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**A PERFECTION OF MEANS AND
CONFUSION OF AIMS:**

**FINDING THE ESSENCE OF AUTONOMY
IN ASSISTED DEATH LAWS**

Ph.D.

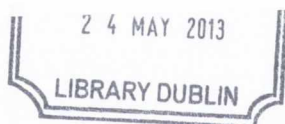
2012

Mary J. Shariff

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SUMMARY

This thesis was developed through standard library-based research methods as well as legal research conducted via the internet and electronic databases including LexisNexis, QuickLaw, Westlaw and HeinOnline as well as the medical database, PubMed. Relevant legislation was identified and downloaded from the official websites of the respective jurisdictional legislatures.

This thesis examines the assisted death law in the jurisdictions of the Netherlands, Belgium, Luxembourg, Switzerland, Washington, Oregon, Montana, England and Canada. Through examining the political, legislative and judicial reform histories as well as the substantive framework of the assisted deaths laws that have emerged from these processes, this work demonstrates that most, though not all, of the assisted death laws ultimately prescribe an fairly homogenous assisted death model, that is, assisted death for irremediable suffering.

The examination also finds that despite the external homogeneity, the internal policy goals of these laws, particularly with respect to how the principle of autonomy and the requirement of suffering are understood, expressed and advanced, are quite different. These internal distinctions appear to operate as internal constraints within respective assisted death models and consequently act as factors of stabilization that can maintain the parameters of the assisted death model as originally contemplated, thus avoiding a process of change that has been described by some as the “slippery slope”. This work suggests that there is insufficient attention being paid to the particular construction of autonomy at the foundation of assisted death reform and an over-emphasis on the legal vehicles (such as constitutional protections of liberty, security, privacy and equality) capable of achieving homogenized external results. Accordingly, constraints inherently logical to and thus intrinsically part of earlier assisted death models appear to be superimposed on to later assisted death schemes thus rendering the preservation of these constraints vulnerable to the same legalistic processes that secured the latter models in the first place.

This discussion suggests that express and nuanced democratic examinations of the construction of the principle of autonomy that is sought to be protected and advanced in emerging assisted death laws is critical to ensuring that current and future laws do not expand beyond that originally contemplated.

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CHAPTER I INTRODUCTION

A perfection of means and confusion of aims,
Seems to be our main problem
Albert Einstein

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

Assisted death is an unfathomably complex and overlapping tangle of moral, ethical, social, medical, economic, political and legal crises. The moral enters because the choice for death over continued life depends on the accumulated values and beliefs of the individual alongside the unique obligations of the state to protect its citizens. The ethical enters because it searches for philosophical and universal justifications to permit or disallow the practice. The social enters because it scrutinizes the motivations of the individual wishing to die, as well as the potential downstream impacts of assisted death practices on society as a whole and on individuals with particular vulnerabilities, such as the elderly and those with disabilities. The medical enters because it sits at the frontline in partnership with the patient and must confront the question of what to do when healing is not perceivably possible or is undesired. The economic enters because it questions the accessibility and adequacy of medical care, as well as the offsetting of state health care costs to the individual or the family. The political enters because it is the principal forum of public engagement, seeking legitimacy when channeling pluralistic beliefs into a monistic formula for conduct. The legal enters because any practice that involves ending or helping to end the life of another human being, for all of the foregoing reasons as well as many others, demands regulation.

Over the past two decades, the Netherlands, Belgium and Luxembourg, and the states of Oregon and Washington in the United States, have passed legislation expressly permitting assisted death (AD) by doctors.¹ Broadly speaking, the AD schemes in the Netherlands, Belgium and Luxembourg (the “Benelux” countries) employ a similar regulatory framework, allowing AD by either direct lethal injection administered by a physician or facilitating patient access to lethal medication for the purposes of self-administration. Similarly, the states of Oregon and Washington have comparable AD schemes but these American schemes are different from the Benelux countries;

¹ As discussed in Chapter III of this paper.

Oregon and Washington restrict physician participation to the provision of a prescription for lethal medication which must then be self-administered by the patient.

The Oregon and Washington schemes are in many ways similar to the practice of AD in Switzerland, where doctors are also restricted to only prescribing lethal drugs for self-administration. It is important to note however that Switzerland does not have express legislation regulating the practice of assisted death. Rather, Switzerland has experienced an incremental evolution in the regulation of AD practice which was facilitated by a unique and expansive penal code provision that criminalizes AD only when it is done for “unselfish” reasons.²

Although the regulatory design of these two (2) general models – the Benelux model and the American/Switzerland model – appear externally similar (as will be discussed), the ethical underpinnings and politico-legal evolution of these models are not equally analogous. Intriguingly, while there is some uniformity among the AD laws, notably with respect to various “safeguards” put in place to help ensure that AD is only provided to competent individuals who have a genuine desire to die, the resolutions internalized by these laws are actually solutions tailored to unique jurisdictional perspectives on the conflicts, principles and policy concerns at play. These perspectives in turn have been framed not only by moral and philosophical considerations but have also been framed by reference to: the reality of who is to shoulder the practical responsibility for carrying out AD services; unique cultural histories and expressions; and the nature of the legislative reform process specific to each jurisdiction – all of which are vital to the perceived legitimacy and stability of the law.

Gaining a general understanding of the heterogenous foundations and meanings for the different AD schemes in each jurisdiction is critical to being able to competently discuss and debate how AD practice should or may be interpreted or regulated in other jurisdictions and into the future. And, as will be discussed, what appear to be the broader AD schemes, i.e. the schemes that provide the more expansive relief (e.g., lethal injection) evolved from narrower ethical justifications, such as the relief of suffering, whereas the AD schemes with the apparently more limited relief (e.g., obtaining a prescription drug for self-administration) are premised on the more expansive ethical justification of respect for autonomy: the individual’s right to self-

² Swiss Penal Code (SR 311.0) art 115.

govern and self-determine, freely in accord with a self-chosen plan.³ Thus the respective AD models appear to possess internal balances which serve to constrain their evolution beyond that originally contemplated by the lawmakers as well as by the majority of organizations in favour of AD within the respective jurisdictions.

When taken together, however, justifications and procedures for establishing and operating an extreme vision of AD - *assisted death for anyone for any reason* - are revealed. While fear of the realization of such an extreme form of AD might be dismissed as a run-of-the-mill “slippery slope”⁴ argument not worthy of serious consideration nor operating as a legitimate impediment to AD reform for those who are suffering greatly, it cannot be escaped that early signs of such a convergence of thought are emerging.⁵ Whether such signs are evidence of actual slippage is, at this time, impossible to determine for a number of reasons, not the least of which includes that the study of slippery slope theory in relation to socio-political change is in its nascency. Nonetheless, it can be observed that it is the principle of autonomy that is widely perceived as the ideological vehicle with the greatest potential to activate a potential collapse or slide to such an extreme form of AD. On the other hand there are many who argue that it is the protection of autonomy (and therefore the obligation to obtain free and informed consent) that is precisely the factor or safeguard that can protect against a slide to what is arguably more frequently heard as the bottom of the slope, that is, involuntary euthanasia.⁶

Simple contemplation of the two positions described above reveals a number of preliminary insights that might assist in addressing, among other things, some of the tension around the application and utility of the slippery slope analogy. First, these two observations indicate that there exists more than one perspective as to what might

³ See discussion on defining autonomy in Tom L Beauchamp and James F Childress, *Principles of Biomedical Ethics* (6th edn, OUP 2009) 99 (Beauchamp and Childress). Note: this definition is provided notwithstanding that the precise definition is the subject of ongoing dispute and discussion as further addressed in Chapter I.C below.

⁴ A slippery slope argument involves the rejection of an otherwise acceptable standard or principle on the basis that its acceptance could lead to the acceptance of an undesirable standard or principle. In the assisted death debate, one argument is that voluntary assisted death will lead to assisted death of involuntary individuals. The structure of the slippery slope argument is discussed in more detail in Chapter II.

⁵ For example see Steven D Edwards, ‘An Argument in Support of Suicide Centres’ (2009) 18(2) *Health Care Analysis* 175.

⁶ See Daniel Callahan, ‘Can the Moral Commons Survive Autonomy?’ (1996) *Hastings Centre Report* 41-2; Daniel Callahan, ‘Can We return Death to Disease’ (1989) 19(1) *Hastings Center Report* S4 and Victor G Rosenblum and Clarke D Forsythe, ‘The Right to Assisted Suicide: Protection of Autonomy or an Open Door to Social Killing’ (1990-1991) 6 *Issues Law and Medicine* 3; Compare with Jocelyn Downie and William FJ Ryan, *Dying Justice: A Case for Decriminalizing Euthanasia and Assisted Suicide in Canada* (University of Toronto Press 2004) 107.

exist at the bottom of the slippery slope (i.e. the activity sought to be avoided) when it comes to the legalization of assisted death. Second, these perspectives illuminate the underlying concern that conceptual safeguards aimed at protecting against one undesirable consequence (i.e. autonomy as protecting against involuntary euthanasia) could also act as the factor that assists in stimulating conditions that could lead to different yet arguably equally undesirable consequences (e.g. AD for non-medical conditions or non-terminal illness). This in turn reveals that different constructions of autonomy might also be in play i.e. assisted suicide constructed on broader libertarian notions of autonomy versus assisted suicide constructed on autonomy connected to medical ethics and thus medicalized circumstances.

On this latter point it is also interesting to consider the evolution of the autonomy-based AD argument: that is, while autonomy (and its counter-part, self-determination),⁷ did not start out as the most significant ideal in the emergence of the first European law to legalize AD, it has since become the most widely accepted justification for legalization of AD in current global debates.⁸ Indeed, in the United States, the United Kingdom and Canada, jurisdictions where AD prohibitions have most recently been challenged in the courtroom (in some cases, in tandem with or following on the heels of legislative debate), autonomy-based AD is heard throughout the argumentation and reveals itself under varied constitutional protections such as privacy, liberty, security and equality as well as in relation to the medico-legal doctrines and informed consent.

The word “dignity” is also regularly used throughout the AD debate and is arguably most strongly perceived from the pro-legalization side. Although dignity also has more than one legal construction, including as it relates to human dignity, the equality of all humans and the sanctity of life (as will be more fully described), the term is again strongly advanced as an expression of autonomy and self-determination, and perhaps even *moreso*, as a specific expression of physical autonomy or the loss thereof due to progressive irremediable illness. A clear example of this is recourse to the phrase, “dying with dignity” in the North American debate regarding assisted death for those suffering from terminal illness.

As will be discussed, in the current judicial treatment of the autonomy-based AD argument, lines that may have existed or been drawn between these different potential expressions of autonomy (including dignity *qua* autonomy) are becoming increasingly

⁷ Autonomy and self-determination are discussed more fully in Chapter II.

⁸ Penny Lewis, *Assisted Dying and Legal Change* (Oxford University Press 2007) 15.

difficult to discern. Furthermore, while the judicial approach to AD legalization reform is a legal mechanism entirely distinct from a legislative or parliamentary process, the frameworks of the resultant AD models being elucidated before the courts are fairly consistent with (although not identical to) the AD models that have been achieved through the legislatures. Thus, apart from the critical question of whether it is appropriate for the court to act as a moral or ethical arbiter in such a disputed area of social policy, another key question that arises is what, if any, are the implications or consequences of a judicial approach to AD reform in terms of prescribing the limits to autonomy.

While the two most commonly asserted justifications for “limits” to autonomy-based AD are the concepts of the *sanctity of life* and the *slippery slope*, these concepts are frequently perceived to be of limited utility in the AD debate in its popular or colloquial form. This is because these concepts are too often advanced or attacked as sweeping conceptual roadblocks, divorced from the specific legal system or processes of the state considering legislative reform. Thus the aim of this discussion is to go beyond a simple enumeration of reasons why a state might choose to not legalize AD. Rather the aim of this discussion is to be able to identify with more exactitude the ways in which states and courts have thus far practically constructed the notion of autonomy in the context of assisted death in order to understand where its limits might logically lie. By paying attention to the evolution of limits as well as the different legal mechanisms involved in assisted death reform, the potential for future convergence or collapse of the current heterogeneous models of AD into one homogenous model can be canvassed and can also serve as a foundation for commencing the identification of the legal approaches with the greatest potential to establish a legal footing for one of the more extreme visions of AD - *assisted death for anyone for any reason*.

It should be pointed out at this juncture that the discussion herein is solely concerned with the situation whereby a competent adult voluntarily requests another person(s) to provide assistance in ending life. The term AD in this discussion does not include other life-shortening medical practices that, to a greater or lesser extent, are considered to be within the bounds of “normal” medical practice and include: withholding or withdrawing of life-sustaining treatment;⁹ medically-indicated pain relief in doses that might hasten death;¹⁰ or palliative/terminal sedation.¹¹ That said, these practices are

⁹ In early discussions, withholding or withdrawing life-sustaining has sometimes been referred to as “passive euthanasia”. John Keown, *Euthanasia, Ethics and Public Policy: An Argument Against Legalization*, (Cambridge University Press 2002) 4.

¹⁰ The legitimacy of this practice is based on the doctrine of double-effect which posits that as long as the primary intention of the physician is to relieve suffering, the act of increasing

nonetheless necessarily referred to from time to time, for example, when describing: the scope of a particular AD law; the safeguards introduced to prevent certain abuses; the ethical arguments used in courtroom debates to justify extension into AD practice; and the socio-political context within which a particular AD law has evolved.

The analytical strategy taken herein will be to firstly deconstruct present assisted death laws to ascertain with more precision, the factors or elements that operate to constrain or broaden approaches and perspectives on AD and that distinguish the respective AD schemes from one another. Against this background, the AD debate in jurisdictions where AD is currently prohibited but legalization is nonetheless being rigorously re-considered in the courts (despite having been rejected in the recent past) is unpacked in order to identify:

- how emerging court discussions on AD reform align or do not align with the AD conflict as articulated in permissive jurisdictions that have legislated AD practice;
- whether similar or different limits to AD are in play and how these limits, if any, are being interpreted or reflected in debate or legal argument; and
- whether there are any signs that indicate potential AD model collapse or convergence and/or the extent to which potential collapse or convergence is connected with the principle of autonomy – the principle at front and centre of the current assisted death debate.

It is hoped that this approach will assist in the development of more robust analytical strategies that can address the overarching legal puzzle of how far can or should assisted death practices be expanded through the logic or rhetoric of autonomy, and, if there ought to be limits to autonomy in driving the assisted death agenda, where might they legitimately lie? As put by Stern and de Fonzo,

medication to the extent that it might hasten death is not culpable. This practice in early discussion has also been described as “indirect” euthanasia. See discussion in Leon R. Kass, ‘I Will Give No Deadly Drug’ in *The Case Against Assisted Suicide* (The Johns Hopkins University Press 2002) 37; See also Keown *ibid* 20-2.

¹¹ Deep, sustained sedation along with the withholding of artificial nutrition and hydration particularly at the terminal phases of a patient’s life. Note that there is ongoing discussion as to the appropriate scope of this practice, its terminology (“palliative” versus “terminal” sedation) and possible improvements to the practice so that it does not become an unregulated alternative to the legal AD practices. For further discussion see Agnes van der Heide et al *End-of-Life Practices in the Netherlands under the Euthanasia Act* (2007) 356 *New England Journal Of Medicine* 1957, 1961-4; See also B Gordijn and R Janssens, ‘Euthanasia and Palliative Care in the Netherlands: An Analysis of the Latest Developments’ (2004) 12 *Health Care Analysis* 195, 195-207.

How much empowerment is too much before it overwhelms the boundaries of our understanding our ability to act intelligently in our own interests and that of others?¹²

Chapter II opens this exploration by establishing key definitions in the assisted death debate. In addition to providing definitions that pertain to the various modes of assisted death, Chapter II provides an overview of how autonomy is defined in the medical context, a brief summary of the concept of dignity in relation to and distinct from the concept of autonomy, as well as a summary of the different academic approaches to defining the slippery slope – arguably one of the most significant analytical analogies to be used in the assisted death legalization debate.

Chapter III turns to a detailed, comprehensive and comparative account of the AD laws in the five (5) jurisdictions that have promulgated express legislation to regulate assisted death – the Netherlands, Belgium, Luxembourg, Oregon and Washington as well as the jurisdiction of Switzerland. While Switzerland does not currently have direct state legislation to regulate AD as is the case in the other jurisdictions, it does have a long legal and political history in the practice and indirect regulation of AD that has evolved from a permissive penal code prohibition. Additionally, because Switzerland has not to date restricted AD to its residents, thereby allowing the participation of non-residents, the Swiss AD model has also served to stimulate both debate and demand for reform in participants' home states. For these reasons, the Switzerland model has been included in Chapter III.

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

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

This highly detailed examination is conducted in order to tease out the full parameters of the conflicts, tensions and factors that ultimately serve to limit or expand the respective AD schemes in these permissive jurisdictions. A thorough accounting

¹² Ruth Stern and J Herbie diFonzo, 'Terminal Ambiguity: Law Ethics and Policy in the Assisted Dying Debate' (2007) 17 Boston University Public Interest Law Journal 99, 100.

further provides opportunity to reflect on the extent to which the notion of autonomy has been incorporated into the respective laws and opportunity to identify how the principle has been practically constrained. Beyond a simple enumeration of principles that can compete with autonomy (such as state interest in protecting vulnerable persons) or simple identification of limiting factors (such as the imposition of a requirement of “unbearable suffering”, for example) this approach focuses on how specific counter-points to autonomy have themselves come to be identified and subsequently incorporated into the AD laws by the respective permissive jurisdictions. Thus this discussion explores how each of these jurisdictions has framed the assisted death conflict, and in turn, the subsequent limits to autonomy that arise from each unique construction. Of particular note here is the varying treatment and relevance of the “suffering” requirement and the interplay between medicine, suffering and autonomy/self-determination particularly in terms of how these requirements have been translated into the laws and in terms of how the laws have come to be justified.

Chapter III concludes with a comparative summary addressing how the conflict has been framed in the respective permissive jurisdictions and an assessment of the limits of the current assisted death laws. The consideration of limits is summarized with the identification of a list of factors or perspectives that could serve to support, or conversely, challenge, the ongoing expansion of assisted death practice beyond the individual scope of the respective laws currently in place.

Chapter IV turns to the task of assessing jurisdictions that have recently legalized AD, or are in the process of debating the legalization of AD in the courts despite having rejected AD legalization in the recent past, whether legislatively or judicially. These jurisdictions are the state of Montana in the United States, England and Canada. The aim of this chapter is to assess the AD debate in these “second generation” jurisdictions against the construction of AD schemes in “first generation” jurisdictions (where AD has been legalized by statute) in order to identify: alignment or non-alignment with the AD models in the permissive jurisdictions; whether similar or different AD models are emerging from the court; distinctions in the construction of autonomy and the limits that might arise therefrom; and any signs or pathways that indicate possible collapse or convergence towards one homogenous model of AD.

Chapter IV thus begins with an overview of the persistent legislative trend to prohibit or maintain AD prohibitions in the “western democracies” of the United States,¹³ the

¹³ With respect to the United States in particular, it might be useful to note that over the years, several bills in favour of the legalization of assisted death have been introduced into numerous

United Kingdom as well as Australia. This overview on legislative trends is provided in this chapter because it has been of particular relevance to the court discussions on AD reform in the United Kingdom and Canadian cases. Recourse to the overall legislative reluctance to legalize AD is used as evidence in court discussion involving the balancing between individual and state interests and regarding the legitimacy of court participation in matters involving significant social policy.

Chapter IV then turns to specifically examine the assisted death cases in the jurisdictions of the state of Montana in the United States, England and Canada.

For each jurisdiction, the following are discussed:

- the legal framework that prohibits the practice of AD;
- the cases challenging the respective AD prohibitions;
- current position statements by medical professional associations and other committees or commissions convened for the purpose of examining AD;
- any concurrent legislative initiatives or proposals regarding the legalization of AD; and
- a comparative analysis of the alignment and limits of the emerging proposed AD model.

