

**EUTHANASIA AND ASSISTED SUICIDE:  
INTERNATIONAL EXPERIENCES**

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## **EUTHANASIA AND ASSISTED SUICIDE: INTERNATIONAL EXPERIENCES\***

### **INTRODUCTION**

Over the last decade, movements have arisen in a number of jurisdictions in favour of the legalization of physician-assisted suicide and, in some cases, euthanasia.<sup>(1)</sup> 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.

### **THE UNITED STATES**

To date, Oregon is the only state that has passed a law explicitly permitting some form of physician-assisted suicide. 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.

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\* This publication was originally part of Current Issue Review 91-9E, *Euthanasia and Assisted Suicide in Canada*, first published in February 1992 and regularly updated since that time.

(1) Although there are many possible definitions for euthanasia and assisted suicide, this paper uses the same definitions as *Euthanasia and Assisted Suicide in Canada, supra*, which are the definitions used in *Of Life and Death*, the report of the Special Senate Committee on Euthanasia and Assisted Suicide (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.

## **A. State Laws that Prohibit Physician-Assisted Suicide**

In 1994, a Federal District Court in Seattle declared unconstitutional a Washington State law prohibiting physician-assisted suicide. In March 1995, a three-member panel of the United States Court of Appeal for the Ninth Circuit overturned this decision, stating that a right to physician-assisted suicide had no place in “the traditions of our nation” and was “antithetical to the defence of human life that has been a chief responsibility of our constitutional government.” In March 1996, however, the full Ninth Circuit reheard the case and decided, by an eight-to-three majority, that the Washington law prohibiting physician-assisted suicide was indeed unconstitutional and violated the liberty interest under the due-process clause of the 14<sup>th</sup> amendment. The decision was binding on all nine western states.

In April 1996, a three-member panel of the United States Court of Appeal for the Second Circuit unanimously struck down a similar law in New York. The court held that the New York law, which made it illegal for physicians to help terminally ill patients end their own lives, violated the equal protection clause of the 14<sup>th</sup> amendment in that it protected the rights of patients on life support to order their life support terminated, while denying comparable relief to terminally ill, mentally competent patients who were not on life support.

On 1 October 1996, the Supreme Court of the United States agreed to hear an appeal of the two Court of Appeal rulings. The Court had previously refused to hear an appeal of a Michigan State Court decision that upheld a Michigan law prohibiting assisted suicide (which had been passed after Dr. Jack Kevorkian began his campaign of assisting terminally ill people to die).

On 26 June 1997, the Supreme Court reversed both Court of Appeal decisions and upheld the Washington and New York statutes prohibiting assisted suicide. However, the court’s finding that these two statutes are constitutional does not mean that a law permitting assisted suicide would be found unconstitutional.

## **B. Oregon’s *Death with Dignity Act***

### **1. Requirements Under the *Death with Dignity Act***

In November 1994, Oregon voters passed Measure 16, which allowed 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 could issue such a prescription, certain conditions would have to be met. For example:

- The patient would have to make two oral requests and one written request for medication.
- A second medical opinion would be required.
- At least 15 days would have to have elapsed since the initial request for a prescription.
- The patient would have 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.”<sup>(2)</sup>
- 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<sup>(3)</sup> 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
  - the potential risks associated with taking the medication to be prescribed
  - the probable result of taking the medication to be prescribed
  - the feasible alternatives, including, but not limited to, comfort care, hospice care and pain control.

## **2. Legal Challenges to the *Death with Dignity Act***

A legal challenge to the legislation prevented the proclamation of Measure 16, and in August 1995 a District Court judge found it to be unconstitutional and invalid. However, in October 1997, the Court of Appeals for the Ninth Circuit found that the plaintiffs in the action had no legal standing to challenge the measure. The Court did not decide the constitutional merits of physician-assisted suicide, and the United States Supreme Court refused to hear an appeal. In June 1997, the Oregon legislature voted to send the *Death with Dignity Act* back to the electorate for a second vote in November 1997, at which time the Oregon voters reaffirmed the Act by a 60% majority.

