

**EUTHANASIA AND ASSISTED SUICIDE:
INTERNATIONAL EXPERIENCES**

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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.⁽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.

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.

* This publication is the second of two on euthanasia, and approaches the issue from the international perspective. The first publication (CIR 91-9E) was originally entitled *Euthanasia and Assisted Suicide* and now bears the title *Euthanasia and Assisted Suicide in Canada*. It was prepared in February 1992 by Mollie Dunsmuir and has been regularly updated since that time.

(1) Although there are many possible definitions of 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 14th 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 14th 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 automatically be found unconstitutional.

In Montana in October 2007, two terminally ill patients, four doctors and a patients’ rights organization brought a lawsuit claiming the right to die with dignity. They allege that the Montana legislation criminalizing assisted suicide contravenes Article 2 of the state constitution, which protects human dignity.

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

(3) *Ibid.*, §1.01(7).

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.

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.⁽⁴⁾

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*.⁽⁵⁾

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

(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.

of medication were written in 2006; the same number as in the preceding 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 Oregon residents was the result of physician-assisted suicide.

The Tenth Annual Report (for 2007) was released in March 2008. Eighty-five prescriptions for lethal doses of medication were written in 2007 (20 more than in the preceding year). The number of deaths increased slightly over 2006, and was thus higher than in any previous year. In 2007, 1.56 of every 1,000 deaths among Oregon residents 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, 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. Bill AB 374, The Compassionate Choices Act (identical to the previous bill, AB 651) was also defeated.

Other states have introduced bills similar to the Oregon legislation that are still before their respective legislatures: Pennsylvania (HB 1435), Rhode Island (Rhode Island Death with Dignity Act, HB 6080) and Wisconsin (Death with Dignity, AB 298 and SB 151).

In August 2007, an on-line Harris poll of 2,694 Americans found that 39% supported medically assisted suicide, 31% opposed it and 21% were neither for nor against it.

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. British MP 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. Ms Winterton said 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. Ms 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 on 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.

Recently Debbie Purdy, who suffers 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 United Kingdom if he accompanied her to Switzerland. She therefore wanted to find out the official policy of the Director of Public Prosecutions in this regard, and thereby to 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 Director of Public Prosecutions' refusal to publish the official policy. The final decision on whether the Director of Public Prosecutions is required to publish the policy on assisted suicide will be handed down in October 2008.

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.

In February 2007, Senator Bob Brown introduced in the Commonwealth Parliament a bill entitled the Australian Territories Rights of the Terminally Ill Bill 2007, based on the Rights of the Terminally Ill Bill 1995 (NT). The new bill did not pass second reading.

In June 2008, Colleen Hartland introduced in the Parliament of the State of Victoria a bill permitting medically assisted suicide. The primary aim of her Medical Treatment (Physician-Assisted Dying) Bill 2008,⁽⁶⁾ which is based on the Oregon law, is:

to recognise the right of a mentally competent adult person, who is suffering intolerably from a terminal illness or advanced incurable illness, to request a doctor to provide medical assistance that allows that person to end his or her life peacefully.⁽⁷⁾

Under the proposed legislation, the following conditions apply to requests for assistance in committing suicide:

- The sufferer is a resident of the State of Victoria.
- No medical treatment, including palliative care, is available that is acceptable to the sufferer and likely to relieve his or her intolerable suffering.
- Two doctors (the treating physician and an independent consultant) must make sure that the sufferer is competent to make the decision and that the decision is informed and voluntary.
- There is a cooling-off period of at least 48 hours (plus 14 days in the case of a patient with an incurable disease) between the first and second requests in writing for assisted suicide.⁽⁸⁾

The sufferer can revoke his or her request at any time.⁽⁹⁾ The bill also provides for legal immunity for healthcare professionals and anyone who supports a sufferer in his or her quest to commit suicide.⁽¹⁰⁾ A doctor is also entitled to decline to assist for any reason.⁽¹¹⁾ Finally, a person who improperly influences a sufferer to apply for assisted suicide would be

(6) Parliament of Victoria [Australia], Medical Treatment (Physician Assisted Dying) Bill 2008, [http://www.legislation.vic.gov.au/domino/Web_Notes/LDMS/PubPDocs.nsf/ee665e366dcb6cb0ca256da400837f6b/97A3D62C55E9C6ACCA2574560026DC28/\\$FILE/561PM12bi1.pdf](http://www.legislation.vic.gov.au/domino/Web_Notes/LDMS/PubPDocs.nsf/ee665e366dcb6cb0ca256da400837f6b/97A3D62C55E9C6ACCA2574560026DC28/$FILE/561PM12bi1.pdf).

(7) Medical Treatment (Physician Assisted Dying) Bill 2008, section 1(a).

(8) Clause 5.

(9) Clause 6.

(10) Clauses 7 and 8.

(11) Clause 9.

committing an offence punishable by a fine of \$250,000, or imprisonment for 14 years or both.⁽¹²⁾

The Medical Treatment (Physician Assisted Dying) Bill 2008 is currently at second reading.

BELGIUM

Belgium legalized euthanasia in 2002.⁽¹³⁾ Unlike the law in the Netherlands, the Belgian Act does not regulate assisted suicide:⁽¹⁴⁾ 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.

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.⁽¹⁵⁾

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 10 years' imprisonment, and

(12) Clause 15.

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

(14) 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>.

(15) See Bruno Waterfield, "Teens need right to 'medically assisted suicide,'" telegraph.co.uk, 26 March 2008, <http://www.telegraph.co.uk/news/worldnews/europe/belgium/1582882/Teens-need-right-to-%27medically-assisted-suicide%27.html>.

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).⁽¹⁶⁾ 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.⁽¹⁷⁾ 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, 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.⁽¹⁸⁾

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. The tabling of the report is scheduled for early 2009.

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⁽¹⁹⁾ 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.

(16) 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>.

(17) Ibid.

(18) Ibid.

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

In March 2008, a court in Dijon turned down a request by Chantal Sebire, 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 is not permitted under the 2005 legislation.

In April 2008, the National Assembly adopted at first reading a bill designed to restrict incitements to extreme thinness or anorexia.⁽²⁰⁾ The bill would create two offences:

- inducing a person to seek excessive thinness that would risk causing death or compromising health;
- propaganda or publicity for products or means of achieving excessive thinness compromising health.

The bill would categorize these two offences, which are punishable by two years in prison and a fine of €30,000, under a section of the Penal Code entitled “Incentives to Suicide and Excessive Thinness.”

LUXEMBOURG

Luxembourg is the most recent country to have passed a law legalizing euthanasia and assisted suicide. Some conditions apply:

- The patient must be suffering from a terminal or incurable illness.
- The request must be made repeatedly.
- The consent of two doctors and a panel of experts is required.

The act was passed in February 2008 and should come into force in the summer of 2008.

(20) The text of the bill is available (in French only) on the National Assembly’s website: France, Assemblée nationale, Session ordinaire de 2007–2008, Proposition de loi visant à lutter contre les incitations à la recherche d’une maigreur extrême ou à l’anorexie, 15 April 2008, <http://www.assemblee-nationale.fr/13/pdf/ta/ta0132.pdf>.