Chapter IV concludes by comparing the essence of the AD conflict in these debating jurisdictions to the Chapter III permissive jurisdictions with a view to identifying how emerging court discussions on AD reform align or do not align with the AD conflict as articulated in the jurisdictions that have legislated AD practice. The first objective of this comparison is to determine whether similar or different limits to AD are in play and how these limits, if any, are being interpreted or reflected in debate or legal argument. The second objective is to ascertain whether there are any signs that point to AD model collapse or convergence and/or the extent to which potential collapse or convergence is connected with the principle of autonomy – the principle at front and centre of the contemporary assisted death debate.

The importance of conducting such a detailed comparative analysis between legislative and judicial AD reform discussion should not be underestimated. In addition to general observations that may be made between these two groupings and an overall improved ability to analyze law reform trends, if any, it can assist in clarifying the relevance and weight that should be given to foreign empirical evidence

state legislatures but have failed without significant debate. For this reason, these states are not included in the overall discussion. See Appendix, Chart 1 however for comprehensive list of bills introduced into State legislatures.

particularly as concerns slippery slope argumentation. The employment of empirical data from the permissive jurisdictions where AD is currently legal is particularly pervasive in assisted death reform discussion before the court. Comparison assists in ascertaining whether current domestic AD debates and proposals for reform indicate an approach consistent, inconsistent or dissimilar to preceding foreign formulations and in turn can assist in illuminating analytical, logical or legal discrepancies or inconsistencies in the politico-legal positioning of autonomy as the factor of most import in the debate over legalized assisted death. Furthermore, illumination of these discrepancies assists in revealing facets of the slippery slope concern that are not addressed by responses to this ethical quagmire that solely focus on empirical data from foreign jurisdictions. While it is outside the scope of this discussion to conduct a comprehensive examination of assisted death evolution solely from the perspective of the slippery slope, what is hoped to be achieved is to provide the first steps that can facilitate improved understanding of the critical disconnect that exists between proponents and opponents of assisted death in terms of the relevance and interpretation of the slippery slope beyond an either/or proposition.

An overall analysis is conducted in Chapter V which specifically addresses the concept of autonomy and assesses how it has been characterized and deployed in the legalization of AD. Chapter V attempts to respond to the questions of what are the precise constructions of autonomy in play, how far might AD practices be expanded through the logic of autonomy, and, if there ought to be limits to autonomy in driving the assisted death agenda, on what might they be premised? It offers a summing up of some of the potential limits to autonomy as understood from: the current approaches to regulating assisted death and intrinsic policy constraints; the different expressions of autonomy pursuant to medical doctrine, dignity and constitutionally protected human rights; and democratic versus judicial processes. Lastly, it attempts to unpack the concept of autonomy pursuant to slippery slope theory, namely, what potential do the different constructions of autonomy hold as vehicles of collapse or trigger for slippage towards more extreme visions of AD.

The discussion concludes in Chapter VI. This work suggests that express and more nuanced democratic examinations of the construction of the principle of autonomy that is sought to be protected and advanced in emerging assisted death laws is critical to ensuring that current and future laws do not expand beyond that originally contemplated.

This work also hopes to re-introduce a largely unexplored yet critical perspective on the assisted death debate: that assisted death should not be “treated out of context.”¹⁴ Current practical limits to autonomy provide insight into potential pathways for the role that it can or should play in advancing assisted death. Obtaining and disseminating this kind of insight is critical to ensuring that any further evolution of assisted death law in a domestic state is not reduced to attempts to mimic or streamline the importation of assisted death regulations from foreign jurisdictions but rather is a result of enlightened discussion that considers the unique personality, qualities and obligations of the individual state not the least of which includes the processes of legal reform. After all, if it is indeed the case that choosing to end one’s own life can be said to be the ultimate expression of autonomy¹⁵ and if autonomy can be said to be the ultimate expression of a secular and democratic society, then the legitimacy of any right to assisted death surely depends on the legitimacy of the processes by which that particular expression of autonomy has come to be defined and regulated.

¹⁴ Johannes JM van Delden, ‘Euthanasia in the Netherlands: The Medical Scene’ in B Sneiderman and JM Kaufert (eds), *Euthanasia in the Netherlands: A Model for Canada?* (Legal Research Institute 1994) 25.

¹⁵ See Dan Brock, ‘Voluntary Active Euthanasia’ (1992) 22(2) *Hastings Center Report* 22 10, 19; See also discussion in Yale Kamisar, ‘Are Laws Against Assisted Suicide Unconstitutional?’ (1993) 23(3) *Hastings Center Report* 32; For counter-argument see Leon R. Kass, ‘Is There a Right to Die’ (1993) 23(1) *Hastings Center Report* 34, 39-40.

CHAPTER II DEFINITIONAL CONSIDERATIONS

II.A. ASSISTED DEATH TERMINOLOGY

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

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

Physician Assisted Suicide (“PAS”): PAS is a form of AS. PAS involves a physician intentionally helping his or her patient to end their life at the patient’s express and voluntary request¹ by providing or prescribing the lethal medication to the patient. Again, the final step (such as swallowing the pills or opening the intravenous valve) must be taken by the person who is ending their own life. Note: The physician may or may not be present when the patient self-administers the lethal medication. In North America, particularly where PAS is legal as is the case in Washington and Oregon, the term “physician assisted death” or “PAD” is also utilized.²

Euthanasia: The direct administration (usually by injection) of a lethal medication (such as a high dose of barbiturate) by a physician to intentionally end the life of a patient at the patient’s express and voluntary request.³ This definition of euthanasia, one which incorporates the voluntariness of the individual, is based on the Dutch definition of euthanasia and is also described by the Dutch as “euthanasia proper”. The Dutch definition of euthanasia is understood to be the current standard in international literature.⁴ The Dutch formulation of “euthanasia” tends to be qualified as “voluntary

¹ Definition expanded from MC Jansen-van der Weide, BD Onwuteaka-Philipsen and G van der Wal ‘Implementation of the project ‘Support and Consultation on Euthanasia in the Netherlands’ (SCEN)’ (2004) 69(3) Health Policy 365, 366 (Jansen-van der Weide 2004 study).

² See generally Kathryn L Tucker, ‘In the Laboratory of the States: The Progress of Glucksberg’s Invitation to Address End-of-Life Choice’ (2008) 106(8) Michigan Law Review 1593, 1594-7 (Tucker).

³ Definition expanded from Jansen-van der Weide 2004 study (n 1) 366.

⁴ John Griffiths, Heleen Weyers and Maurice Adams, *Euthanasia and Law in Europe* (Hart Publishing 2008) 56, 76 (Griffiths, Weyers and Adams).

active” euthanasia in United Kingdom and North American discussions, which from the Dutch perspective, would be an exercise in redundancy.⁵

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

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

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

II.B. DEFINING AUTONOMY

As described, one of the major tasks in this paper is to assemble a practical picture of autonomy based on an analysis of the limits imposed by laws that currently allow assisted death. Notwithstanding this task however which will be addressed in the chapters that follow, it is still important to at least briefly highlight some of the general perspectives on autonomy that emerge from the disciplines of philosophy, medicine and the law in order to provide some additional analytical grounding. It is also

⁵See discussion in John Keown, *Euthanasia, Ethics and Public Policy: An Argument Against Legalization*, (Cambridge University Press 2002) 9-10, 84 (Keown).

important to note that while it is possible to consider these constructions of autonomy as discrete formulations, there are significant areas of overlap and furthermore “little agreement exists about this principle’s “nature, scope and strength”.⁶ As we shall see through the course of the discussion that follows in Chapters II through IV, these different conceptions of autonomy are reflected in a variety of ways throughout the assisted death laws and in current assisted death debate.

The word autonomy is derived from the Greek *autos* meaning ‘self’ and *nomos* meaning ‘rule’, ‘governance’ or ‘law’ and was originally developed in reference to the ability of independent city-states to self-govern.⁷ In extending the notion of autonomy to medicine and particularly health care, autonomy has come to be considered the core ethical value, replacing to a large extent the previous “widespread practice in which physicians make decisions on behalf of their patients, without the full understanding or consent of the patient”⁸ otherwise known as paternalism. Medical decision-making based on paternalism focuses on the patient’s well-being, and so can be distinguished from actions the doctor might take out of self-interest.⁹

According to Beauchamp and Childress, respect for autonomy is one of four central ethics principles in biomedical ethics, the other three being non-maleficence (do not inflict harm), beneficence (do and promote good) and justice (fair allocation of health care through both egalitarian - equal access - and utilitarian - maximizing public utility- approaches) none of which should be afforded moral priority over the other.¹⁰ That said, it is autonomy that is often thought of as the guiding paradigm in a western-view of health care.¹¹

⁶ Tom L Beauchamp and James F Childress, *Principles of Biomedical Ethics* (6th edn, OUP 2009) 99 (Beauchamp and Childress).

⁷ *ibid.*

⁸ Susan Sherwin, *No Longer Patient: Feminist Ethics and Healthcare* (Temple University Press 1992) 138 (Sherwin).

⁹ “Because it bypasses patients’ normal authority over themselves, paternalism is generally challenged as an infringement on patient autonomy. It is usually thought to be justified only in those circumstances where patients are incapable of making decisions in their own best interests; under such conditions, someone who is presumably better qualified must choose for them”. *ibid.* 138.

¹⁰ Beauchamp and Childress (n 6) 99. The four principles approach by Beauchamp and Childress is otherwise known as “Principlism” and is considered to be one of the most significant contributions and influences in bioethics theory.

¹¹ See Daniel Callahan, ‘Can the Moral Commons Survive Autonomy?’ (1996) Hastings Centre Report 41-2; See also J Rendtorff and P Kemp, ‘Basic Ethical Principles in European and Bioethics and Biolaw’ in *Autonomy, Dignity, Integrity and Vulnerability*, vol 1 (Centre for Ethics and Law 2000); See also Mette Ebbesen and Brithe D Pedersen, ‘The Principle of Respect for Autonomy- Concordant with the Experience of Oncology Physicians and Molecular Biologists in their Daily Work’ (2009) 9(5) BMC Medical Ethics 1 (Ebbesen and Pedersen); See also Margaret Brazier, ‘Do No Harm- Do Patients Have Responsibilities Too?’ (2006) 65(2) Cambridge Law Journal 397, 399 (Brazier).

Per Beauchamp and Childress:

Personal autonomy encompasses at minimum, self-rule that is free from both controlling interference by others and from certain limitations such as an inadequate understanding that prevents meaningful choice. The autonomous individual acts freely in accordance with a self-chosen plan, analogous to the way an independent government manages its territories and establishes its policies.¹²

There are at least three facets of autonomy being articulated under this biomedical definition of autonomy:

1. autonomy embodies a form of negative right, that is, the right to be free from interference or constraint by others;
2. autonomy imposes a positive obligation on others, the obligation to disclose information and take action that fosters autonomous medical decision-making;¹³ and
3. the overall expression of autonomy involves the values and goals of the individual - the right to make decisions freely in accordance with a self-chosen plan. Thus while an autonomous decision must be an informed decision, it is not the information provided that determines the course of treatment, rather it is the “emotion, desires, hopes and goals of the patient [that] are of overriding importance in making a decision which will reflect his or her concept of a meaningful life.”¹⁴ It is in this third facet of autonomy where the notion of “self-determination” is reflected.

From a legal perspective, the first two facets of biomedical autonomy find expression in the legal right of “informed consent” to medical treatment¹⁵ and its corollary, the “right to refuse consent to treatment” also called the “right to refuse treatment”¹⁶ with the medical right of self-determination being perceived at the foundation of both.¹⁷

¹² Beauchamp and Childress (n 6) 99.

¹³ According to Beauchamp and Childress, “respect for autonomy is more than noninterference in others’ personal affairs. Rather it involves acknowledging the value and decision-making rights of persons and enabling them to act autonomously. *ibid* 103-4.

¹⁴ Gordon DuVal, ‘Assisted Suicide and the Notion of Autonomy’[1995-1996] 27 *Ottawa Law Review* 1, 4 (DuVal).

¹⁵ The obligation to provide the patient with sufficient knowledge about treatment, risks and alternatives such that the giving of consent is free and informed. *Salgo v Leland Stanford Jr. University Board of Trustees* (1957) 317 P.2d 170 (Cal Ct App) On absent of consent generally see Cardozo J in *Schloendorff v Society of New York Hospital* (1914) 105 N.E. 92 at 93 (NY Ct App); See also discussion regarding doctrine of informed consent and the Nuremberg Code in George J Annas, ‘American Bioethics after Nuremberg: Pragmatism, Politics and Human Rights’ (2005) Boston University Lecture 8.

¹⁶ For further discussion on the influence of legal decisions in tort law in the shaping of the doctrines of informed consent and the right to refuse treatment see Brazier (n 11) 400 and

Self-determination however also finds expression in law much earlier than as a component of autonomy in the medical context. Self-determination is understood to be part of the expression of the politico-legal notions of liberty, individual choice and freedom of the will. To give but one example, in 1891 Justice Gray of the U.S. Supreme Court proclaimed:

No right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.¹⁸

It should be noted that the idea of self-determination as “self-rule” conceptually engages not only a liberty right but also triggers a privacy right, both however being reflected as a form of negative right i.e. the right to be *free from* restraint or interference. These libertarian ideals – the rights to liberty and privacy – are protected by various international declarations, conventions and domestic constitutions and will be discussed in more detail in Chapters III and IV below as far as they concern the legalization of AD. What should be kept in mind for now however, is that constitutionally protected rights to liberty and privacy along with the biomedical construction of autonomy as the right to not be treated in the absence of informed consent, can be independently or jointly deployed in legal argument to support the medical right to refuse life-preserving treatment – a medical touchstone that plays a central role in the debates concerning the proper scope of AD practices.¹⁹

In addition to the self-rule idea of the “freedom from interference or constraint” angle of autonomy, under the biomedical model, the principle of autonomy is also particularly concerned with an individual’s capacity to act autonomously in the first place. That is, an individual must have the ability to deliberate rationally²⁰ or in other words, have the capacity for intentional action.²¹ Consequently, an obligation to respect autonomy would not extend to persons incapable of acting in a sufficiently

Daniel Sperling, ‘Law and Bioethics: A Rights-Based Relationship and its Troubling Implications’ (2008) 11 Current Legal Issues 52, 52-62 (Sperling).

¹⁷ See *Malette v Shulman* (1990) 72 O.R. (2d) 417, 47 D.L.R. (4th) 18 (Ont.C.A.) 424.

¹⁸ *Union Pacific Railway Company v Botsford* (1891) 141 U.S. 250 at 251; See also discussion in DuVal (n 14) 3.

¹⁹ See for example *Matter of Quinlan* (1976) 335 A.2d 647 (N.J.S.C.); *Bouvia v Superior Court* (1986) 225 Cal. Rptr. 297, 301 (Ct. App.); *Cruzan v Director, Missouri Dept. of Health* (1990) 110 S. Ct. 2841, 497 U.S. 261; See also *Campbell v Mirror Group Newspapers Ltd.*, [2004] 2 A.C. 457 (HL) and see P Case, ‘Confidence Matters: The Rise and Fall of Informational Autonomy in Medical Law’ (2003) 11 Medical Law Review 208; Brazier (n 11) 399.

²⁰ JF Childress, ‘Who Should Decide? Paternalism in Health Care’ (Oxford University Press 1982).

²¹ Beauchamp and Childress (n 6) 100.

autonomous manner or those who cannot be rendered autonomous such as infants, irrationally suicidal individuals, and those with drug-dependence.²²

When the capacity view of autonomy is combined with the view of autonomy involving negative rights and possible correlative positive duties within the larger milieu of *self-determination*, the biomedical view of autonomy can be seen to have two essential constructions, “agency (capacity for intentional action or internal agency) and *liberty* (independence from controlling influences),²³ the former of which is addressed by law as “capacity to consent” and the determination of mental competence and the latter of which is addressed by law as “informed consent”.²⁴

The authenticity of the biomedical model of autonomy has however been criticized from a number of angles, all of which make an argument that autonomy – in the sense of decision-making that is free and voluntary, reasonably informed and rationally directed in fulfillment of one’s own goals and values – is an ideal that can never be fully realized, even in the medical context.²⁵ The reasons behind this criticism are extensive and varied and stem from lines of questioning that explore among other things: an individual’s capacity for self-reflection and/or ability to assess and reconcile first-order and second-order desires;²⁶ the influence and outcomes of imperfect information;²⁷ the impact of emotions;²⁸ and the social components²⁹ or communal context in which decisions are made, i.e. the “contextual” or “relational” components of autonomy.³⁰ While a full discussion of these and other critiques is beyond the scope of this discussion, the contextual or relational component of autonomy merits a brief explanation.

The gist of the contextual or relational criticism is that the biomedical model of autonomy too narrowly focuses on the individual self as being rational, controlling³¹

²² *ibid* 105.

²³ *ibid* 100.

²⁴ See discussion in Philip H Osborne, ‘Informed Consent’ in *Canadian Medical Law* (Thompson Canada Ltd 2003) 31 et seq; See also discussion in Beauchamp and Childress (n 6) 111.

²⁵ See DuVal (n 14) 20.

²⁶ See discussion in Beauchamp and Childress (n 6) 100-1.

²⁷ DuVal (n 14) 21.

²⁸ *ibid* 21-2.

²⁹ Anne Donchin, ‘Autonomy, Interdependence, and Assisted Suicide: Respecting Boundaries/Crossing Lines’ (2000) 14(3) *Bioethics* 187-8 (Donchin).

³⁰ Carolyn Ells, ‘Shifting the Autonomy Debate to Theory as Ideology’ (2001) 26 *Journal of Medicine and Philosophy* 417-30 (Ells); See also discussion in Beauchamp and Childress (n 6) 105.

³¹ Beauchamp and Childress (n 3) 103.

and static³² and altogether ignores the realities of how a person's identity is shaped through social relationships and "complex social determinants".³³ As put rather bluntly by Anne Donchin, "Any conception of autonomy that fails to incorporate socially situated interpersonal relations rests on illusion."³⁴

The argument advanced does not reject autonomy but revises atomistic conceptions of autonomy by centering autonomy on "the conviction that persons are socially embedded and that agents' identities are formed within the context of social relationships."³⁵ The view carries with it the caution that oppressive socialization or social relationships can impair autonomy by, among other things, influencing or forming the agent's desires, beliefs and attitudes.³⁶

Apart from the substantive challenge that such a criticism imposes at the micro-level, that is, at the level of the individual seeking assisted death and the identification of safeguards that will ensure voluntariness and competency, the contextual criticism echoes a key macro-level concern of the AD debate. That is, it resonates with the broader question of the impact that AD practice, if accepted, will have on social relationships over the long term. The main concern here is the potential of widespread AD practice to transform into an oppressive or coercive force and in turn impair the autonomy of society's most vulnerable agents – those who experience disability, advanced age, illness or other dis-ease. The contextual criticism thus evokes, albeit to a greater or lesser degree, that which has come to be known as the "slippery slope" concern, which is discussed in more detail at II.D. below.

II.C. DEFINING DIGNITY

Similar to the above overview of the general perspectives on autonomy it is important to also provide a brief explanation of some of the different perspectives on the concept of dignity. This is particularly so because of the common use of the term "dignity" in the assisted death debate, perhaps most visibly in the phrases, "dying [or] death with dignity".

³² Leslie Bender, 'A Feminist Analysis of Physician-Assisted Dying and Voluntary Active Euthanasia' (1992) 59 *Tennessee Law Review* 519, 536.

³³ Beachamp and Childress (n 6) 103.

³⁴ Donchin (n 29) 189.

³⁵ Ebbesen and Pedersen (n 11) 5.

³⁶ See discussion in Beachamp and Childress (n 6) 103; See also Ells (n 30) 417-30; See also generally Donchin (n 29).