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(2) *The Oregon Death with Dignity Act*, Oregon Revised Statutes, Chapter 127, 127.800 §1.01(3).

(3) *Ibid.*, §1.01(7).

Opponents of the *Death with Dignity Act* quickly began lobbying for federal intervention against the state initiative. In June 1998, Attorney General Janet Reno announced that federal officials did not have the authority under the U.S. Controlled Substances Act to prosecute physicians who assisted in suicides in Oregon, but that under the Act action might be taken in cases of physician-assisted suicide where it is not permitted by state law.<sup>(4)</sup>

Following a change in administration, Attorney General John Ashcroft issued an Interpretative Rule in November 2001 stating that he had determined that assisting suicide was not a “legitimate medical purpose” and that physicians who prescribed, dispensed, or administered federally controlled substances to assist suicide would be violating the *Controlled Substances Act*. The Interpretive Rule’s validity was challenged in federal court by the State of Oregon and by a group of Oregon residents, which included a physician, a pharmacist and terminally ill patients. In January 2006, the Supreme Court of the United States affirmed the decision of the Court of Appeals for the Ninth Circuit that the Interpretive Rule was invalid because it went beyond the Attorney General’s authority under the *Controlled Substances Act*.<sup>(5)</sup>

### **3. *Death with Dignity Act* Annual Report**

The *Death with Dignity Act* requires the Department of Human Services to annually review and report on information collected in accordance with the Act. The Ninth Annual Report (for 2006) was released in March 2007. Sixty-five prescriptions for lethal doses of medication had been written in 2006; the same number as in the previous year. The number of resulting deaths (as distinct from prescriptions) was higher than in any previous year. In 2006, 1.47 out of every 1,000 deaths among residents of Oregon was the result of physician-assisted suicide.

#### **C. Other State Initiatives**

There has been a renewed focus on the issue over the past two years, likely resulting from the controversy surrounding the case of Terry Schiavo, a Florida woman with severe brain damage whose death in March 2005 resulted from the removal of her feeding tube,

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(4) *Statement of Attorney General Reno on Oregon’s Death with Dignity Act*, 5 June 1998, <http://www.usdoj.gov/opa/pr/1998/June/259ag.htm.html>.

(5) *Gonzales v. Oregon* (04-623) 368 F.3d 1118, 17 January 2006.

and, more recently, in light of the decision of the Supreme Court of the United States in *Gonzales v. Oregon*, which 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.

In Vermont, a bill similar in both form and substance to Oregon's *Death with Dignity Act* was introduced on 28 February 2003. Bill H.0318, the Vermont Death with Dignity Act, did not get past first reading. It was reintroduced on 4 February 2005 with some amendments as Bill H.0168, Death with Dignity. In April 2005, the House Health and Human Services Committee held four meetings on the bill and heard a number of witnesses, but the bill did not proceed. A subsequent bill was defeated on the floor of the House in March 2007.

Initiatives similar to Oregon's *Death with Dignity Act* have failed in other states. For example, in 2000, Maine voters rejected a ballot initiative for a Maine Death with Dignity Act. There have been a number of attempts in Hawaii to pass legislation, the most recent being the Death with Dignity Bill HB 1454; after hearing some testimony on the bill, the House Health Committee voted in February 2005 against moving it forward. In California, Bill AB 651, The Compassionate Choices Act, (which, like the Oregon *Death with Dignity Act*, would allow a patient with less than six months to live to obtain a prescription for medication that would end his or her life) was approved by two Assembly committees in 2005 but defeated by the Senate Judiciary Committee in 2006. A subsequent bill of the same name is currently being held in abeyance.

## **UNITED KINGDOM**

End-of-life decisions have caused considerable controversy in the United Kingdom. In the last five years, a number of events have generated significant debate on the subject. These events included a case brought before the European Court of Human Rights and a bill to allow physician-assisted suicide.

