecutions*, [2009] UKHL 45, 30 July 2009.
22. Crown Prosecution Service, "DPP publishes assisted suicide policy," News release, 25 February 2010; Crown Prosecution Service, "Public Consultation Exercise on the Interim Policy for Prosecutors in respect of Cases of Assisted Suicide Issued by The Director of Public Prosecutions Summary of Responses," February 2010.
23. Crown Prosecution Service, "Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide," February 2010.
24. Lindsay McIntosh, "MSP Margo MacDonald Sets Out Proposals to Legalise Assisted Suicide," *The Times*, 21 January 2010; Public Prosecution Service, "PPS Publishes Policy on Assisted Suicide," News release, 25 February 2010.
25. United Kingdom, The Scottish Parliament, "End of Life Assistance (Scotland) Bill (SP Bill 38)"; Severin Carrell, "Scotland to consider legalising assisted suicide: Margo MacDonald, an MSP who has Parkinson's disease, wins cross-party backing to present bill at Holyrood parliament," *The Guardian*, 30 July 2009.

26. Eduard Verhagen and Pieter J.J. Sauer, "The Groningen Protocol – Euthanasia in Severely Ill Newborns," *New England Journal of Medicine*, Vol. 352, 10 March 2005.

27. Ibid.; and Hilde Lindemann and Marian Verkerk, "Ending the Life of a Newborn: The Groningen Protocol," *The Hastings Center Report*, Vol. 38, No. 1, 2008.

28. Regionale Toetsingscommissies Euthanasia, "Due Care Criteria," 31 May 2006. An unofficial translation of the law can be found at World Federation of Right to Die Societies, *Dutch law on Termination of life on request and assisted suicide*.

29. Folkert Jensma, "Citizens group argues 'right to die': A citizens action group wants to legalise assisted suicide for all people over 70," *NRC Handelsblad*, 8 February 2010.

30. Tony Sheldon, "Being 'tired of life' is not grounds for euthanasia," *BMJ: British Medical Journal*, Vol. 326, 11 January 2003; and Shariff (2010), p. 7.

31. Catherine Lorimer and Elibritt Karlsen, *Restoring Territory Rights (Voluntary Euthanasia Legislation) Bill 2010*, Parliament of Australia, Parliamentary Library, Bills Digest No. 36, 10 November 2010.

32. Ibid., p. 9.

33. Australia, Parliament of Victoria, *Medical Treatment (Physician Assisted Dying) Bill 2008*, 561PM12B.I-26/5/2008, 27 May 2008.

34. Australia, Parliament of Western Australia, *Voluntary Euthanasia Bill 2010*, Bill 108. There have been a number of other euthanasia bills in Western Australia since 1997.

35. Australia, Parliament of South Australia, *Consent to Medical Treatment and Palliative Care (End of Life Arrangements) Amendment Bill 2010*, Bill 54, 16 September 2010; Parliament of South Australia, *Voluntary Euthanasia Bill 2010*, Bill 23, 24 June 2010; and Parliament of South Australia, *Consent to Medical Treatment and Palliative Care (End of Life Arrangements) Amendment Bill 2010*, Bill 42.

36. Belgium, Belgian Federal Parliament, *Loi relative à l'euthanasie*, F. 2002-2141 [C-2002/09590], 28 May 2002.

37. Herman Nys, "Euthanasia in the Low Countries: A comparative analysis of the law regarding euthanasia in Belgium and the Netherlands," *Ethical Perspectives*, Vol. 9, June–September 2002, pp. 73–85.

38. Belgian Federal Parliament (2002), Article 3.

39. See Bruno Waterfield, "Teens need right to 'medically assisted suicide,'" *The Telegraph*, 26 March 2008.

40. Switzerland, Confédération suisse, RS 331.0 *Code pénal suisse*; and Christian Schwarzenegger, Sarah J. Summers, "Criminal Law and Assisted Suicide in Switzerland," Submission to the Select Committee on the Assisted Dying for the Terminally Ill Bill, House of Lords, Zurich, 3 February 2005.

41. Imogen Foulkes, "Switzerland plans new controls on assisted suicide," *BBC News Europe*, 1 July 2010; Shariff (2010), pp. 6–7.

42. Foulkes (2010).

43. Confédération suisse, Office fédérale de la justice, "Assistance au décès," 17 September 2010.

44. European Court of Human Rights News, "Judgment Haas V. Switzerland (31322/07), refusal to deliver lethal drug without prescription: no violation of article 8," 3 July 2011.

45. France, L'Assemblée nationale de la France, *Code de la santé publique*, Loi n° 2005-370, J.O., 23 April 2005.

46. Le Post, "Euthanasie: Le dossier Chantal Sébire définitivement clos," 24 March 2009.

47. Laetitia Clavreul, “Le Sénat fait un premier pas vers l’adoption d’une loi légalisant l’euthanasie,” *Le Monde*, 20 January 2011; and Sénat de la France, “Assistance médicalisée pour mourir : Proposition de loi relative à l’aide active à mourir.”

48. Luxembourg, Chamber of Deputies of Luxembourg, *Loi du 16 mars 2009 sur l’euthanasie et l’assistance au suicide*.

49. Ibid.

50. Vanessa Mock, “Luxembourg monarch muzzled over euthanasia,” *The Independent*, 11 December 2008.

51. Corte constitutionnel de Colombia, Sentencia C-239/97, 20 May 1997 (available in Spanish only); Barreau du Québec, *Pour des soins de fin de vie respecteux des personnes*, September 2010, p. 14.

52. Associated Press, “Euthanasia regularly practiced in Colombia: Lawmaker hopes to establish guidelines for doctors, patients,” 31 July 2005; Catholic News Agency, “Bill meant to legalize euthanasia in Colombia dies mercifully,” 5 November 2007.

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

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

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