As with the term “autonomy”, the term “dignity” has also been criticized for its indeterminacy, but the criticism of “dignity” has been much more severe, being consistently described as “useless”, “abstract” and even an “empty shell”.³⁷ One of the principal reasons behind such critique, is that much academic investigation into the legal use of the term dignity has consistently demonstrated that the term tends to be advanced rhetorically in conjunction with other human rights ideals such as equality and autonomy, thus rendering its unique contribution to human rights unclear if not also questionable.³⁸ Indeed, the harshest skeptics of the term claim that dignity can be done away with altogether, and in the field of medical ethics have gone so far as to argue that once autonomy has been recognized, dignity adds nothing.³⁹

To be sure, in the assisted death debate, “dignity” is frequently equated with the term “autonomy”,⁴⁰ and, as earlier touched upon, perhaps most perceptibly so within the context of the Swiss and American “death with dignity” assisted suicide debates.⁴¹ That said, it does not necessarily follow that these two terms are precisely interchangeable. Apart from scholarship that counters the skeptical view of dignity on the basis that the term is a useful tool that can assist in solving a variety of theoretical problems in human rights law with the capacity to express numerous concepts and ideas,⁴² a polarization of dignity and autonomy can also be directly observed in cases that have unsuccessfully challenged the illegality of assisted suicide whereby the courts have used “dignity” in order to constrain the autonomous wishes of the individual.

For example, in the Canadian case of *Rodriguez*⁴³ which is discussed in detail later in Chapter IV.C.3, Sopinka J, speaking for the majority of the Supreme Court of Canada, described the “the inherent dignity of every human being” in connection with “the intrinsic value of human life” to suggest that a right to life protection can operate to protect the dignity of human life in general, independent of the individual’s right to be

³⁷ Ruth Macklin, ‘Dignity is a Useless Concept’ (2003) 327 *British Medical Journal* 1419 (Macklin); C McCrudden, ‘Human Dignity and Judicial Interpretations of Human Rights’ (2008) 19 *European Journal of International Law* 655, 698 (McCrudden); *R v Kapp* 2008 SCC 41 (Supreme Court of Canada) para 22.

³⁸ Tarunabh Khaitan, ‘Dignity as an Expressive Norm: Neither Vacuous Nor a Panacea’ (2012) 32(1) *Oxford Journal of Legal Studies* 1, 3 (Khaitan).

³⁹ Macklin (n 37) 1420.

⁴⁰ See for example Ronald Dworkin, *Life’s Dominion: An Argument About Abortion, Euthanasia and Individual Freedom* (Vintage Books 1994) 30-1.

⁴¹ *ibid*; See also discussion in Chapters III.B.4 (Switzerland) and III.B.5 and 6 (Oregon and Washington).

⁴² Khaitan (n 38) 2 et seq; See also, G Moon and R Allen, ‘Dignity Discourse in Discrimination law: A Better Route to Equality’ (2006) 6 *European Human Rights Law Review* 610.

⁴³ *Sue Rodriguez v. British Columbia case ((Attorney General), [1993] 3 SCR 519 (Rodriguez).*

free from unwanted interference.⁴⁴ In this way, dignity can be seen to operate as a constraint⁴⁵ to individual autonomy which would include descriptors such as the “dignity of humanity” or dignity *qua* sanctity of life, rejecting any affirmative actions that would end human life.⁴⁶

While the overall ideal of human dignity can be traced to various disciplines including theology, philosophy and political theory,⁴⁷ the legal polarization of dignity and autonomy, and indeed the grounding of dignity itself in human rights law, finds its origins at the United Nations, specifically within its foundational documents.⁴⁸

For example, the preamble of the Charter of the United Nations (UN Charter) states:⁴⁹

... to reaffirm faith in fundamental human rights, **in the dignity and worth of the human person, in the equal rights of men and women** and of nations large and small.

[author’s emphasis]

Similarly, the Universal Declaration of Human Rights recognizes human dignity in five instances⁵⁰ including within the preamble and Article 1 which respectively read:⁵¹

Whereas recognition of the **inherent dignity and of the equal and inalienable rights of all members of the human family** is the foundation of freedom, justice and peace in the world, ...

All human beings are born free and equal in dignity and rights. They are **endowed with reason and conscience** and should act towards one another in a spirit of brotherhood.

[author’s emphasis]

When dignity was included in the United Nations foundational documents there was no agreement as to its precise meaning. Rather it was inserted in order to facilitate the developing theories and meanings of human rights, and, precisely because of its

⁴⁴ *ibid* paras 129, 130 and 149.

⁴⁵ For discussion on dignity as constraint see Roger Brownsword, ‘Bioethics Today, Bioethics Tomorrow: Stem Cell Research and the “Dignitarian Alliance” ’(2002) 17 *Notre Dame Journal of Law, Ethics and Public Policy* 15, 25-8 (Brownsword).

⁴⁶ Leon R Kass, *Life, Liberty and the Defence of Dignity* (Encounter Books 2002) 249.

⁴⁷ Khaitan (n 38) 1-2; Naomi Rao, ‘The three concepts of dignity in constitutional law’ (2011) 86 *Notre Dame Law Review* 183, 193 (Rao).

⁴⁸ Rao *ibid* 193; Note that prior to the United Nations usage of “dignity”, the term had already appeared in a number of national constitutions at the beginning of the twentieth century but its use was sporadic. See *ibid* and McCrudden (n 37) 664.

⁴⁹ United Nations, Charter of the United Nations, 24 October 1945, 1 UNTS XVI preamble.

⁵⁰ Universal Declaration of Human Rights (adopted 10 December 1948 UNGA Res 217 A(III) (UDHR) preamble, arts 1, 22 and 23.

⁵¹ *ibid* preamble, art 1.

plasticity, it was a term that “people of disparate beliefs and backgrounds could agree about.”⁵² Accordingly, pursuant to its most basic legal form, dignity can be seen to rest on the idea of the inherent or intrinsic worth of the individual; an inherent worth arising simply by virtue of being human and belonging to all humans. This intrinsic dignity is to be recognized and respected and furthermore establishes that all individuals are equal in dignity and rights.

Because dignity is therefore understood to be at the foundation of human rights and because it is up to individual states to implement the protection of dignity, there has been a tendency to connect it to the articulation of individual rights including negative rights such as privacy, liberty and freedom from unwanted interference. In this manner, dignity correlates strongly to the concepts of autonomy and self-determination, a type of dignity *qua* agency (or external agency), whereby the individual takes recourse to dignity in order to challenge unwanted intrusions by the state.⁵³ Furthermore, because inherent dignity is equal and universal, it is poised to attach to equality rights’ arguments, in the sense that everyone is entitled to the same scope of freedom from state interference. These autonomous agent conceptions of dignity are reflected throughout the assisted suicide debates, particularly within court challenges to assisted death prohibition, as will be seen later in Chapter IV of this discussion.

It should also be noted that in addition to the foregoing correlation between, or in the view of some, conflation of, dignity and autonomy, there also co-exists the view that inherent human dignity is actually rooted in autonomy. This view, derived from the writings of Immanuel Kant, again stems from the perspective that inherent dignity arises from our unique humanness. Our unique humanness however exists because of our capacity for rational thought and self-awareness and distinguishes us from other animals. Thus dignity of the human is grounded in the autonomous, self-legislating individual.⁵⁴ Accordingly, pursuant to Kant’s categorical imperative, a person is an end in himself and must not be treated as a means to another’s end and thus in turn triggers the practical duty to acknowledge the dignity of the individual.⁵⁵ If autonomy is indeed the *sine qua non* of dignity, then the argument that asserts that constraining

⁵² Rao (n 47) 194; Mary Ann Glendon, *A World Made New: Eleanor Roosevelt and the Universal Declaration of Human Rights* (Random House 2002) 147.

⁵³ See discussion in Rao *ibid* 202-4.

⁵⁴ Immanuel Kant, *Grounding for the Metaphysics of Morals* (first published 1785, James W Ellington (tr), 3d edn, Hackett Publishing Company 1993, orig 1785) 41; See also discussion in Rao *ibid* 201-2.

⁵⁵ Kant *ibid* 25.

individual rights on the basis of the dignity of humanity is logically flawed, can be readily appreciated.

On the other hand, if dignity is grounded on the simpler notions of being human and the equality of all humans, then dignity *qua* sanctity of life and dignity as constraint positions become more perceptible provoking at minimum, a call to also consider the possible yielding of individual rights to state interests aimed at achieving broader social protectionist objectives.⁵⁶

Additionally, dignity in the form of “being left alone” does not prescribe a type of dignity that could easily compel participation by third parties, which, in the context of this discussion, would mean physicians or others participating in actively assisting death. Thus the notion of inherent dignity being grounded in a generalized idea of autonomy is seemingly irrelevant, in a practical and logical sense. As will be discussed, under the American AD models, the protection of autonomy has only been interpreted to compel PAS and not euthanasia, with the term “dignity”, being legally constructed more strongly in association with the right to refuse treatment at end-of-life.⁵⁷ Accordingly, if dignity is the foundation upon which all modes of assisted death become justified, then it is arguable that its definition cannot or should not be understood as synonymous with a generalized definition of autonomy.

Notwithstanding the foregoing, it is important to note that the right-to-die movement has also frequently utilized the term “dignity” in the context of the loss of independence, specifically, the loss of physical independence as an illness or disease progresses, which in turn carries with it significant emotional and psychological distress.⁵⁸ Dignity in this experiential or normative context (which is also reflected in end-of-life case law),⁵⁹ has been described as “giving individuals the choice to end life not simply to further autonomy but in order to avoid a life without certain forms of dignity.”⁶⁰ While the avoidance of indignity can be construed as related to the exercise of control over one’s own body and hence may still reflect a form of autonomy, it is

⁵⁶ See discussion by Brownsword which suggests dignity as constraint can also be interpreted from the writings of Immanuel Kant. Brownsword (n 45) 27.

⁵⁷ See for example, *Cruzan v. Director Missouri Department of Health* (1990) 497 US 261, 289-311 (*Cruzan*).

⁵⁸ See for example, discussion of *Carter* case in Chapter IV.C.3.ii.; See also discussion in Lois Shepherd, ‘Dignity and Autonomy after *Washington v. Glucksberg*: An Essay About Abortion, Death and Crime’ (1998) 7 *Cornell Journal of Law and Public Policy* 431, 449-150; See also Rau (n 62) 232-3.

⁵⁹ See *Cruzan* (n 57) 310-1 and *Rodriguez* (n 43) 129.

⁶⁰ Rau (n 47) 233.

not entirely clear that the normative understanding of dignity is fully related to the recognition of the exercise of autonomy.⁶¹ Furthermore, because indignity can exist in the absence of its experience (for example in patients who are unconscious),⁶² autonomy or the exercise of autonomy cannot fully account for the central features of dignity.

The normative description of dignity therefore not only demonstrates that there exists a lack of symmetry between certain constructions of autonomy and dignity but also reveals that deeper consideration must be given to ascertaining with more precision, how rights and corresponding duties are legally constructed in assisted death practice. That is, if, on the one hand, a right is theoretically grounded on the basis of a number of legally-protected expressions of autonomy (e.g. liberty, privacy), yet the duty (or sense of duty) to respond arises, on the other hand, from a different premise (e.g. responding to a patient's loss of independence), the lack of transparent integration or correlation between the right and duty, carries with it the potential to create a situation whereby the duty may be inadvertently expanded to include circumstances different from that which the right logically entails and vice versa.

As noted, the protection of autonomy is not only advocated as the primary legal justification for assisted death, but also advanced as the principal safeguard that can protect against expansion of AD and undesirable consequences. If however different conceptions of autonomy and dignity are being cherry-picked in order to establish certain rights and duties, or similarly, if an expression of autonomy is being constructed in a piecemeal legal manner in order to quickly achieve a particular end result, then it stands that the capacity to maintain newly proposed boundaries will be variable and less predictable – a concern that also reflects a slippery slope line of argumentation, which is the subject to which we now turn.

II.D. THE SLIPPERY SLOPE RUBRIC

The overall objective of the slippery slope discussion herein is to move beyond theoretical descriptions of the slippery slope argument and into the legal domain by observing the ways in which slippery slope concerns might tangibly manifest within

⁶¹ See discussion in Margaret A Somerville, 'The Song of Death: The Lyrics of Euthanasia' (1993) 9 *Journal of Contemporary Health Law and Policy* 1, 18.

⁶² Dworkin (n 40) 235; See also discussion on dignity not ending with death of the person, Joel Feinberg, 'The Rights of Animals and Unborn Generations' in *Rights, Justice and the Bounds of Liberty* (Princeton Univ Press 1980) 159.

and across legal systems. Prior to entering these discussions however, a review and analysis of slippery slope theory is provided in order to assist with the identification and organization of slippery-slope aspects of the AD laws under review.

In other countries [than the American colonies], the people ... judge of an ill principle in government only by an actual grievance; here they anticipate evil, and judge of the pressure of the grievance by the badness of the principle. They augur misgovernment at a distance and snuff the approach of tyranny in every tainted breeze.⁶³
Edmund Burke, 1775

The above quote is a useful reflection of the slippery slope idea. It draws attention to a distinction between judging an individual act and judging a principle and describes the rejection of a principle on the basis of its potential for future evil.

A more detailed articulation of the slippery slope concept hones in on the mechanics of the argument and the potential for a slide from one principle or standard to another.

For example,

At its most basic, the slippery slope involves questions about a certain standard (usually but not always a legal one) we can refer to as 'A'. Slippery slope arguments are unlike many other philosophical arguments in that there is little discussion about the rightness or wrongness of A as a standard in itself. 'A' may be good, bad, or it may be uncertain whether A is good or bad, at least on its own. However, A may lead to a different standard we can refer to as 'B'. B, unlike A, is considered to be bad (however we wish to define bad) and is therefore something we should avoid. Since A might lead to B, it is argued that one should avoid implementing A in order to avoid the bad consequence of B, even if that is the only reason to avoid implementing A.⁶⁴

Slippery slope arguments have been heavily criticized in particular for being too metaphorical, for lacking empirical support,⁶⁵ for simply being a tool of conservatism, and that realistically speaking, there is no reason why, if we can make sound distinctions today, we cannot continue to make them tomorrow.⁶⁶

Accordingly, the slippery slope concern identified at the end of the above section on autonomy could be criticized in much the same manner; the argument that over time AD practice could transform into an oppressive or coercive force to impair the autonomy of those of advanced age or disability, can be dismissed, for example, for

⁶³ Edmund Burke, 'On Moving His Resolutions for Conciliation with the Colonies, Speech to Parliament, Mar. 22, 1775' as quoted in Eugene Volokh, 'The Mechanisms of the Slippery Slope' (2003) 116(4) *Harvard Law Review* 1026, 1028 (Volokh).

⁶⁴ Stephen W Smith, 'Evidence for the Practical Slippery Slope in the Debate on Physician-Assisted Suicide and Euthanasia' (2005) 13(1) *Medical Law Review* 17, 17, fn 2 (Smith).

⁶⁵ Beauchamp and Childress (n 6) 177.

⁶⁶ See for example discussion in Smith (n 64) 17, 20.

lacking empirical support and also on the basis that distinctions between autonomous and non-autonomous decision-making can continue to be made.

Eugene Volokh (and others)⁶⁷ however point out that slippery slope arguments should not be so readily dismissed. According to Volokh, slippery slope arguments are about scrutinizing public policy and that realistically speaking, “every decision changes the political, economic and psychological conditions under which future decisions are made.”⁶⁸

Taking the basic concern of the slippery slope a step farther, Volokh argues that the most useful definition of the slippery slope is “one that covers all situations where decision *A*, which you might find appealing, ends up *materially increasing the probability* that others will bring about decision *B*, which you oppose.” [author’s emphasis].⁶⁹ The focus of the argument then becomes one of *measurement* and the *likelihood* of incremental shifts occurring.

Pursuant to this perspective, it would seem that the most relevant question when tackling a slippery slope concern, is ultimately whether it “makes sense” to support *A* when it might lead others to support *B*.⁷⁰ Thus, according to Volokh, a more cogent slippery slope analysis calls for a consideration of “all mechanisms through which *A* might lead to *B*, whether they are logical, judicial or legislative, gradual or sudden”.⁷¹

Volokh further notes that the analysis also calls for a consideration of any change in the conditions – whether those conditions are “public attitudes, political alignments, costs and benefits” and so forth – under which others will consider *B*.⁷² It should be noted that while Volokh’s concept of mechanisms incorporates a consideration of conditions, these two categories, i.e. *mechanisms* and *conditions* might also be considered as distinct and different elements of the slope (see 1. and 2. in Figure 1 below).

⁶⁷ *ibid* 17.

⁶⁸ Eugene Volokh, ‘Eugene Volokh, of The Volokh Conspiracy, Discusses Slippery Slope Arguments’ (4 October 2011) <www.law.harvard.edu/news/2011/10/04_volokh-feldman-slippery-slope-arguments.html> accessed 31 May 2012.

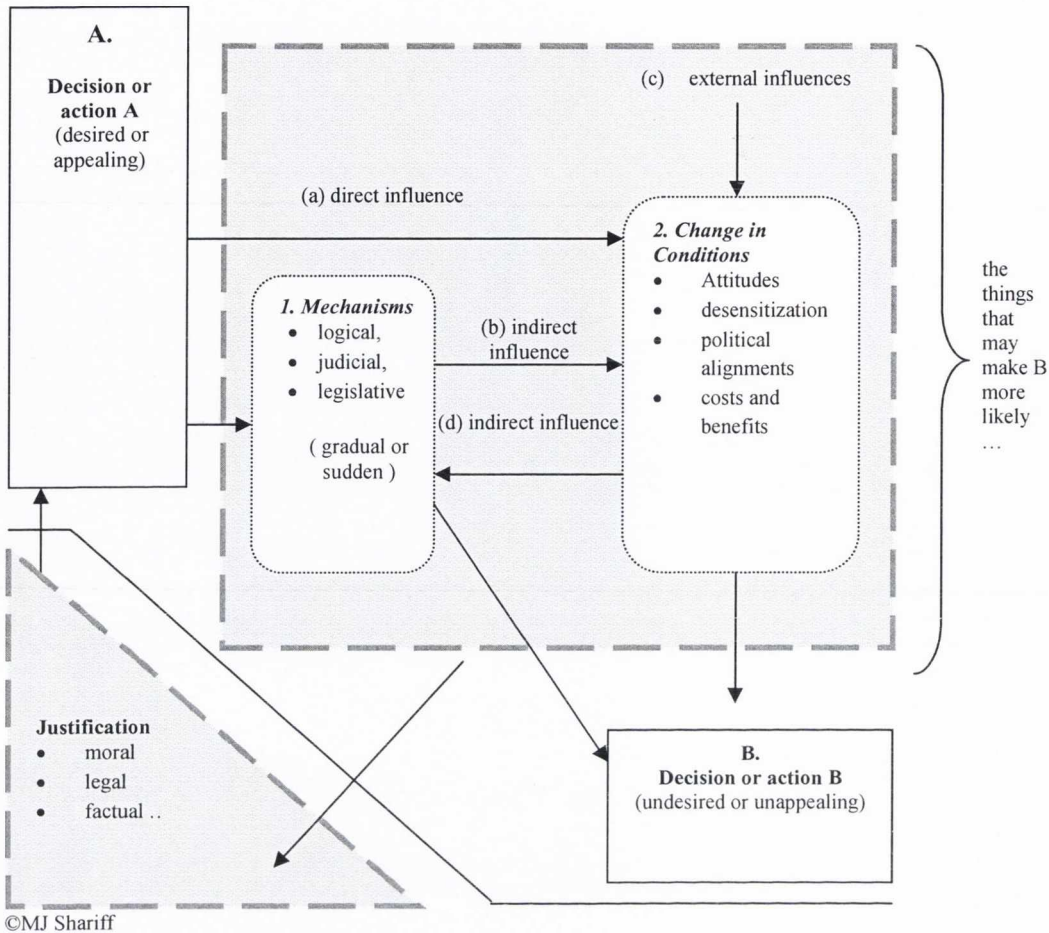
⁶⁹ Volokh (n 63) 1030. See also RG Frey, ‘The Fear of a Slippery Slope’ in G Dworkin, RG Frey and S Bok (eds), *Euthanasia and Physician-Assisted Suicide* (Cambridge University Press 1998) 44.