Euthanasia is unlawful throughout the United Kingdom. However, it is lawful in certain cases to withhold or withdraw life-prolonging treatment from patients, thus hastening their death. The issue came to the fore in 1993, when the parents and doctors of Tony Bland, a young man who had been in a persistent vegetative state for several years, sought court



permission to end artificial nutrition and hydration. The House of Lords decided that artificial feeding and hydration constituted medical treatment and could be lawfully withdrawn; this would constitute an omission, not an act. Subsequent cases established that there are circumstances in which doctors may lawfully cease to offer life-prolonging treatment, on the basis that the quality of life made possible by the treatment is intolerable to the individual patient.

In June 1999, the British Medical Association (BMA) published guidelines on withholding and withdrawing life-prolonging treatment, including artificial hydration and nutrition. In early December 1999, a series of press reports alleged that older patients were being starved to death in public hospitals. A British MP, Mrs. Ann Winterton, having concluded that many people, particularly disabled and elderly individuals, were increasingly fearful of entering hospital because of the BMA guidelines on the withdrawal of medical treatment (including tubal feeding) from patients who were not dying, introduced a bill to prevent doctors from intentionally bringing about the death of their patients. The Medical Treatment (Prevention of Euthanasia) Bill would have made it unlawful for any person responsible for the medical care of a patient to withdraw or withhold medical treatment or sustenance if the purpose, or one of the purposes, of doing so was to hasten or cause the patient's death. Mrs. Winterton stated that her bill did not aim to force doctors to continue life-prolonging treatment for dying patients or in cases where the treatment would have no effect or be burdensome to the patient. Rather, she intended it to prevent doctors or others from taking quality-of-life issues into account when deciding whether future treatment should be withheld. Debate on the bill was adjourned in April 2000, and the bill was dropped.

The case of Diane Pretty was heard by the European Court of Human Rights on 19 March 2002. Mrs. Pretty, who was paralysed from the neck down as a result of a motor neurone disease, had unsuccessfully sought assurances from the Director of Public Prosecutions 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 Director of Public Prosecutions and the UK prohibition of assisted suicide infringed her rights under Articles 2, 3, 8, 9 and 14 of the *Convention for the Protection of Human Rights and Fundamental Freedoms*. The Court found no violation of any of the Articles.

In November 2004, a Select Committee was established to review the Assisted Dying for the Terminally Ill Bill, which had been introduced by Lord Joffe in March. 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, 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 Lords in October 2005. A subsequent bill introduced by Lord Joffe was effectively defeated by the Lords on 12 May 2006.

## **THE NETHERLANDS**

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 punishable by up to 12 years in prison. However, although it was a criminal offence, euthanasia was practised in the Netherlands and was not prosecuted as long as certain guidelines were followed. These 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.

Before 1990, reliable estimates of the extent of euthanasia in the Netherlands were unavailable. In September 1991, the Rummelink Commission (a Dutch government commission of inquiry into euthanasia and other medical decisions concerning the end of life) reported that its scientific studies revealed that about 2,300 cases of euthanasia had occurred in the previous year in the Netherlands, representing 1.8% of the year's deaths. Many more requests (about 9,000) had been made for euthanasia in that year than were actually carried out. Furthermore, most patients who requested euthanasia (i.e., about 70%) were terminally ill with cancer.

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

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, Hilly Bosscher, who was 50 years old, had simply not wished to live. She had experienced a violent marriage, the death of one son by suicide, and the death of her second son from cancer. She had a 20-year history of depression, and had attempted to commit suicide immediately after the death of her second son. She was determined to commit suicide but wished to do so in a way that would cause the least suffering to herself and the least distress to others.

Dr. Chabot undertook to work with her in the hope of altering her viewpoint, and suggested she keep a journal. What emerged from this intervention was confirmation of Ms. Bosscher's unswerving determination to die. Although there was no physical or psychiatric illness, Dr. Chabot was of the opinion that Ms. Bosscher was experiencing intense, long-term psychic suffering with no prospect of improvement. He sent transcripts of the therapy sessions to seven expert colleagues, all of whom agreed with his assessment. 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 held that such situations required extreme caution; it found that Dr. Chabot had violated procedural requirements in that none of the seven experts had personally examined Ms. Bosscher. Nonetheless, the Court declined to impose a penalty on Dr. Chabot, which may well have indicated its ambivalence toward such a difficult situation. 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. These cases illustrate the troubling gap that can exist between the right of parents to refuse treatment for a child, even when death is the inevitable result of such refusal, and their limited ability to relieve pain during the dying process.