⁷⁰ Volokh *ibid* 1030.

⁷¹ *ibid*.

⁷² *ibid*.

Figure 1. How to Measure the Probability of the Slippery Slope from A to B



In addition to the two broad categories of *mechanisms* and *change in conditions*, one might also include consideration of any anticipated changes in conditions unrelated or external to the implementation of decision *A*, such as shifts in population demographics, the entry of a health epidemic or economic stress, for example. Thus as illustrated in Figure 1 above (an illustration that incorporates but also expands upon Volokh’s idea) a “change in conditions” could result from the direct or indirect influence of *A*, for example because of the dissemination of *A* itself (a); or because of recourse to a new mechanism (b); and also could result from influences external or extrinsic to the dissemination of *A* – as indicated by (c). Similarly, a change in conditions could also lead to the identification of mechanisms that would permit advance toward the bottom of the slope – as indicated by (d). Mechanisms and conditions could also operate together to form new justifications that could transform *A* into *B*.

What is particularly useful about expressly tackling the *probability* of slide is that it shifts focus from the narrow view of safeguards to prevent a specific slide (or “stabilizing” factors) to a focus on the broader concept of opportunities for slide (or

“destabilizing” factors). This brings further clarity to analysis of a reform proposal because it encourages the analysis of *opportunity* to occur along two lines namely: 1) *mechanisms* that could increase the chance of getting to *B*; and 2) *conditions* (qualitative or otherwise) that could trigger future consideration or implementation of *B*. The clarity that this distinction makes improves capacity for assessing the relevance and scope of the safeguards implemented for protecting against “the slippery slope” as well as for conducting a more rational and deliberate *a priori* evaluation of slippery slope risks generally.

In addition to the *mechanisms* and *conditions* distinction which together or separately might lead to slippage from Activity *A* to Activity *B* (as the argument goes), the principal academic approach to slippery slope has been to distinguish two forms of the slippery slope argument – the “logical” (or “conceptual”) and the “empirical” (also known as the “psychological” or “practical”).⁷³ The characterization of slippery slope arguments along these two lines has been frequently repeated across AD literature⁷⁴ and is described as follows:

The logical [or conceptual] form of the argument goes like this. Once a certain practice is accepted, from a logical point of view we are committed to accepting certain other practices as well, since there are no good reasons for not going on to accept the additional practices once we have taken the all-important first step. But, the argument continues, the additional practices are plainly unacceptable, therefore, the first step had better not be taken. ... The [empirical or psychological] form of the argument is very different. It claims that once certain practices are accepted, people shall in fact go on to accept other, more questionable practices. This is simply a claim about what people will do and not a claim about what they are logically committed to.⁷⁵

In other words, the logical version of the argument “holds that we are logically committed to allow *B* once we have allowed *A*”⁷⁶ – similar to a “floodgates” image perhaps rather than a “slope” – whereas the empirical form holds that “the effect of accepting *A* will be that, as a result of psychological and social processes, we sooner or later will accept *B*.”⁷⁷ Pursuant to this explanation, Figure 1 above can be seen to include both considerations with the logical argument being primarily cast as one of

⁷³ See James Rachels, *The End of Life: Euthanasia and Morality* (Oxford Univ. Press, 1986) 172-3 (Rachels).

⁷⁴ Wibren van der Burg, ‘The Slippery Slope Argument’ (1991) 102(1) *Ethics* 42, 43 (van der Burg). A third version has also been identified, called the “apocalyptic slippery slope” or “Doomsday argument” which warns against accepting *A* because of the horror, rather than the likelihood of *B*. van der Burg *ibid* 43.

⁷⁵ Rachels (n 73) 172-3.

⁷⁶ van der Burg (n 74) 43.

⁷⁷ *ibid*.

the potential mechanisms of slide and the empirical argument most readily associated with the change in conditions category.

In addition to these two major divisions of the slippery slope argument (the logical and the empirical) the logical has been further divided by Wibren van der Burg into two sub-categories “L1” and “L2”,⁷⁸ which herein will be respectively called “logical-consistency” and “logical-creep”. Logical-consistency (L1) requires that *B* be accepted because logically there is no relevant conceptual difference between *A* and *B* (i.e. $A=B$) or that the justification (“j”) for *A* also justifies *B* (i.e. j supports both *A* and *B*). Logical creep (L2) on the other hand requires that *B* be accepted because *A* is consistent with *m*, *m* is consistent with *n*, *n* is consistent with *o* ... and so on until *z* and *B* are reached.⁷⁹

As already noted, Figure 1 can be seen to reflect the logical formulation of the slippery slope argument in the category of *mechanisms* that could lead from *A* to *B*. For example, per Wibren van der Burg,

When there is a decision of a court allowing *A*, then this is a new element in the body of legal norms from which courts must make their own theory of law. It may make one decision in a related case much stronger in the ‘dimension of fit’ than it would have been without this precedent, and this may tip the scales.⁸⁰

Similarly, *mechanisms* of slippage (such as precedent that could open the “floodgates” for example) are not limited to consideration solely from the perspective of logical-creep for example, but also merit consideration from the perspective of *conditions*, in that a change in the political, psychological or economic conditions (to borrow Volokh’s terminology) could lead to the identification, selection or availability of particular mechanisms (as has already been described above with respect to Figure 1 and (d) indirect influences).

It should be mentioned that in the assisted death debate, the logical-consistency and logical-creep slippery slope arguments are primarily criticized for being weak arguments; the former because, the justification for *A* (for example, voluntary euthanasia) is rarely premised on one factor, it includes for example, both physician assent and patient request⁸¹ and therefore will not justify *B* when *B* is non-voluntary

⁷⁸ *ibid.*

⁷⁹ See also D. Enoch, ‘Once You Start Using Slippery Slope Arguments, You’re on a Very Slippery Slope (2001) 211 OJLS 629. 631.

⁸⁰ van der Burg (n 74) 46.

⁸¹ See for example, Hallvard Lillehammer, ‘Voluntary Euthanasia and the Logical Slippery Slope Argument’ (2002) 61(3) Cambridge Law Journal 545, 546-7 and Stephen W Smith,

euthanasia. With respect to logical-creep, the simple argument against it is that once logical lines have been identified then they can be easily drawn.⁸²

It can also be noted that analysis of slippery slope arguments in the assisted suicide debates provoked by court challenges tend to direct the focus of slippery slope analysis entirely towards the empirical slippery slope which is said to have the most credibility.⁸³ The approach typically taken is to assess the empirical data from jurisdictions that have implemented assisted death schemes to ascertain *ex post facto* whether the data shows evidence of slippage from *A* to *B*. If plotted against Figure 1, this approach would correspond to examination of pathway A-(a)-2-B. Three specific points to this approach can be noted here.

First, *B* is typically represented as being non-voluntary or involuntary euthanasia meaning that if voluntary euthanasia is implemented it could lead to one or both of these consequences. Again, recourse is made to current available empirical data to argue that these outcomes are not demonstrated in jurisdictions that have legalized voluntary euthanasia.⁸⁴ A second argument is also sometimes made - that if assisted suicide is implemented it could lead to the acceptance of euthanasia.⁸⁵ This second variant is typically dismissed as being less significant given either that permissive jurisdictions have implemented both euthanasia and PAS practices from the outset or that jurisdictions that have implemented PAS only show no signs of legalizing euthanasia.⁸⁶

While these conclusions can support an argument that an empirical slope therefore does not exist, what the approach ignores is how the modes of assisted death are determined in the first place. As will be discussed in the chapters that follow, the matter of limiting assisted death to the practice of PAS for terminal illness has been criticized and refuted on the basis that it is discriminatory for those who are suffering equally, demonstrating the operation of what would fit into the logical category of the slope. If the choice to include both the practices of euthanasia and PAS arises through logical mechanisms (like equality considerations), then plotted against Figure 1, *A*

'Fallacies of the Logical Slippery Slope in the Debate on Physician-Assisted Suicide and Euthanasia' (2005) 13 Medical Law Review 224, 229.

⁸² See Alister Browne, "Assisted Suicide and Active Voluntary Euthanasia" (1989) 2 The Canadian Journal of Law and Jurisprudence 35, 46-7.

⁸³ Penney Lewis, 'The Empirical Slippery Slope from Voluntary to Non-Voluntary Euthanasia' (2007) 35(1) Journal of Law Medicine and Ethics 197, 197 (Lewis).

⁸⁴ Empirical data is described in Chapter III and use of empirical data in the judicial setting is discussed in Chapter IV .

⁸⁵ See Lewis (n 83) 197-8.

⁸⁶ *ibid.*

cannot be euthanasia and PAS, but rather must be something else – such as the need or desire to respond to persons experiencing irremediable pain and suffering, for example. This raises the second and third points, that the logical form of the slope should not be so readily dismissed and the importance of considering that there is more than one possible *B*. The identification of undesirable *B* and the operation of the slope from desirable *A* to undesirable *B* is complex, and is at least partially determined, as noted by Stephen Smith, by the audience to whom the argument is presented.⁸⁷ This illuminates particular considerations of key relevance to the discussion of whether AD reform should proceed by way of judicial or legislative processes.

Indeed, a significant weakness in an approach that focuses only on an *ex-post-facto* snapshot in time to address empirical slope apprehension and that superficially dismisses the credibility of logical slope considerations is that it is bluntly indifferent to the substance of the slippery slope metaphor – that is – it is unresponsive to people’s rational desire to better understand the mechanisms of how their decisions today will affect social conditions or outcomes in the future. Accordingly, Beauchamp and Childress point out that slippery slope arguments at the very minimum, “force us to think carefully about whether unacceptable harm is likely to result from attractive and apparently innocent first steps.” And, as put by David Lamb,

The force of the slippery slope argument is not so much in its appeal to the moral superiority of the *status quo*, although it does serve as a warning against the difficulties of maintaining newly proposed boundaries. In the absence of absolute knowledge and consequently absolute control over the consequences of our actions and decisions, we cannot afford to ignore the possible misuses of proposed reforms [emphasis original].⁸⁸

To summarize then, what the slippery slope metaphor in its variety of formulations and constructions does, is call attention to the reality of imperfect knowledge and the lack of full control over consequences and provides a word of warning that, depending on the pathway chosen, the probability of slippage from *A* to *B* could be greater or lesser.

Thus a practical approach to application of a slippery slope rubric, *i.e.* an approach that looks at a proposal from the perspective of *probability*, would at minimum ask the following question, “How can we make it less likely that *A* (desired and socially beneficial) will lead to *B*, so that we can reach agreement on *A* despite some peoples

⁸⁷ Smith (n 64) 20.

⁸⁸ David Lamb, *Down the Slippery Slope: Arguing in Applied Ethics* (Routledge 2003) 120.

concern about B?” However, it should be noted that key to the legitimacy in proceeding with asking this probability question is to first answer the precipitating question, “what precisely is A anyway?”.

II.E. SUMMARY OF CHAPTER II

To summarize, autonomy can be construed broadly or narrowly. In its broad constructions, it represents the notion of self-rule and self-determination. These libertarian concepts can find protection in the law in the form of constitutional rights, and most often, in the form of negative rights – the right to be free to act and to be free from restraint or interference. This would include rights such as the right to liberty and the right to privacy. As will be discussed later in Chapter IV.C.3 below, the right to autonomy has also been reflected and protected by the right to security i.e. the right to make choices concerning one’s own body.

In the medical context, the scope of autonomy is constructed more narrowly in the sense that although it conceptually incorporates the notions of liberty, self-determination and freedom from interference, it is constrained to circumstances of medical decision-making. Thus legal protection of autonomy in this context is expressed as the doctrine of informed consent and its corollary, the right to refuse treatment. Underpinning these doctrines, which again are aimed at protecting the exercise of autonomy in medical decision-making, is the requirement that the individual have capacity for autonomous decision-making, that is, capacity for intentional action or, as described by Beauchamp and Childress, a form of internal agency.

Dignity can and has been equated with autonomy or alternatively, autonomy has been articulated to be at the root of dignity, and in that sense, dignity can be viewed as synonymous with autonomy. Thus dignity can also find protection in the same rights instruments that protect freedom or liberty and which operate to challenge unwanted intrusions by the state. Additionally, because all humans are to be equal in dignity and rights, dignity *qua* autonomy might also find expression and protection in equality rights. Furthermore, the right to make choices and exercise control over one’s own body protected by, for example, rights to security or privacy, has been interpreted as also protecting dignity.⁸⁹ However, dignity in this sense is perhaps less aligned with the furtherance of autonomy *per se*, and more aligned with the concept of for example, the avoidance of experiential indignity at the end of life.

⁸⁹ *Rodriguez* (n 43) para 21.

The concept of dignity particularly as it connects to the equality of all humans and the sanctity of life, can also operate as a constraint and requiring a yielding of individual rights to state interests in the preservation of life and safeguarding the lives of others.⁹⁰

As will be observed in the chapters that follow, the perspective of dignity as constraint tends to be assessed in a slippery slope context whereby a balancing between individual and group rights is conducted, with an infringement on autonomy rights being argued as justifiable on the basis that it is necessary in order to protect the rights of others. The focus of these arguments from opponents of assisted death is on both empirical and logical forms of the argument whereas the focus from proponents of assisted death tends to be on the empirical or practical category of the slope and largely ignore the logical. In defence of the emphasis on the empirical approach, it is important to recognize, that “you cannot do ethics until you know the facts”.⁹¹ However, as described, it is open to discussion whether the logical slope should be so easily set aside, and there is room for deeper consideration of the logical outside of the balancing approach noted immediately above, particularly with respect to identifying the mechanisms by which logical distinctions are made in the first place and in the identification of *A*.

Additionally, there are other models for slippery slope analysis (including that advanced by Eugene Volokh) which appear to integrate both logical and empirical evaluations. An integrated model can assist in better understanding how a decision *A* (the desired activity), might materially increase the probability of decision *B* (and the undesirable activity) being brought about. The merit in such a model is that it provides the foundation for a methodology that can help identify potential factors that could operate to destabilize the parameters of activity *A*, an important addition to the arguably more straight-forward task of identifying the legal safeguards that can help stabilize *A*, once identified. Given the desirability for fulsome debate on this issue, such a model offers a novel approach to responding more concretely to concerns about the potential coercive force AD will have on particularly vulnerable members of society, including those of advanced age and those with disability.

As has been alluded to in the Introduction, one very significant and potential factor(s) of destabilization, is the insufficient attention being paid to the specific construction of

⁹⁰ *ibid* paras 23-60.

⁹¹ Johannes JM van Delden, ‘Slippery slopes in flat countries – a response’ (1999) 25 *Journal of Medical Ethics* 22, 24.

autonomy at the heart of current assisted death reform activities and an over-emphasis on the legal vehicles (such as constitutional protections of liberty, security, privacy and equality) that are capable of achieving homogenized external results. Whether this can also be characterized or considered as a potential mechanism of the slippery slope (notwithstanding that as a preliminary matter, A and B must first be identified) will be explored in the final chapters of this discussion. Prior to that discussion however, it is essential to first explore the regulation of assisted death laws in order to, among other things, tease out the factors that limit or constrain the respective AD schemes from extending beyond the scope as intended by the legislator and, in turn, the varied constructions of autonomy at play in the evolution of this controversial practice.

CHAPTER III
DECONSTRUCTION OF ASSISTED DEATH LAWS
IN PERMISSIVE JURISDICTIONS

The life of the law has not been logic; it has been experience.¹

III.A. INTRODUCTION TO CHAPTER III

This section undertakes a comprehensive and comparative examination of the AD laws in jurisdictions that have promulgated express legislation to regulated assisted death, namely the Netherlands, Belgium, Luxembourg, Oregon and Washington as well as Switzerland, which does not currently have express legislation but does have a long legal history concerning the practice of AD.

This approach has been taken in order to reveal and evaluate the essence of the AD laws and the different principles and policies at play in their development and legal manifestation. Thus for each jurisdiction, the following aspects of the AD laws are presented:

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

The focus of this section is to explore how each unique jurisdiction perceives the conflict at issue in order to tease out the factors that limit or constrain the respective AD schemes from extending beyond the scope as intended by the legislator. Factors addressed here therefore include constraints that might be considered as being implicit to the essence of the AD conflict as perceived by each jurisdiction in addition to the more commonly discussed due care safeguards that are implemented in order to ensure that a request for AD is voluntary, informed and competent. This section also considers factors that might be considered external or tangential to the essence of the AD conflict but which theoretically could operate to further constrain or limit the expansion of AD schemes in other jurisdictions.

¹ Oliver Wendell Holmes, Jr., *The Common Law* (Little Brown and Company 1881) 5.

The chapter concludes with a comparative summary addressing how the conflict has been framed in the respective jurisdictions and a preliminary assessment of the practical limits to the current assisted death laws that emerge thereto.

III.B. JURISDICTIONS

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

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

III.B.1. The Netherlands

In the Netherlands, the term “euthanasia” means the termination of life upon request.² In practice however, the term is sometimes used to indicate both “euthanasia proper” (the termination of life upon request by a medical doctor through direct injection) and PAS (the provision of lethal medication to the patient for self-administration upon request). The reason for this definitional flexibility is that Dutch law does not draw any distinction between the two practices in terms of how they are legally justified.³ That is, both practices will be considered legal if carried out by a doctor who has acted

² Note: Killing a person without an individual’s express request, while possibly justifiable, is not ‘euthanasia’ but rather, in Dutch discussion is called, ‘termination of life without an explicit request.’ Such activity will generally be prosecuted as murder. Euthanasia in the Netherlands also excludes other life-shortening medical practices that are generally considered to be within the bounds of “normal” medical practice namely: withholding or withdrawing life prolonging treatment either on the basis of futility or in order to honour the patients refusal of treatment; and the administration of medically-indicated doses of pain relief with life shortening effect. John Griffiths, Heleen Weyers and Maurice Adams, *Euthanasia and Law in Europe* (Hart Publishing 2008) 76 (Griffiths, Weyers and Adams).

³ *ibid* 77. See also discussion in Else Borst-Eilers, ‘Euthanasia in the Netherlands: Brief Historical Review and Present Situation’ in Robert I. Misbin (ed), *Euthanasia: The Good of the Patient, the Good of Society* (Univ Pub Group 1992) 58; See also statement by the Royal Dutch Medical Association, which identifies a position that there is no difference between euthanasia and assisted suicide. Koninklijke Nederlandse Maatschappij Ter Bevordering Der Geneeskunst, *Standpunt inzake euthanasia [Vision on Euthanasia]* (1984) 39 Medisch Contact 990-8 (KNMG, Vision on Euthanasia).

on a patient's express request and has adhered to the requirements of due care (discussed further below).

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

a. Historic Overview

In April 2002, with the passing of the *Termination of Life on Request and Assisted Suicide (Review Procedures) Act* ("the Dutch Law of 2002"),⁴ the Netherlands became the first country to formally effect through statute, the practice of euthanasia.

Prior to 2002, however, the Netherlands Supreme Court had already effectively legalized euthanasia practice in the 1984 *Schoonheim* case,⁵ where the Supreme Court held that notwithstanding the absolute prohibition of the practice in the Dutch Penal Code, euthanasia by a physician might be legally justifiable on the basis of "necessity" or "overmacht" (discussed in more detail below).⁶ Furthermore, even before the clear articulation of the necessity defence by the Supreme Court in *Schoonheim*, many physicians were not being prosecuted for euthanasia practice on the basis that they had met the requirements of "careful practice"⁷ – requirements that had been developed, refined and articulated over the course of two decades through Dutch courts,⁸

⁴ *Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding* [Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002]. Staatsblad van het Koninkrijk der Nederlanden 2001;194 The Law of 2002 was tabled in 1999, passed in 2001 and entered into force on 1 April 2002. <wetten.overheid.nl/BWBR0012410/geldigheidsdatum_10-02-2009> accessed 31 May 2012. An English translation is available at KU Leuven <www.kuleuven.be/ep/viewpic.php?LAN=E&TABLE=EP&ID=58> accessed 31 May 2012 (The Dutch Law of 2002).

⁵ Supreme Court, 27 November 1984, *Nederlandse Jurisprentie* 1985, no 106 (*Schoonheim*). In this case, Dr. Schoonheim gave a lethal injection to his patient, Mrs. Barendregt, upon her repeated requests. Mrs. Barendregt was 95-years-old and although not suffering from a terminal illness, she was bedridden, experienced dizziness and had great difficulty seeing and hearing. A full English translation of the case can be found in J Griffiths, A Bood and H Weyers, *Euthanasia and Law in the Netherlands* (Amsterdam University Press 1998) 322-8 (Griffiths, Bood and Weyers).

⁶ *Schoonheim* *ibid* 459.

⁷ Netherlands Ministry of Security and Justice, *Euthanasia and assisted suicide control act takes effect on 1 April 2002* (Press Release, 26 March 2002).

⁸ *Nederlandse Jurisprudentie* 1973, no. 183 (*Postma*). The 1973 case of Dr. Geertruda Postma is considered to be the genesis of the Dutch debate on Euthanasia. E Vermeersch, 'The Historical and Ethical Background: The Belgian Law on Euthanasia' (2002) 102 *Acta chir belg* 394, 394 (Vermeersch); See also B Sneiderman and M Verhoef, 'Patient Autonomy and the Defence of Medical Necessity' (1996) 34 *Alberta Law Review* 374, 385 (Sneiderman and Verhoef). Acting on her 78-year-old mother's repeated requests, Dr. Postma injected her

prosecutorial practices⁹ and professional guidelines such as those issued by the Royal Dutch Medical Association (“KNMG”).¹⁰

By the 1990s, an intricate pre-statutory regulatory scheme had emerged. For example, a non-prosecution agreement entered into by the KNMG’s executive board and the Dutch Ministry of Justice set out due care criteria and reporting requirements to be followed by physicians who were providing euthanasia to their patients.¹¹ Additionally, to encourage doctor reporting of these “non-natural” deaths, the Dutch government established five Regional Review Committees to act as a type of “buffer” between the physician and the public prosecutor.¹² These committees were tasked with assessing whether a case of euthanasia was in compliance with the due care

mother with a lethal dose of morphine. Her mother was suffering from partial paralysis, deafness and incontinence. Dr. Postma was found guilty of killing on request, a violation under the Penal Code. The Leewarden District Court acknowledged that in certain situations, doctors are not required to prolong a patient’s life and that it may be permissible to administer pain relief at the risk that death might be hastened, provided certain conditions were met, i.e. incurable illness; unbearable suffering; and request by the patient. The court did not find Dr. Postma’s decision to be reasonable, sentencing her to a suspended sentence of one week’s imprisonment and one year of probation.

In the 1982 Wertheim case, Mrs. Wertheim, a euthanasia activist and volunteer, assisted the suicide of a 67-year-old woman suffering from physical and mental conditions. The district court articulated that in certain situations, assistance with suicide might be justified. These included: unbearable suffering; enduring desire to die; and no alternatives for relief. The court also identified procedural safeguards that should be met: assistance by physician and consultation. Mrs. Wertheim was not a doctor and was therefore found guilty of assisted suicide and given a six month conditional sentence subject to one year of probation and two weeks house arrest. *Nederlandse Jurisprudentie* 1982, no. 63:223 (*Wertheim*); See also discussion of additional Dutch cases in Griffiths, Bood and Weyers (n 5) 63-5 and in Sneiderman and Verhoef (n 8) ibid 388-92 .

⁹ Because of cases such as *Postma* and *Wertheim* (n 8), the College of Procurators-General (the highest authority in the prosecutorial system) made a policy decision that the determination of whether to prosecute cases of euthanasia were only to be made by the College based on the guidelines and criteria emerging from the courts. See discussion in Griffiths, Bood and Weyers (n 5) ibid 58-60; See also discussion in Griffiths, Weyers and Adams (n 2) 30; See also *Admiraal* case where Dr. Admiraal, an anesthetist performed euthanasia to a patient with multiple sclerosis suffering from a state of total physical dependency. The court found that Dr. Admiraal had made a justifiable choice and was in compliance with the requirements of careful practice. *Nederlandse Jurisprudentie* 1985, no. 709 (*Admiraal*). Following the *Admiraal* case, the Ministry of Justice advised that doctors who were in compliance with the “requirements of careful practice” would be exempt from prosecution for euthanasia. For full discussion see Griffiths, Bood and Weyers (n 5) ibid 66-67 and John Keown, *Euthanasia, Ethics and Public Policy: An Argument Against Legalization*, (Cambridge University Press 2002) 83-6 (Keown).

¹⁰ For example, following the *Postma* case (n 8) the Royal Dutch Medical Association (KNMG) issued a report in 1973 accepting euthanasia in cases where there was no other relief for extreme suffering. Royal Dutch Medical Association, *The Problem of Euthanasia* (1973) 28 *Medisch Contact* 857. KNMG, *Vision on Euthanasia* (n 3); For a discussion see Guenter Lewy, *Assisted Death in Europe and America* (Oxford University Press, 2011) 19 (Lewy); see also discussion in Sneiderman and Verhoef (n 8) 385.

¹¹ Johan Legemaate, ‘Twenty-five Years of Dutch Experience and Policy on Euthanasia and Assisted Suicide: An Overview’ in David C Thomasma (ed) *Asking to Die: Inside the Dutch Debate about Euthanasia* (Kluwer Academic Publishers 1998); See also KNMG, *Vision on Euthanasia* ibid.

¹² Griffiths, Weyers and Adams (n 2) 32; Lewy (n 10) 25.

requirements. The public prosecutor in turn would take the committee reports into account when making a determination on whether to proceed with a criminal investigation and prosecution. A project entitled, Support and Consultation in the Netherlands (“SCEN”) was also implemented throughout the Netherlands to train physicians to act as consultants to other physicians considering euthanasia requests from their patients.¹³ Under SCEN, consultant physicians provide consulting physicians with information and advice and assist in ascertaining whether the requirements of careful practice are being met.¹⁴

The Dutch assisted death scheme was therefore able to evolve despite clear prohibitions on the practice in the Dutch Penal Code. Prior to 2002, the provisions of the Dutch Penal Code¹⁵ relevant to euthanasia and assisted suicide in the Netherlands were as follows:¹⁶

- Article 289: Anyone who deliberately and wilfully takes another person’s life is guilty of murder. The maximum sentence is life imprisonment.
- Article 293: It is an offence for anyone to take the life of any person at his express and serious request. The maximum sentence is twelve years imprisonment.
- Article 294: He who deliberately incites another to commit suicide, assists him to do so, or provides him with the means of doing so, commits an offence if the suicide takes place. The maximum sentence is three years’ imprisonment.
- Article 40: It is a defence to a criminal charge if the accused was forced by overmacht [circumstances beyond one’s control] to commit an offence.

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

¹³ MC Jansen-van der Weide, BD Onwuteaka-Philipsen and G van der Wal ‘Implementation of the project ‘Support and Consultation on Euthanasia in the Netherlands’ (SCEN)’ (2004) 69(3) Health Policy 365, 366 (Jansen-van der Weide 2004 study).

¹⁴ *ibid*; see also discussion of use of SCEN consultants in Regional Euthanasia Review Committee, *Regional Euthanasia Review Committee: 2009 Annual Report* (2009) 8 <[http://www.euthanasiecommissie.nl/Images/JVeuthanasie%202009%20Engels%20DEF%20\(EU16.01\)_tcm52-30367.pdf](http://www.euthanasiecommissie.nl/Images/JVeuthanasie%202009%20Engels%20DEF%20(EU16.01)_tcm52-30367.pdf)> accessed 31 May 2012 (2009 RRC Annual Report).

¹⁵ Wetboek van Strafrecht [Dutch Penal Code] Titel XIX. Misdrijven tegen het leven gericht (Dutch Penal Code).

¹⁶ English Translation of Dutch Penal Code provisions from Sneiderman and Verhoef (n 8) 375.

Since 1923 this provision had been interpreted to include the defence that the act took place in a situation of necessity in which the actor made a justifiable choice between two conflicting duties. Based on this existing doctrine, the Supreme Court held in *Schoonheim* that a doctor, confronted by the request of a patient who is unbearably and hopelessly suffering, can be regarded as caught in a situation of conflict of duties. On the one hand, there is a duty to respect life, as reflected in articles 293 and 294 of the Penal Code. On the other hand, there is the doctor's duty to relieve suffering. If in such situation of conflict of duties, the doctor chooses a course of action that, considering the norms of medical ethics, is 'objectively' justifiable, he is not guilty of an offence ...¹⁷

Hence, in the Netherlands, euthanasia developed into a permissible course of action if the physician experienced a conflict of duties – the duty to respect life and the duty to relieve suffering. It would appear, in this formulation that the duty to “respect life” is also a duty to “protect life” otherwise the conflict as articulated, would be less perceptible. Under these circumstances, the physician must, out of *necessity*, make a choice and the choice must be objectively justifiable. Thus, it is the physician's conflict of duties that “forms the basis of the justification of necessity” and which is codified in the Dutch Law of 2002.¹⁸

Accordingly, the legality of euthanasia in the Netherlands is grounded in the duties that a physician has to his or her patient.¹⁹ On its face, this policy foundation functions as an important limit on assisted death practices not involving a similar conflict of professional duties.²⁰ Moreover, the legitimacy of the physician's assistance in dying that arises from this formulation of professional duty and competence also necessitates that the type of suffering that can be properly relieved by a doctor is suffering arising out of a *medically classifiable* disorder – physical or psychiatric.

b. Legislative Framework

The Dutch Law of 2002 is for the most part a codification of the rules of careful practice developed over the years and, in principle, euthanasia remains punishable under Articles 293 and 294 of the Dutch Penal Code. The Dutch Law of 2002

¹⁷ Griffiths, Weyers and Adams (n 2) 77. For further discussion on the interplay between the courts' treatment of the *Schoonheim* case and political discussion and emerging policy statements and guidelines from professional bodies such as the KNMG and the Association of Nurses see Lewy (n 10) 21-2.

¹⁸ Griffiths, Weyers and Adams (n 2) 33, 41; For full discussion of the evolution of the defence of necessity in Dutch case law with respect to euthanasia, see Sneiderman and Verhoef (n 8).

¹⁹ The necessity underpinning to the assisted death scheme in the Netherlands is reiterated in the most recent report of the KNMG. Koninklijke Nederlandsche Maatschappij tot Bevordering der Geneeskunst, *The Role of the Physician in the Voluntary Termination of Life* (KNMG June 2011) (KNMG 2011 Position Paper); For critique of necessity defence see Keown (n 9) 84 et seq.

²⁰ Griffiths, Weyers and Adams (n 2) 49.

however, amends these articles by providing physician immunity from criminal liability when a physician has complied with the statutory due care criteria and the reporting requirements pursuant to the Law of 2002.²¹

i. *Due Care Requirements*

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

- a. holds the conviction that the request by the patient was voluntary and well considered;
- b. holds the conviction that the patient’s suffering was lasting and unbearable;
- c. has informed the patient about the situation he was in and about his prospects;
- d. and the patient hold the conviction that there was no other reasonable solution for the situation he was in;
- e. has consulted at least one other, independent physician who has seen the patient and has given his written opinion on the requirements of due care, referred to in parts a – d; and
- f. has terminated a life or assisted in a suicide with due care.

The due care requirements are generally understood as being comprised of both “substantive” and “procedural” criteria despite the fact that the legislator failed to make this distinction.²² Substantive criteria are concerned with the conditions that “qualify the patient as a candidate”²³ i.e., “the patient’s request, the patient’s suffering and the doctor-patient relationship”.²⁴ Therefore the substantive criteria include: voluntariness, competency and a free and informed request;²⁵ that it is a medical

²¹ The Dutch Law of 2002 (n 4) art 20.

²² For further discussion on the impact of this failure to distinguish, see Griffiths, Weyers and Adams (n 2) 82-4.

²³ Barney Sneiderman, ‘Euthanasia Safeguards: Legal and Socio-Political’ in Barney Sneiderman and Joe Kaufert (eds) *Euthanasia in the Netherlands: A Model for Canada?* (Legal Research Institute 1994) 100 (Sneiderman, Safeguards).

²⁴ Griffiths, Weyers and Adams (n 2) 78.

²⁵ Implementation of the request criteria over the years has demonstrated that requests must be: specific, directly made and timely; well-informed (full and open discussion between physician and patient); and internally and externally voluntary i.e. mental capacity and free from external pressures or influence, respectively. In the case of psychiatric illness or disorder, great caution must be taken in assessing voluntariness and competence and consultation with a psychiatric expert is required. A patient suffering from depression may not have decisional competence and if there is any doubt, consultation with a psychiatrist in addition to an independent physician is advisable. Similar caution is to be exercised in case of dementia. See also discussion in Compassion and Suffering, Autonomy and Self-Determination in Chapter III.B.1.iii. below.

Advance written directives are also permissible in the case of a patient who is no longer competent as well as for those who are competent. In the case of a competent patient, while a written directive may be helpful, it is not required. The physician should

measure of last resort because the suffering has become unbearable; and there are no other reasonable solutions for improvement (these latter two criteria discussed further below). With respect to the doctor-patient relationship, while the legislative provisions do not expressly require the attending physician to have a medical treatment history/relationship with the patient, the Regional Review Committees have identified that there must be a doctor-patient relationship that will allow the doctor to form a judgment concerning the requirements of due care.²⁶

The procedural safeguards on the other hand are “mechanisms designed to ensure that the substantive criteria are in fact satisfied.”²⁷ Thus the procedural criteria include consultation with an independent consultant²⁸ and that the termination of life or assisted suicide be carried out with due care i.e., in a professionally responsible manner with appropriate attention to the patient. A “professionally responsible manner” has been interpreted to include: use of the appropriate method, substance and dosage as recommended by professional guidelines; that the physician stay with the patient until death occurs, or, in the case of PAS, that the physician hand the euthanatics to the patient and remain until patient pronounced dead in case complications arise which might then indicate that euthanasia be administered.²⁹

It should be pointed out that the lines between substantive (qualification as a candidate for AD) and procedural due care requirements (safeguards in place to make sure patients are indeed qualified) are often unclear. For example, while the Netherlands appears to position the physician-patient relationship within that which qualifies a patient (conceptually tying into the physician conflict and necessity defence), other jurisdictions, as will be seen, position the physician-patient relationship more towards the procedural due care requirements, i.e. in order to ensure that a patient’s voluntary request is indeed voluntary, for example.

however record in detail, discussions with patient regarding the patient’s wish for termination of life and the decision-making process. 2009 RRC Annual Report (n 14) 9-12.

²⁶ See for example, Regional Euthanasia Review Committee, *Regional Euthanasia Review Committee: 2005 Annual Report* (2005) 27; Note: this also appears to be the basis for the position taken by the Ministry of Justice that Euthanasia is only available to residents. Ian Ireland, ‘The Netherlands Euthanasia Legislation’, Research Note 31 2000-01 (22 May 2001) <www.aph.gov.au/library/pubs/rn/2000-01/01RN31.htm> accessed 31 May 2012 (Ireland). The 2009 RRC Annual Report does not describe this relationship as strongly. 2009 RRC Annual Report (n 14) 7.

²⁷ Sneiderman, Safeguards (n 23) 100.

²⁸ This is interpreted as including consultation with an independent physician (independent of physician and patient) who will give an expert opinion on whether the due care criteria have been fulfilled in a timely manner and will see the patient to determine if the consulting physician has overlooked anything regarding due care criteria. 2009 RRC Annual Report (n 14) 29. See also discussion on suffering criteria below in Chapter III.B.1.c below.

²⁹ 2009 RRC Annual Report *ibid* 36-8, 42-3.

With respect to patients who are minors, the Dutch Law of 2002 allows physicians to provide euthanasia to minors as young as 12 provided they are “deemed to have a reasonable understanding of his interests.”³⁰ For a minor between the ages of 16 and 18, in addition to the patient having a reasonable understanding of his or her interests, a physician may grant a request for euthanasia provided that the patient’s parents or guardian have been “involved in the decision-making process” but they do not necessarily have to agree with the decision.³¹ With respect to minors between the age of 12 and 16, however, the parents or guardian must agree with the request for euthanasia.³²

There is no express requirement that the patient be a Dutch citizen or resident, relying instead on the doctor-patient relationship to restrict euthanasia to appropriate candidates.³³

ii. *Reporting and Review*

The Dutch Law of 2002, establishes reporting requirements through amendments to the *Burial and Cremation Law*.³⁴ When death is the result of a termination of life on request (euthanasia proper) or assisted suicide, the attending physician must, in appropriate form, notify and provide a detailed written report to the relevant municipal pathologist showing that he or she has complied with the due care criteria.³⁵ The pathologist in turn is required to conduct an examination of the deceased patient, determine cause of death, substances used, ascertain completeness of the physician’s report, compile findings, reports, advance directives (if any), and notify the relevant Regional Review Committee (RRC) submitting all required and relevant documents.³⁶

The five RRCs hold the major responsibility for reviewing euthanasia cases. Each RRC must be comprised of an uneven number of members, and at minimum must

³⁰ The Dutch Law of 2002 (n 4) art 2.

³¹ *ibid* art 2.3.

³² *ibid* art 2.4.

³³ Ireland (n 26).

³⁴ The Dutch Law of 2002 (n 4) art 21.

³⁵ Current reporting model is available on the RRC website <www.toetsingscommissieseuthanasie.nl/en> accessed 31 May 2012; See also 2009 RRC Annual Report (n 14) 44.

³⁶ The Dutch Law of 2002 (n 4) art 21.C. The relevant RRC is determined by place of death. For detailed description see Regional Euthanasia Review Committee, ‘Procedure’ <www.euthanasiecommissie.nl/procedure/> accessed 31 May 2012 and Ministry of Health, Welfare and Sport document, ‘Euthanasie: zorgvuldig van begin tot einde’ [Euthanasia: carefully from beginning to end] (11 December 2010) 4.3 <www.rijksoverheid.nl/onderwerpen/euthanasie/documenten-en-publicaties/publicaties-pb51/euthanasie-zorgvuldig-van-begin-tot-einde.html> accessed 31 May 2012.

include a lawyer, a physician and an ethics or philosophy expert.³⁷ An RRC determines whether a doctor has conducted “careful” practice by acting in accordance with the statutory due care criteria³⁸ and is to report its findings, with reasons, back to the doctor.³⁹

The most significant change from the pre-statutory rules is the expanded authority of the RRCs. Prior to the Dutch Law of 2002, the RRCs simply played an advisory role by providing their opinion to the public prosecutor as to whether the due care requirements had been met in a given case. Under the Dutch Law of 2002 however, the initial review by the RRC of a reported case of euthanasia lies entirely outside the criminal law system. It is only when an RRC has determined that the due care requirements have not been met, that the public prosecutor is notified.⁴⁰ The public prosecutor then has the authority to commence a criminal investigation. Therefore if the RRC forms the opinion that the due care criteria have been met in a particular case, the case will not be reviewed any further.