In August 1995, the Royal Dutch Medical Association adopted new guidelines for euthanasia and assisted suicide. These stated that, where possible, the patient rather than the

doctor should administer the lethal drug. The new guidelines also emphasize that the required consultation with a second physician should involve an experienced doctor who has no professional or familial relationship with either the patient or the first doctor.

In August 1999, the Minister of Justice and the Minister of Health tabled a legislative proposal in the Lower House of Parliament legalizing euthanasia and assisted suicide. The bill was passed by the Lower House 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 Act came into effect on 1 April 2002.

The new statutory provisions make no substantive change to the grounds on which euthanasia (termination of life on request) 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.

The most controversial aspect of the new 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 *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 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.



## 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 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 inquire into 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.

Unsurprisingly, 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. In the interim, the Northern Territory Legislative Assembly had passed further amendments to the legislation whereby the number of doctors 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 numerous administrative safeguards as well as numerous references to treatment and levels of suffering "acceptable to the patient." Section 4 stated the essential philosophy of the Act:

A patient who, in the course of a terminal illness, is experiencing pain, suffering and/or distress to an extent unacceptable to the patient, may request the patient's medical practitioner to assist the patient to terminate the patient's life.

A "terminal illness" was defined as one that would result in the death of the patient unless extraordinary measures, or treatment that is unacceptable to the patient, were used. A medical practitioner who received a request for assistance and followed all the procedures laid out in the legislation could legally assist the patient to terminate his or her life. The assistance could consist of prescribing or preparing a lethal substance that would either be given to the patient for self-administration or be administered to the patient. Alternatively, the physician could, at any time and for any reason, refuse to give such assistance.

The other criteria that had to be met included the following:

- The patient had to be at least 18 years old.
- There could be no palliative care options reasonably available to the patient that would alleviate pain and suffering to a level he or she found acceptable.
- There had to be two “cooling off” periods, totalling nine days, between the first request to the doctor and the assistance itself.

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 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 common law. By a two-to-one majority, the court 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.

Although some critics had argued that the amended bill was too cumbersome to be workable, 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. Three other people used the provisions of the Act before it was 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, Mr. 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.



## BELGIUM

Belgium legalized euthanasia in 2002.<sup>(6)</sup> Unlike the law in the Netherlands, the Belgian Act does not regulate assisted suicide:<sup>(7)</sup> 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. The legislation establishes 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 conditions and procedures of the legislation. If two-thirds of the Commission are of the opinion that the conditions were not fulfilled, the case is referred to the public prosecutor.

## 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 ten years' imprisonment, and manslaughter carries a mandatory minimum sentence of one year's imprisonment, 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 sentenced to a term of imprisonment (the duration is not specified).<sup>(8)</sup> 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 sentenced to imprisonment.<sup>(9)</sup> Thus, assisted suicide is permitted if the person assisting the suicide does so for unselfish reasons. Article 115 does not require that a physician be the person to assist a suicide,

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(6) *Loi relative à l'euthanasie*, F. 2002-2141 [C-2002/09590].

(7) Herman Nys, "Euthanasia in the Low Countries: A comparative analysis of the law regarding euthanasia in Belgium and the Netherlands," *Ethical Perspectives* Vol. 9, No. 2-3 (June-September 2002), pp. 73-85, <http://www.ethical-perspectives.be/viewpic.php?LAN=E&TABLE=EP&ID=51>.

(8) 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, 3 February 2005, <http://www.rwi.unizh.ch/schwarzenegger/unterlagen/unterlagen/assisted-suicide-Switzerland.pdf>.

(9) *Ibid.*

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.<sup>(10)</sup>

## **FRANCE**

In France, the Health Minister reopened the euthanasia debate in an interview published in *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<sup>(11)</sup> relating to end-of-life care were approved by the French Senate. 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.

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(10) *Ibid.*

(11) *Code de la santé publique*, Loi n° 2005-370, J.O. 23 avril 2005.