The RRCs are required to issue a joint annual report which includes information related to the number of reported cases of termination of life on request and assisted suicide, the nature of the cases and the opinions and considerations involved.⁴¹ The RRCs are the principal source of information for ongoing public debate and awareness as well as for the ongoing transparency in the development of Dutch euthanasia law.⁴²

c. Compassion and Suffering, Autonomy and Self-Determination

As described above, the type of suffering that can be relieved by a physician under the Dutch Law of 2002 is suffering that arises out of *any* medically classifiable disease or condition.⁴³ That said, the medical condition does not have to be considered “terminal” or in a terminal phase. So, for example, a condition such as multiple sclerosis would qualify for assistance, provided the suffering is unbearable, lasting and with no other reasonable solution. Furthermore, requisite suffering can arise from a somatic (physical) or non-somatic (non-physical) disease or condition such as a

³⁷ The Dutch Law of 2002 *ibid* art 3.

³⁸ *ibid* arts 3 and 8.

³⁹ *ibid* art 9.

⁴⁰ *ibid* arts 8-10.

⁴¹ *ibid* art 17.

⁴² See 2009 RRC Annual Report (n 14), the Regional Euthanasia Review Committee, *Regional Euthanasia Review Committee: 2008 Annual Report* (2008) (2008 RRC Annual Report) and the Regional Euthanasia Review Committee, *Regional Euthanasia Review Committee: 2007 Annual Report* (2007) <www.euthanasiecommissie.nl/en/review-committees/> accessed 31 May 2012 (the RRC Annual Reports).

⁴³ The Brongersma Case, *Nederlandse Jurisprudentie* 2003, no. 167 (*Brongersma*).

psychiatric condition.⁴⁴ Justifiable suffering can also arise as the result of a combination of conditions that overwhelm the patient to the extent that suffering becomes unbearable.⁴⁵

Psychiatric patients or patients with early stage dementia, provided they are competent and have made a voluntary request, can receive assistance with suicide as long as the physician proceeds with great caution.⁴⁶ It should be pointed out that in practice, however, there exists an assumption that physicians are only permitted to provide PAS (and not euthanasia) in cases of non-somatically based medical disorders,⁴⁷ notwithstanding the lack of legal distinction between the justifiability of euthanasia and PAS as earlier discussed.

Prior to and pursuant to the Dutch Law of 2002, the requisite suffering must be both unbearable and lasting, with no other reasonable solution.⁴⁸ The notion of assessing unbearable suffering poses practical difficulties as suffering is both a highly subjective experience and potentially prospective or anticipatory in nature – for example, when it takes the form of fear of a loss of dignity and/or fear of increasing physical debilitation and dependency. While the acceptance of non-somatic suffering might resolve some of the subjectivity dilemma, it does not resolve the dilemma with respect to anticipatory suffering which can be the case where the individual has been diagnosed with a progressively debilitating disease such as multiple sclerosis, amyotrophic lateral sclerosis, Parkinsons Disease or Alzheimers at its beginning stages – when suffering may not as yet have become “unbearable”. Another situation that raises a similar conundrum is that of a patient who has made a request for euthanasia in an advance statement but is currently in a coma or suffering from dementia. The patient at that point is arguably not suffering unbearably if at all because of the apparent lack of awareness of their physical deterioration.⁴⁹

⁴⁴ The Chabot Case, *Nederlandse Jurisprudentie* 1994, no. 320 (*Chabot*). In this case the Supreme Court ruled that a physician could lawfully assist a patient who was suffering from a non-somatic medical condition, but only in exceptional circumstances. Dr. Boudewijn Chabot was found guilty of assisted suicide for assisting the death of his patient, 50-year-old Hilly Bosscher who was suffering from inconsolable grief after the successive deaths of her two sons. After numerous consultations with other doctors (none of whom though had actually examined the patient), Dr. Chabot determined that Mrs. Bosscher was experiencing intense, psychic suffering with no prospect of improvement and provided the means for her to commit suicide. Lewy (n 10) 48; See also extensive discussion of the case in Sneiderman and Verhoef (n 23) 398 et seq.

⁴⁵ 2009 RRC Annual Report (n 14) 6.

⁴⁶ Extra precautions must be taken in these situations in order to ensure that patient voluntariness in these circumstances. See (n 25) and 2009 RRC Annual Report (n 14) 7,11; See also *Chabot* (n 44).

⁴⁷ Griffiths, Weyers and Adams (n 2) 107 and 113.

⁴⁸ The Dutch Law of 2002 (n 4) arts 2.1.b and 2.1.d.

⁴⁹ See discussion in Griffiths, Weyers and Adams (n 2) 90.

With respect to the general difficulty in assessing suffering on account of its subjective nature, the RRCs have resolved the dilemma by identifying that unbearable suffering is to be assessed objectively - it must be understandable or “palpable” to a physician.⁵⁰ With respect to anticipatory suffering, “unbearable” is again qualified by what is “palpable” to the physician.⁵¹ The RRCs and prosecutorial guidelines have come to identify that requisite grounds of suffering are not only comprised of pain, but also include “fear of future suffering”⁵² related to personal deterioration, immobility, dependency, suffocation and other circumstances that “increase the prospects of not being able to die in a dignified manner.”⁵³

With respect to the suffering of an unconscious or unaware patient, the Dutch Law of 2002 has addressed this directly by expressly allowing a physician to provide euthanasia to an incompetent patient (“no longer capable of expressing his will”) pursuant to an advance written statement, so long as it was made by the patient when the patient was still competent (“deemed to have a reasonable understanding of his interests”).⁵⁴ The physician is still obligated to comply with all due care requirements in this circumstance.⁵⁵ In sum, competency does not have to temporally coincide with suffering, and suffering does not actually have to manifest, keeping in mind that a medical condition is always required.

The requirement that suffering be “lasting” and “without a reasonable solution” has posed the least interpretive difficulty. The RRCs have interpreted this requirement to mean that the condition causing the suffering is incurable and that “there is no realistic prospect of alleviating the symptoms.”⁵⁶ In determining whether symptoms can be “realistically” relieved, any improvements that might be achieved by treatment are to be balanced against the burden that such treatment might place on the patient.⁵⁷ Thus, symptom relief is to be assessed from the patient’s perspective.

⁵⁰ “The question here is not whether people in general or the physician himself would find suffering such as the patient’s unbearable, but whether it is unbearable to this specific patient.” 2009 RRC Annual Report (n 14) 22.

⁵¹ *ibid* 7, 24; Compare with discussion in Tony Sheldon, ‘Dutch Approve Euthanasia for a Patient with Alzheimer’s Disease’ (2005) 330 *British Medical Journal* 1041 (Sheldon).

⁵² 2009 RRC Annual Report (n 14) 24 and Cases 4, 5 and 6.

⁵³ *Aanwijzing vervolgingsbeslissing inzake actieve levensbeëindiging op verzoek (euthanasie en hulp bij zelfdoding)* [Note prosecution decision on euthanasia on request (euthanasia and assisted suicide)] 23 December 2003 *Staatscourant* No. 248, 19; See also Griffiths, Weyers and Adams (n 2) 89, 92.

⁵⁴ The Dutch Law of 2002 (n 4) art 2.2.;

⁵⁵ For further discussion on assessing unbearable suffering in comatose patients and where euthanasia may be justified see 2009 RRC Annual Report (n 14) 24-5.

⁵⁶ *ibid* 22.

⁵⁷ *ibid*.

This balancing of available treatment options is also in keeping with and perhaps also extended by the legal doctrine of informed consent and the right of the patient to refuse treatment. Thus euthanasia will not be denied if the patient who is suffering unbearably⁵⁸ refuses treatment that could alleviate his or her suffering, provided that the refusal is “reasonable” or “acceptable” in the circumstances.⁵⁹ As expressly required by the Dutch Law of 2002, a physician must discuss the patient’s situation and prospects with the patient but whether there exists a solution for the patient’s situation is again dependent upon the patient’s “conviction”, not the doctor’s, as to what is reasonable.⁶⁰

The doctor-centered approach that underlies the justification for the Dutch practice of euthanasia and PAS reflects how the general notion of autonomy is not a central value to AD practice either as developed by the courts or indeed under the Dutch Law of 2002 which makes absolutely no mention of autonomy or self-determination. Again, the codification of euthanasia practice in the Dutch Law of 2002 stems from an acknowledgment that the physician must necessarily make a choice – a choice that will have to be justified – if faced with a conflict of duties – the duty to protect life versus the duty to relieve suffering.⁶¹ Self-determination is not the grounding principle underlying legalization of assisted death in the Netherlands; it is only a “precondition for the doctor’s behaviour, in the sense that relief of suffering in such a drastic way is usually done at the explicit and well-considered request of the patient.”⁶² Thus, a marker of the Netherlands’ scheme is the distinction between autonomy/self-determination *qua* consent to relief of suffering and autonomy/self-determination as potential driver for the legality of assisted death.

Hence, the scope of assisted death practice based on the autonomy principle in the Netherlands’ AD law can be located where a request for death intersects with the doctor’s conflicting duties and might be conceptualized as follows:

⁵⁸ This will be the case for non-somatic as well as somatic based suffering despite the Supreme Court’s earlier decision in *Chabot* (n 44) that in principle, suffering will not be legally considered to be lacking any prospect for improvement when the person has refused a realistic therapeutic alternative.

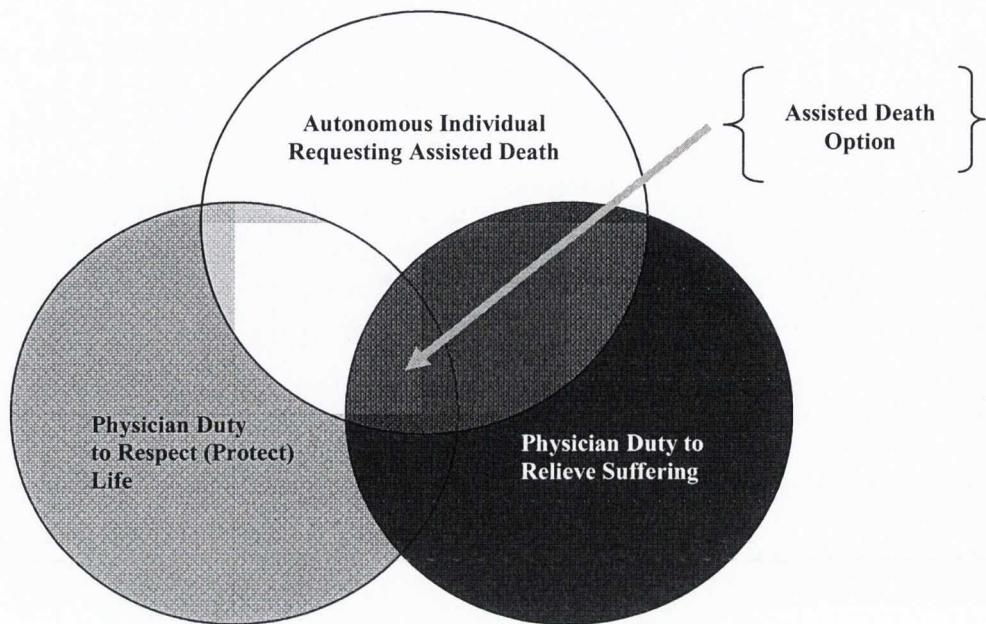
⁵⁹ 2009 RRC Annual Report (n 14) 26 and case 10. A recent 2005 study of 158 reported cases indicated that in 35% of the cases there had been alternatives to relieve the patient’s suffering but were not applied. In 81% of the cases where alternatives available the patients had refused them. Additionally, the review committees relatively often scrutinized the consultation (41%) and suffering (32%); they rarely scrutinized possible alternatives (1%). H Buiting, J Van Delden, B Onwuteaka-Philipsen, and others, ‘Reporting of euthanasia and physician-assisted suicide in the Netherlands: Descriptive Study’ (2009) 10(18) BMC Medical Ethics 2, 9, 12, 13 (Buiting).

⁶⁰ The Dutch Law of 2002 (n 4) arts 2.1.c and 2.1.d.

⁶¹ KNMG 2011 Position Paper (n 19) 6.

⁶² Griffiths, Weyers and Adams (n 2) 49.

Figure 2: AD Advanced through Conflicting Duties of Physician



Significantly, this foundational formulation (i.e. that a physician may be justified in terminating the life of a patient on the basis of “necessity”) allows the scope of the medical choice made by the physician to be interpreted more broadly and thus in turn allows for the medical practice of both euthanasia and PAS. On the other hand, this construction constrains assisted death practice by imposing a medical professional judgment filter. On the other hand, because of the suffering component, some have argued that this approach may also have the effect of increasing the scope of AD practice to cases of suffering that are not clearly linked to a specific enumerated medical or psychiatric condition because of the reliance on individual physician interpretations of concepts of “disease” and “justifiable” suffering.⁶³

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

As the criterion of unbearable and hopeless suffering is extended, the request of the patient becomes the central issue and the medical professional judgment disappears to the background. Such a route leads ultimately to self-determination, as the NVVE [Dutch Voluntary Euthanasia Society] calls it ... This differs from our ideas about how to deal with death ... and the role doctors play.⁶⁴

⁶³ *ibid* 37-8; See also *Chabot* (n 44).

⁶⁴ Griffiths, Weyers and Adams (n 2) 36 citing Trouw, 2 November 2000.

Not long after this statement however, the Dutch Supreme Court in 2002, ruled on the case of Dr. Sutorius who had provided euthanasia to his patient, 86-year-old former Labour Party senator, Edward Brongersma. Although Mr. Brongersma had a number of age-related conditions such as incontinence and loss of balance, the Supreme Court found that Mr. Brongersma's suffering did not arise primarily out of a medically classifiable disease or disorder but rather arose because his life had become "meaningless". In other words, his suffering was primarily existential. According to the Supreme Court, if a doctor provides euthanasia in this type of situation, the doctor will be acting outside the scope of his domain of expertise. The court did not however impose any penalty on Dr. Sutorius.⁶⁵

Notwithstanding the position taken by the Supreme Court in the 2002 *Brongersma* case, the apparent exclusion of euthanasia for emotional, existential or life-fatigue suffering exists without full professional consensus in the Netherlands and tensions continue to expand.⁶⁶

It is important to underscore that the medical conflict of duties policy behind the statutory legalization of euthanasia in the Netherlands is not expressly acknowledged in the Dutch Law of 2002 although in a recent KNMG 2011 policy paper, the medical conflict of duties foundation is strongly re-asserted, discussed in more detail below.⁶⁷

Regardless, the Dutch Law of 2002 (as is the case with all the AD laws under review in this paper) does not provide patients with an absolute right to assisted death; physicians are not under a duty to provide euthanasia - they can and do refuse.⁶⁸ If they refuse however, physicians appear to be under an obligation to refer their patient to

⁶⁵ *Brongersma* (n 43). Although the District Court acquitted Dr. Sutorius, he was later found guilty by the Court of Appeals in 2001 which was upheld by the Supreme Court in 2002 (though no punishment was imposed).

⁶⁶ See JH Dijkhuis, *Searching for Norms for Physician Intervention When Help is Requested to End Life in Case of Emotional Suffering* (Report, Dijkhuis Commission). Report recommended that life fatigue be a valid reason for euthanasia with physician decision-making on a case by case basis; See also discussion in Tony Sheldon, 'Dutch euthanasia law should apply to patients "suffering through living," report says' (2005) 330(7482) *British Medical Journal* 61 (Sheldon, *Suffering through Living*); KNMG 2011 Position paper (n 19) 12.

⁶⁷ KNMG 2011 Position paper *ibid* 6.

⁶⁸ Ilinka Haverkate, Bregje D Onwuteaka-Philipsen, Agnes van der Heide and others, 'Refused and Granted Requests for Euthanasia and Assisted Suicide in the Netherlands: Interview Study with Structured Questionnaire' (2000) 321 *British Medical Journal* 865; MC Jansen-van der Weide, BD Onwuteaka-Philipsen, G van der Wal, 'Granted, Undecided, Withdrawn, and Refused Requests for Euthanasia and Physician-Assisted Suicide' (2005) 165(15) *Archives of Internal Medicine* 1698-1704; See however discussion on position taken by in a recent 2012 report by a Royal Society of Canada Expert Panel in Chapter IV.C.3.iii.

another doctor.⁶⁹ Furthermore, the KNMG has also from time to time informally indicated that it believes euthanasia should indeed be available to all patients.⁷⁰

Finally, it ought to be pointed out that in the Netherlands, a national health insurance scheme provides broad and extensive coverage to all Dutch citizens. National health insurance is “regarded by the Dutch as the cornerstone of their euthanasia policy”,⁷¹ meaning that for the Dutch, euthanasia is perceived as a measure of last resort.⁷²

d. Statistics and Trends

According to the RRC 2010 Annual Report there were 3136 AD cases reported⁷³ up from 2636 AD cases reported for 2009. This number represents a “sharp increase” of 19% from 2009, which also saw an increase of 13.1% from 2008, where 2331 cases were reported.⁷⁴ According to the RRC, since 2006, notifications have been increasing by approximately 10% every year⁷⁵ and the trend has been apparent since 2003.⁷⁶ It is unclear whether the increase is an indicator of increased physician willingness to notify or whether there has been an increase in euthanasia numbers overall.⁷⁷ The position of the RRC in its 2010 report is that the cause of the continuing increase is “not known”.⁷⁸ An evaluation has been commissioned by the Dutch Health Ministry to determine the actual number of cases of euthanasia and the causes of the annual increases.⁷⁹

Of the 3136 AD cases reported in 2010, 2910 were euthanasia, 182 were PAS and 44 were a combination of both. The majority of reported cases involved the “classic”

⁶⁹ KNMG 2011 Position paper (n 19) 8.

⁷⁰ For further discussion see Griffiths, Weyers and Adams (n 2) 107-8 regarding statements by the Royal Medical College regarding obligations to the patient and that Euthanasia should be available to all eligible patients.

⁷¹ Sneiderman and Verhoef (n 8) 414.

⁷² See also KNMG 2011 Position paper (n 19) 6.

⁷³ Regional Euthanasia Review Committee, *Regional Euthanasia Review Committee: 2010 Annual Report* (2010) 3
<http://www.rtde.eu/sites/default/files/JV%20RTE%202010%20ENGELS%20%28EU12.01%29_tcm52-30364-1.pdf> accessed 31 May 2012 (2010 RRC Annual Report).

⁷⁴ The 2009 RRC Annual Report (n 14) 4.

⁷⁵ *ibid* 2.

⁷⁶ The 2008 RRC Annual Report (n 42) 3.

⁷⁷ See discussion in forewords of the 2009 RRC Annual Report (n 14) and the 2008 RRC Annual Report *ibid*.

⁷⁸ The 2010 RRC Annual Report (n 73) 3.

⁷⁹ The 2009 RRC Annual Report (n14) foreword. A similar assessment conducted in 2005, indicated that the increase in reported euthanasia from 2001 to 2005, was attributable to an increase in reporting compliance - from 54% of cases in 2001 being reported to 80% in 2005. See Ministry of Health Welfare and Sport, ‘Less cases of euthanasia’ (Press Release, 5 October 2007) <www.rijksoverheid.nl/onderwerpen/euthanasie> accessed 31 May 2012.

category of cases, that is, cancer (2548).⁸⁰ Other conditions involved: cardiovascular disease (158) (up from 54 in 2009); neurological disorders (75) (down from 131 in 2009); other conditions (237) (up from 168 in 2009); and a combination of conditions (118) (similar to 130 in 2009).⁸¹ In all notifications reviewed, it was found that suffering was connected with a recognized disease or disorder, with 2 notifications being connected with a mental illness or disorder.⁸²

In the majority of cases (2499), patients died at home.⁸³ Of the cases reported in 2010, the RRC only found nine (9) cases where the physician had not acted with due care.⁸⁴

In recent years, patient advocates and organizations (as well as supporters of the 2002 legislation) see the self-determination principle as the *de facto* justification underlying the legalization of euthanasia and PAS in the Netherlands, as opposed to only operating as a pre-condition to be met before assisted death can be contemplated as a medical option. On the basis that self-determination is the justification for the practice of AD, these groups are seeking expansion of the practices beyond medically-classifiable suffering, arguing that “respect for life” includes not just protecting life but also avoiding an “undignified” death.⁸⁵

This evidences a significant evolution in thinking from a justification of AD based on a physician’s conflicting duties (the duty to respect/protect life versus the duty to relieve suffering) to justification of AD based on the merging of these duties provoked by a re-conceptualization of respect for life not through the physician’s medical lens but rather through the patient’s dignity lens - a much more individual and subjective viewpoint capable of simultaneously reflecting both general autonomy ideals related to agency as well as normative views concerning the experience of indignity. This

⁸⁰ The 2010 RRC Annual Report (n 73) 34.

⁸¹ *ibid*; The 2009 RRC Annual Report (n 14) 48, Annexe I.

⁸² The 2010 RRC Annual Report (n 73) 13.

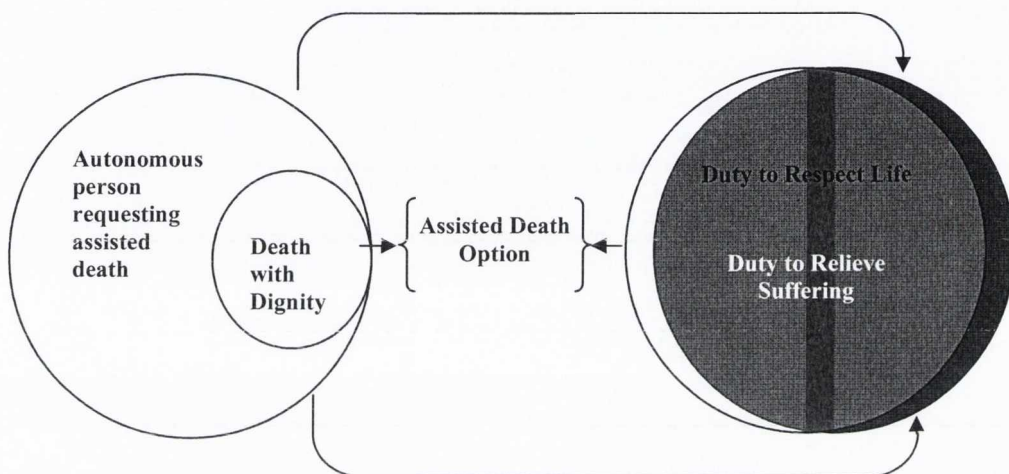
⁸³ The remainder of patients died in hospital (182), nursing home (109), care home, and elsewhere, for example, a relative’s home or hospice (219). The 2010 RRC Annual Report *ibid* 34.

⁸⁴ Of those 9 cases, 5 related to the way in which euthanasia or assisted suicide was performed. In all notifications reviewed, it was found that suffering was connected with a recognized disease or disorder, with 2 notifications being connected with a mental illness or disorder. *ibid*. This was the same figure reported for 2009. 2009 RRC Annual Report (n 14) 48, Annexe I. See also discussion 2009 RRC Annual Report *ibid* 9.

⁸⁵ See discussion in KNMG 2011 Position Paper (n 19) 12; See also discussion in Griffiths, Weyers and Adams (n 2) 33-49; Additionally some commentators observe the extension of euthanasia to non-somatic suffering as notably addressed in *Chabot* (n 44) is also an indicator of movement away from the doctor-centred approach towards individual-centred with greater weight on principle of autonomy. See discussion generally in G Bosshard, B Broeckaert, D Clark and others, ‘A Role for Doctors in Assisted Dying? An Analysis of Legal Regulations and Medical Professional Positions in Six European Countries’ (2008) 34(1) *Journal of Medical Ethics* 28, 28-32 (Bosshard); See also Sheldon, *Suffering through Living* (n 66).

integrated perspective, sets the foundation for both a potential expansion in the scope of the physician’s obligations to the patient, as well as for the potential expansion in the type of suffering that might justify assisted death.

Figure 3: Merging of physician duties compelled by patient perspective of death with dignity



The most visible activity from this integrated dignity perspective to date is the emergence of a Dutch citizens group that includes legal scholars, physicians and politicians, collectively known as Uit Vrije Will or the “By Free Will” initiative.⁸⁶ This organization has launched a petition to lobby the Dutch government to legalize access to assisted death on demand for people who have reached the age of 70 years or over who feel they have completed life.⁸⁷

In response to this increasing “vocal claim” to AD as part of a broader right to self-determination,⁸⁸ the KNMG recently and firmly re-iterated that the AD law in the

⁸⁶ Also translated as “Out of Free Will”. See Folkert Jensma, ‘Right to Die for Elderly Back at Centre of Dutch Debate’ *Radio Netherlands Worldwide (NRC)* (Netherlands, 9 February 2010); See also Bruno Waterfield, ‘Dutch plan to let healthy elderly people commit suicide’ *The Telegraph UK* (England, 10 March 2010).

⁸⁷ E Sutorius, J Peters and S Daniels S. ‘Proof of a Law’ (The Hague, Netherlands: Uit Vrije Wil) <<http://sparta.projectie.com/~uitvrije/index.php?id=1006>> Accessed 31 May 2012; ‘Tired of Life. Group calls for assisted suicide’ *Dutch News* (Netherlands, 31 January 2011); See also discussion in KNMG 2011 Position Paper (n 19) 12 which sees proposals by Uit Vrije Wil as problematic; See also discussion on “Drion’s Pill” in Lewy (n 10) where a former chairman of the Dutch Supreme Court published an article in 1991 advocating a pill be available to all those over the age of 75.

⁸⁸ KNMG 2011 Position Paper (n 19) 7.

Netherlands is established upon the medical conflict of duties noting that “there must be a medical basis in such cases, meaning that a patient must have a condition that is defined as a disease or combination of diseases/ailments”.⁸⁹ However, the KNMG also stated that the absolute criterion of the presence of a medically classifiable condition is not to be confused as the measure for assessing suffering.⁹⁰ Thus, the KNMG foresees a role for physicians in addressing the suffering of senior citizens “who voice a serious wish to die, even where this wish stems from the sense of having completed a life”⁹¹ as well as existential or psychosocial suffering.⁹² As explained by the KNMG, “vulnerability – extending to such dimensions as loss of function, loneliness and loss of autonomy – should be part of the equation physicians use to assess requests for euthanasia.”⁹³

Similarly, because suffering stemming from mental, psychosocial and spiritual ailments may require alleviation or remediation through palliative care, psychosocial or existential suffering properly falls within the medical domain.⁹⁴ According to the KNMG, the current statutory framework and concept of suffering is broader than present physician interpretation and application, but also recommends, among other things, the commencement of studies to chart the nature and scale of the AD issue as it relates to suffering that is not solely medical.⁹⁵

To summarize then, the essence of AD law in the Netherlands is the regulation of a medical activity, grounded in the defence of necessity. Therefore assisted death was (and continues to be from the perspective of the KNMG) considered an exceptional medical measure of last resort, with safeguards having been implemented to constrain AD to this circumstance, e.g. physician and patient nexus. In this way, the specific exercise of autonomy principally relates to decision-making surrounding treatment, with enhanced yet standard medical safeguards in place to ensure the voluntariness and competency of the patient in making treatment decisions. Although autonomy is not the original justification for the emergence of the Netherlands’ law, discussions using the flexible concept of “death with dignity” are challenging the grounding of the law and in turn, testing its boundaries with respect to suffering and medical condition requirements.

⁸⁹ *ibid* 7.

⁹⁰ *ibid* 25.

⁹¹ *ibid* 13-4.

⁹² *ibid* 21-3.

⁹³ *ibid* 22-3.

⁹⁴ *ibid* 21-3.

⁹⁵ *ibid* 21.

III.B.2. Belgium

After a relatively brief political and public discussion, Belgium passed *The Law Concerning Euthanasia* in 2002 (the “Belgian Law of 2002”).⁹⁶ The Belgian Law of 2002 is very similar to the Dutch scheme, permitting euthanasia and PAS (although not expressly PAS)⁹⁷ since September 2002.⁹⁸ Unlike the Netherlands however, Belgium did not experience the lengthy history of physician prosecution or professional medical guidance on the matter of euthanasia from which to formulate perspectives, precedents and practices for potential legislative intervention.⁹⁹ While there were certainly elements of a euthanasia discussion taking place in both private and public sectors since the 1980s,¹⁰⁰ these discussions could not be said to possess a comprehensive evolution similar to that which can be observed in the Netherlands.

a. Historic Overview

The general ambivalence for euthanasia reform in Belgium has been attributed to the dominance of the government by the Christian democrats during the 1980s and early 1990s¹⁰¹ but also to the Belgian medical profession which was largely opposed to

⁹⁶ Wet van 28 mei 2002 betreffende de euthanasie, Belgisch Staatsblad [Law concerning euthanasia 28 May 2002] 22 June 2002 <www.health.belgium.be/internet2Prd/groups/public/@public/@dgl1/@> accessed 31 May 2012. In French: *Loi relative à l'euthanasie*, F. 2002-2141. The Belgium House of Representatives approved the Bill on 16 May 2002, signed by the King 28 May 2002, published in the Belgisch Staatsblad 22 June 2002 and came into force 22 September 2002. For an English translation see Dale Kidd, ‘The Belgium Act on Euthanasia of May, 28th 2002’ (2002) 9 Ethical Perspectives 182 <www.kuleuven.be/cbmer/viewpic.php?LAN=E&TABLE=DOCS&ID=23> accessed 31 May 2012 (the Belgian Law of 2002).

⁹⁷ The legislation has been later interpreted to include PAS. See (n 129) and associated text.

⁹⁸ Life-shortening medical practices by physicians such as withholding or withdrawing life prolonging treatment on the basis of futility, proportionality or at the patient’s direction and the administration of appropriate pain relief with life shortening effect are considered to be within the realm of “normal medical practice” and therefore not subject to criminal sanction. Advice of the Council of State, *Parliamentary Proceedings* (Senate 2000-01, 2-244/21:1D); See also Article 97 of the Deontological Code (Code of Medical Ethics) of the Belgian Order of Physicians and the avoidance of “therapeutic obstinacy”. Conseil Nationale de L’Order de Medecin, ‘Code of Déontologie médicale’ [Deontological Code (Code of Medical Ethics) of the Belgian Order of Physicians] (Part II, Chapter I, Relations avec le patient, 2000) <<http://www.ordomedic.be/fr/code/contenu/>> accessed 31 May 2012 (Belgian Deontological Code).

⁹⁹ Bosshard (n 85) 29; “[T]he legal debate on euthanasia was not accompanied by internal preparation of guidelines among the medical profession.” R Vander Stichele et al, ‘Drugs used for Euthanasia in Flanders Belgium’ (2004) 13 *Pharmacoepidemiology and Drug Safety* 89, 90.

¹⁰⁰ For example the establishment of two right-to-die organizations: *Association belge pour le droit de mourir dans la dignité* (Belgian Association for the Right to Die with Dignity) (1981) and its Flemish counterpart *Vereniging voor het recht op waardig sterven* (Association for the Right to Die with Dignity) (1983). Vermeersch (n 8) 394; Commencing in 1984, a variety of bills regarding discontinuation of futile treatment, right to refuse treatment, euthanasia and assisted suicide were introduced into parliament by independent members. For further discussion see Vermeersch *ibid* 394.

¹⁰¹ Griffiths, Weyers and Adams (n 2) 275-6.

euthanasia. Indeed, into the 1990s, Belgian physician codes of professional conduct explicitly opposed the practice of euthanasia.¹⁰² From the perspective of one physician organization post-legalization, “euthanasia was imposed on the medical profession and exemplifies the intrusion of politics into the practice of medicine.”¹⁰³

This is not to say however that euthanasia and PAS were not occurring in Belgium despite their illegality¹⁰⁴ and that there weren't Belgian doctors who supported such practices.¹⁰⁵ Although no physician had ever been the subject of a euthanasia prosecution in Belgium until 2000 (after the formal legislative process was already underway),¹⁰⁶ studies conducted in Belgium revealed that euthanasia was a part of medical end-of-life practice for many physicians.¹⁰⁷

¹⁰² Under Article 95 of the earlier Deontological code, a doctor could not intentionally cause the death of one of his patients or help him to take his own life and under Article 96, the doctor was limited to provision of palliative care in the case of a dying patient. For further discussion see Bosshard (n 85) 29. After the Belgian Law of 2002 (n 96) was passed, the Code of conduct was changed to incorporate legalization of euthanasia. Articles 95-98 of the Belgian Deontological Code (n 98) now state that when a physician receives a question regarding the end of life, the physician is to inform the patient of all possible options and provide any medical and moral assistance required. Bosshard (n 85) 29; See also discussion in Lewy (n 10) 82; See also discussion in E Michiels, R Deschepper and J Bilsen, ‘Information disclosure to terminally ill patients and their relatives: self-reported practice of Belgian clinical specialists and general practitioners’ (2009) 23 *Palliative Medicine* 345, 345.

¹⁰³ Lewy (n 10) 82; See also observation by Vice President of the Belgian Order of Physicians during hearings in 2000 who expressed the unease felt by doctors concerning their new role as “bringer of death” as well as skepticism from one of the chairpersons of a private doctors’ organization, that softening the law on euthanasia will alter abuse already in existence. Parliamentary Proceedings, (Senate 2000-2001, 2-244/24:108) reported in Griffiths, Weyers and Adams (n 2) 287-8 (Belgian Parliamentary Proceedings 2000); See also L Deliens and G van der Wal, ‘The Euthanasia Law in Belgium and the Netherlands’ (2003) 362 (9391) *The Lancet* 1239: “no medical association supported the process in Belgium.”

¹⁰⁴ Unlike Netherlands, there were no specific provisions on Euthanasia or assisted suicide in the Belgium Penal Code. 8 Juin 1867 - Code Penal (The Belgium Penal Code). Euthanasia was treated in the same manner as intentionally causing death under criminal law. See The Belgium Penal Code *ibid* Articles 393 and 394, voluntary homicide and murder respectively. Article 397 regarding poisoning might also have been relevant. Suicide was not prohibited and therefore the legal status of providing assistance with suicide was unclear. Assisted suicide may have been addressed by Article 422b which addresses failure to provide assistance to a person in grave danger. Belgian Parliamentary Proceedings 2000 (n 171) and Griffiths, Weyers and Adams (n 2) 304, fn 38.

¹⁰⁵ See Griffiths, Weyers and Adams (n 2) 293, fn 53 regarding 2001 petition in support of legalization of euthanasia of which 2400 of the 12,000 signatures were doctors; See discussion in R Cohen-Almagor, ‘Belgian Euthanasia Law: a Critical Analysis’ (2009) 35 *Journal of Medical Ethics* 436 at 436 (Cohen-Almagor).

¹⁰⁶ In January 2000, the public prosecutor arrested two physicians on suspicion of administering a lethal drug to a man suffering from a chronic lung condition. Ultimately, the physicians were not prosecuted. Griffiths, Weyers and Adams (n 2) 305, fn 42.

¹⁰⁷ Three studies were conducted in Flanders in the years of 1996, 1998 and 2001. Flanders is the Dutch speaking part of Belgium where 60% of the population of Belgium resides. The 1996 pilot study was conducted only in the city of Hasselt, Flanders while the 1998 and 2001 studies were conducted throughout Flanders. These three studies are: F Mortier, L Deliens, J Bilsen and others, ‘End-of-life decisions of physicians in the city of Hasselt (Flanders, Belgium)’ (2000) 14(3) *Bioethics* 254-67 <onlinelibrary.wiley.com/doi/10.1111/1467-8519.00195/pdf> accessed 31 May 2012; Luc Deliens and others, ‘End-of-life Decisions in Medical Practice in

Perhaps spurred on by events taking place in the Netherlands¹⁰⁸ (although there is no specific evidence to support this), Belgium began its own political discussion on euthanasia sometime after a 1987 national colloquium, entitled, “Bioethics in the 90s”.¹⁰⁹ Following the colloquium in 1993, an independent Advisory Committee on Bioethics (the “Advisory Committee”) was established.¹¹⁰ Its mandate was and remains twofold:¹¹¹

- to *provide advice* on the problems raised by research and research applications in the fields of biology, medicine and health care; these problems are studied from the ethical, social and legal points of view, particularly from the angle of the respect for human rights;¹¹²
- to *inform* the public and the authorities about these problems.

At the request of the presidents of the Chamber and the Senate, the Advisory Committee provided its first opinion in 1997 on “the advisability of a legal regulation of euthanasia” (“Opinion 1”).¹¹³ The Advisory Committee restricted Opinion 1 to euthanasia proper which, similar to the Dutch standard, was defined as, an “act performed by a third party who intentionally puts an end to a person’s life at the request of the said person”.¹¹⁴

Flanders, Belgium: a Nationwide Survey’ (2000) 356(9244) The Lancet 1806-1811 <[www.thelancet.com/journals/lancet/article/PIIS0140-6736\(00\)03233-5/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(00)03233-5/fulltext)> accessed 31 May 2012 (the 2000 Deliens study); and A Van der Heide, L Deliens, K Faisst and others, ‘End-of-life Decision-Making in Six European Countries: Descriptive Study’ (2003) 362(9381) The Lancet 345-50 (the EURELD Study). As will be later described, the results from the 2000 Deliens Study were released during senate debate of proposed euthanasia legislation. For a succinct overview of scope and variation of Euthanasia, PAS and pharmacological practices in Belgium prior to legalization see Lewy (n 10) 71.

¹⁰⁸ Vermeersch (n 8) 394; Cohen-Almagor (n 105) 436.

¹⁰⁹ Griffiths, Weyers and Adams (n 2) 277.

¹¹⁰ The Belgian Advisory Committee on Bioethics was established by a co-operation agreement between the federal Government, the French-speaking Community, the Dutch-speaking Community, the German-speaking Community and the Joint Commission for Community Matters. The Advisory Committee is to be comprised of 35 voting members from both languages and varied disciplines (academics, doctors, philosophers, legal experts, sociologists, etc.) in order to establish ideological, philosophical and linguistic balance. Belgium Advisory Committee on Bioethics, ‘Belgium Advisory Committee on Bioethics’ <www.health.belgium.be/eportal/Healthcare/Consultativebodies/Committees/Bioethics/index.htm> accessed 31 May 2012 (Belgium Advisory Committee on Bioethics).

¹¹¹ Belgium Advisory Committee on Bioethics *ibid* art 1.

¹¹² The phrase “particularly from the angle of the respect for human rights”, has also been interpreted as “in particular the rights of the individual”. Lewy (n 10) 72, fn 12.

¹¹³ Belgian Advisory Committee on Bioethics, *Opinion no. 1 of 12 May 1997 concerning the advisability of a legal regulation on euthanasia* (1997) <www.health.belgium.be/filestore/13080481/opinion%201%20web_13080481_en.pdf> accessed 31 May 2012 (Advisory Committee Opinion no. 1).

¹¹⁴ *ibid* 1. The Advisory Committee left issues related to other medical acts (such as the administration of drugs which can shorten life and the withdrawal and withholding of futile

In accordance with the Advisory Committee's non-consensus rule,¹¹⁵ Opinion 1 did not articulate a unified view, rather, it presented the following four possible alternatives:¹¹⁶

- 1) Legislative amendment to decriminalize euthanasia provided the doctor has fulfilled specific conditions: advanced under the concept that the law cannot prohibit acts that do not cause harm to others or society;¹¹⁷ a form of *ex-post facto* control.
- 2) Maintain criminal prohibition but regulate the procedure *ex-post-facto*: similar to Dutch scheme, the doctor relies on the legal justification of "necessity" when certain substantive conditions are present and complies with procedural safeguards;
- 3) Regulate procedure *a priori*: compulsory consultation and ethical debate imposed prior to a decision on a case by case basis with shared-decision making by the patient and the doctor; also advanced under the legal justification of necessity.
- 4) Maintain status quo: on basis of the "eminent value of life as the natural medium for all the other rights of the person" and requires medicine and law to give precedence to the "right to live", by seeking relief of suffering through other means such as palliative care.

Opinion 1 stimulated and framed the euthanasia debate in Belgium and six months later led to majority support in the Senate for the *a priori regulation* of euthanasia.¹¹⁸ Progress on a draft bill however was stalled because of a re-polarization in the Senate due to a differing viewpoint from the socialist faction of government¹¹⁹ (who preferred an *ex-post facto* approach like the Dutch scheme) and because of complexities generated by the next Advisory Committee report, Opinion No. 9.¹²⁰ Opinion No. 9 revealed that there was little consensus on the issue of euthanasia for individuals incapable of expressing their wishes. Consequently, the political consensus to take an *a priori* approach had been lost.

medical treatment) and cases involving patients unable to express their wishes for future discussion.

¹¹⁵ For further description of this rule, see Jeanine-Anne Stiennon, 'The Belgian Advisory Committee on Bioethics' in *UNESCO, Social and Human Sciences Sector Division of Ethics of Science United Nations and Technology, National Bioethics Committees in Action* (UNESCO, 2010) 27-8.

¹¹⁶ Advisory Committee Opinion no. 1 (n 113) Part III.

¹¹⁷ "The law must guarantee the right of every individual to do as he wishes, and according to own convictions, with respect for others" *ibid*.

¹¹⁸ Griffiths, Weyers and Adams (n 2) 282.

¹¹⁹ *ibid* 282-3.

¹²⁰ Belgian Advisory Committee on Bioethics, *Opinion no. 9 of 22 February 1999 concerning active termination of the lives of persons incapable of expressing their wishes* (1999) <www.health.belgium.be/internet2Prd/groups/public/@public/@dg1/@legalmanagement/documents/ie2divers/13080483.pdf> accessed 31 May 2012.

An election in June 1999 produced a new coalition government (comprised of Socialists, Liberals and Greens) with the Christian Democrats, formerly the majority, becoming the opposition.¹²¹ Led by the Liberals, the coalition government made it clear that Parliament had a responsibility to address medical matters including euthanasia and that its responsibility must be fulfilled on “the basis of each individual’s convictions.”¹²² By December 1999, a common bill, similar to the Dutch scheme was achieved and a mixed Senate Committee was established to hear additional views from expert groups and to debate the draft bill.

During Senate discussions in late 2000, the results of a second study of euthanasia practices in Flanders (the Dutch speaking part of Belgium) were published.¹²³ The main objective of the study was to estimate the frequency of euthanasia, PAS and other end-of-life decisions. While the study confirmed that euthanasia and PAS were part of medical end-of-life practice among Belgian doctors (1.1% and .2% respectively out of total deaths examined) it also showed that other medical practices, such as pain relief in doses with a potential life-shortening effect and the withholding or withdrawing of treatment (39% of total deaths examined) were much more common.¹²⁴ The study also revealed that termination of life without a request was almost three (3) times more common than euthanasia and PAS combined (3.2% of total deaths examined).¹²⁵ Despite this striking latter statistic, Belgium parliamentary debate remained exclusively focused on the less frequent practice of euthanasia proper.

After hundreds of amendments, the bill was approved by a majority of the Belgian Senate in October 2001 and encompassed *ex post facto* regulation – a physician exemption from criminal liability provided certain conditions were met. The bill was approved by the Chamber of Representatives in May 2002 and came into force 22 June 2002.¹²⁶

¹²¹ Griffiths, Weyers and Adams (n 2) 283.

¹²² Regeerakkoord [Coalition Agreement](July 1999) para 11; See also Griffiths, Weyers and Adams (n 2) 283;

¹²³ The 2000 Deliens study (n 107) 1806.

¹²⁴ Pain relief with life shortening effect (18% of total deaths examined) and withdrawal or withholding of treatment (16% of total deaths examined). *ibid* 1806;.

¹²⁵ *ibid*; One possible explanation for the high rate of termination of life without a request (pre-legalization) in competent patients was physician fear of legal complications if discussed in an open manner. See discussion in Johan Bilsen, Robert Vander Stichele, Freddy Mortier and others, ‘The Incidence and Characteristics of End-of-Life Decisions by GPs in Belgium’ (2004) 21 Family Practice 282, 286. See also discussion in M Otlowski, ‘The effectiveness of legal control of euthanasia. Lessons from comparative law’ in A Klijn, M Otlowski and M Trappenburg (eds) *Regulating Physician-negotiated Death*. (Elsevier, 2001) 137–155.

¹²⁶ Griffiths Weyers and Adams (n 2) 291.

In 2003, a scheme similar to the Netherlands SCEN scheme was established for Belgian doctors considering euthanasia for their patients. The Forum for End of Life Information (“LEIF”) was established in Flanders to provide consultation services and training to doctors with respect to euthanasia requests. A similar scheme was also set up for nurses in 2006.¹²⁷

b. Legislative Framework

Substantively speaking, the legal rules regulating euthanasia and PAS in Belgium are largely the same as those in the Netherlands,¹²⁸ however, the rules have been articulated in greater detail under the Belgian law.

Additionally, Section 2 of the Belgian Law of 2002 defines euthanasia as “intentional life-terminating action by someone *other than the person concerned*, at latter’s request” [author’s emphasis]. Although this in plain reading excludes assisted suicide, it has since been settled by the reviewing authority, the Federal Control and Evaluation Commission¹²⁹ that PAS does fall within the law’s definition of euthanasia.¹³⁰ The use of the term “intentional” serves to exclude other medical acts such as pain relief with life shortening effect.

i. Due Care Requirements

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

¹²⁷ *ibid* 321.

¹²⁸ Main difference is that unlike the Dutch Law of 2002 (n 4), the Belgian Law of 2002 (n 96) expressly address the issue euthanasia via advance directives and additional safeguards for non-terminal patients. See text to fn 138-141 below.

¹²⁹ *Federale Controle- en Evaluatiecommissie Euthanasie* [the Federal Control and Evaluation Commission] is the evaluation body established under the Belgian Law of 2002 (n 96) art 6§1.

¹³⁰ Commission Fédérale de Contrôle et d’évaluation de l’euthanasie [Federal Control and Evaluation Commission], *Premier Rapport aux Chambres Législatives, 22 Septembre 2002 - 31 Decembre 2003* (2004) 23 <www.health.belgium.be/eportal/healthcare/consultativebodies/commissions/euthanasia/publications/index.htm> accessed 31 May 2012 (FCEC 2004 Report); The Order of Physicians, also took the position that PAS was equivalent to euthanasia as long as conditions under the Belgian Law of 2002 (n 96) were adhered to. *Ordre des Médecins, Bulletins du Conseil National No. 100* (2003).

With respect to the substantive requirements, in order for the attending physician to be exempt from criminal liability when terminating the life of a patient, the attending physician must:¹³¹

- be sure that the patient is over the age of majority (or is an emancipated minor),¹³² and is conscious and competent when making the request;
- be sure that the request is voluntary, well considered, repeated and not the result of external pressure; and
- be sure that the patient is in a medically futile condition and the patient's suffering (physical or mental) is constant and unbearable, arising from a serious and incurable disorder caused by illness or accident.

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

Procedural requirements involving the physician-patient relationship require that the attending physician:¹³³

- inform the patient about his/her condition and life expectancy and discussed euthanasia (and PAS) together with therapeutic options, including that of palliative care;
- through several conversations with the patient over a reasonable period of time, be certain of the patient's constant physical or mental suffering and durability of the request; and

¹³¹ The Belgian Law of 2002 (n 96) arts 3§1.

¹³² Notwithstanding the use of the term "emancipated minor" in the Belgian Law of 2002, euthanasia for minors is a contested issue in Belgium. An emancipated minor for the most part appears to be limited to exceptional cases for persons aged 16 years or over and requires decision by a judge. For further discussion Cohen-Almagor (n 105) 437 and Vermeersch (n 8) 396. Contrast with *Loi du 22 août 2002 relative aux droits du patient [Law on Patient's Rights]* (M.B. du 26/09/2002, p. 43719) art 12§2 (Law on Patients Rights) which provides that minors can exercise patient rights in keeping with age and level of maturity. If they can reasonably appreciate their circumstances, they may exercise rights on their own behalf.

¹³³ The Belgian Law of 2002 (n 96) art 3§2.

- together with the patient, come to the belief that there is no reasonable alternative.

Similar to the Netherlands legislation, there is no express requirement that the doctor have a history with the patient, nor is there a requirement that the patient be a Belgium citizen or resident, potentially introducing the possibility of euthanasia for non-residents.¹³⁴ However, the legislation implies that the doctor have a fairly strong degree of familiarity with the patient given that the strength of the request must be ascertained over time and through several conversations. The only exception to this familiarity requirement is when a request is pursuant to an advance directive.¹³⁵ Requests must be in writing but can be revoked at any time.¹³⁶

Procedural safeguards under the Belgian Law of 2002 also include consultation with another physician independent of the patient and consulting physician.¹³⁷ The consultant physician must be competent on that particular condition and must review the medical record, examine the patient, and ensure that the patient's suffering is constant and unbearable and cannot be alleviated. The consultant physician report is shared with the patient, the patient's nursing team and family members, if so requested by the patient.

The Belgian Law of 2002 imposes additional safeguards for individuals who are "not expected to die in the near future"¹³⁸ that is, individuals who are not in a terminal phase or suffering from a terminal condition (i.e. an illness expected to end in death) such as those with neurological conditions like quadriplegia¹³⁹ or are experiencing anticipatory suffering. In these situations, there must be at least one month between the request and the termination act.¹⁴⁰ Furthermore, a second consultant (a psychiatrist or specialist in the condition) must examine the patient and the medical record in order to ascertain whether the request is voluntary and the suffering persistent and unbearable.¹⁴¹ The patient is to be informed of the results of this second consultation.

¹³⁴ See report by BBC News indicating that five foreigners "in great suffering had already come to Belgium to die. Staff, 'Euthanasia: a continent divided' (BBC News, 11 February 2009) <news.bbc.co.uk/2/hi/europe/7322520.stm> accessed 31 May 2012.

¹³⁵ See The Belgian Law of 2002 (n 96) art 4.

¹³⁶ If the patient is unable to write due to physical disability for example, the request can be written by another person chosen by the patient and who has no material interest in the patient's death. Belgian Law 2002 *ibid* art 3§4.

¹³⁷ *ibid* art 3§2.

¹³⁸ *ibid* art 3§3.

¹³⁹ Cohen-Almagor (n 105) 37.

¹⁴⁰ Belgian Law 2002 (n 96) art 3§3.

¹⁴¹ *ibid* art 3§3.

ii. Reporting and Review

Unlike the Netherlands which requires a pathologist to conduct the post-mortem examination and to report findings, Belgian doctors under the Belgian Law of 2002 can conduct the post-mortem examination and issue a death certificate. Also distinct from the Dutch Law of 2002, under the Belgium Law of 2002, euthanasia can be considered a natural cause of death¹⁴² and doctors routinely fill in “no medical-legal objection.” Thus in Belgium there is again little opportunity for the prosecutorial authorities to learn of a case of euthanasia (or PAS) unless it is brought to their attention via the Federal Control and Evaluation Commission (FCEC).

The FCEC consists of 16 members including medical doctors, lawyers, professors and individuals who routinely deal with problems of incurable patients.¹⁴³ A physician who has performed euthanasia or PAS must notify the FCEC within four (4) working days.¹⁴⁴ The physician must provide information to the FCEC including the details of the termination of life act, the patient’s condition and nature of suffering and the procedures that have been fulfilled in compliance with the law.¹⁴⁵ The FCEC can turn a case over to the public prosecutor if a two-third majority of the FCEC is of the opinion that the required conditions have not been fulfilled.¹⁴⁶ The FCEC is required to submit a biennial report to Parliament identifying statistical information, its evaluation of the implementation of the law as well as recommendations, if any, on potential changes to the law.¹⁴⁷

c. Compassion and Suffering, Autonomy and Self-determination

As described above, the Belgian Law of 2002 allows euthanasia (or PAS) for unbearable physical or “mental” suffering,¹⁴⁸ and the requesting individual does not have to have a terminal illness. However, the patient must be in a “medically futile condition” as the result of an “incurable disorder” caused by “illness or accident”.¹⁴⁹

¹⁴² See also *ibid* art 15 where euthanasia is classified as “natural” for the purposes of insurance contracts for example.

¹⁴³ *ibid* art 6 §2. There are also linguistic and gender diversity requirements.

¹⁴⁴ *ibid* art 5.

¹⁴⁵ *ibid* art 7.

¹⁴⁶ *ibid* art 8.

¹⁴⁷ *ibid* art 9; Federal Control and Evaluation Commission (FCEC) biennial reports available online Federal Public Service, Health, Food Chain Safety and Environment, ‘Publications’ <www.health.belgium.be/eportal/Healthcare/Consultativebodies/Commissions/Euthanasia/Publications/index.htm> accessed 31 May 2012.

¹⁴⁸ The Belgian Law of 2002 (n 96) art 3§1.

¹⁴⁹ *ibid* art 3§1.

This requires that the disorder be medically classifiable and might therefore operate to exclude the availability of euthanasia (or PAS) for existential suffering. On the other hand, commentators have argued that because the law considers a mental condition that leads a patient to wish to die as an accepted grounds for euthanasia (or PAS), the Belgian law opens the door for otherwise physically healthy persons to request AD on the basis of being “tired of life”, notwithstanding the difficulty in assessing whether the criteria for euthanasia have been satisfied in the absence of symptoms related to a physical condition.¹⁵⁰

Persistent and unbearable suffering is to be determined from the patient’s perspective only; there is no requirement that suffering must be understandable or palpable to the physician as required under the Dutch law.¹⁵¹ Furthermore, the requirement that the patient be in a medically futile condition that cannot be alleviated, does not imply that a patient must undergo alternative treatments before a doctor can agree to a request. As is the law in several jurisdictions, including the Netherlands as discussed, patients are entitled to refuse treatment.¹⁵² This, taken together with mental suffering provides the latitude to allow for euthanasia on the basis of prospective or anticipatory suffering.

The Belgian Law of 2002 overcomes the dilemmas posed by the apparent lack of suffering in an unconscious patient, by expressly removing the “unbearable” requirement in this circumstance and allowing euthanasia for irreversibly unconscious patients pursuant to a written advance request of the patient,¹⁵³ which among other things, gives the patient the opportunity to identify “persons of confidence” who can later inform the attending physician of the patient’s wishes.¹⁵⁴ An advance directive is only valid for the five years prior to a patient’s loss of ability to express his or her wishes¹⁵⁵ and doctors must still meet all basic due care requirements.¹⁵⁶

¹⁵⁰ Cohen-Almagor (n 105) 438.

¹⁵¹ Note the most recent biennial report from the FCEC indicates a consensus in committee that unbearable suffering is to be determined by consultation between physician and patient. Commission Fédérale de Contrôle et d’évaluation de l’euthanasie, *Quatrième Rapport aux Chambres Législatives (Années 2008 et 2009)* (2010) 24 <www.health.belgium.be/eportal/Healthcare/Consultativebodies/Commissions/Euthanasia/Publications/index.htm?fodnlang=fr> accessed 31 May 2012 (FCEC 2010 Report).

¹⁵² Law on Patients Rights (n 132) art 8(4) describes the patient’s right to refuse or withdraw consent for medical intervention.; See also Belgian Law of 2002 (n 96) art 3§2 whereby a doctor is only required to discuss the options with the patient.

¹⁵³ The Belgian Law of 2002 *ibid* Chpt III.

¹⁵⁴ *ibid* art 4§1.

¹⁵⁵ *ibid*.

¹⁵⁶ *ibid* art 4§2.

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

Indeed, during its debates, the Belgian Senate identified that the scope of the duty to protect the right to life imposed by human and civil rights conventions had to be interpreted pursuant to the right to self-determination and reflect the will of the individual.¹⁵⁷ The principal human rights at issue are the "Protection of the Right to Life" and the "Right to Respect for Privacy" found respectively under Articles 2 and 8 of the European Human Rights Convention (European Convention).¹⁵⁸ Recourse to and the interpretation of these rights are of particular importance to the evolution of AD law and are discussed in more detail below in Chapters III.B.3 and III.B.4, which address Luxembourg and Switzerland respectively.

Notwithstanding the influence of a self-determination perspective in advancing the Belgian law, maintaining the legal requirement that unbearable suffering be rooted in a medical disorder indicates that additional medico-ethical duties and principles, such as physician beneficence and mercy are also implicitly incorporated into the law.¹⁵⁹ On the other hand, because there is no need to build the physician defence of necessity and it is the patient that fully identifies whether the suffering is unbearable the question is raised as to what exactly is the ethical or practical function of the

¹⁵⁷ *Proposition de loi sur le droit de mourir en dignité* 1) *Exposé des motifs* 2) *Texte de la proposition de loi* 3) *Commentaire des articles* (J-2001-O-0277) 4909/00 (19 February 2002) 3 (Huss and Err Proposal).

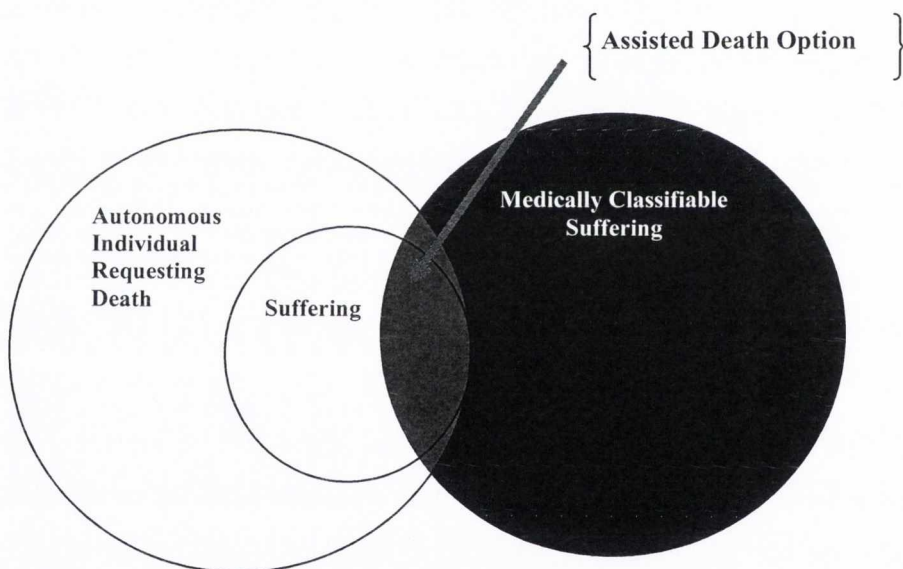
¹⁵⁸ Convention for the Protection of Human Rights and Fundamental Freedoms as amended by Protocols No. 11 and No. 14 Rome, 4.XI.1950 (European Convention). These rights are echoed in numerous other conventions such as Articles 6 and 17 in the International Covenant on Civil and Political Rights. UN General Assembly, International Covenant on Civil and Political Rights, 16 December 1966, United Nations, Treaty Series, vol. 999, 171.

¹⁵⁹ "... for the Dutch, Belgian and Luxembourg Acts, addressing the patient's suffering is the most important principle underlying the Act." Buiting (n 59) 4.

medically-based suffering criteria, positioning these criteria as potentially vulnerable to critiques of arbitrariness or superficiality.

At this point in the discussion one can surmise that the suffering criteria relates back, at least in part, to the authority given to the medical profession to actively terminate a life, though not necessarily an authority rooted in a professional conflict of duties. Thus what appears to be occurring here is a theoretical expansion of the doctor's obligations to the patient with respect to assisted death as a medical practice provoked by an expansion of a patient's right to self-determine what is and what is not acceptable suffering within a loose context of treatment (keeping in mind that under the Belgian Law of 2002, there is currently no positive right to AD).

Figure 4: AD advanced when patient suffering arises from a medical condition



It should also be noted that the physician is performing an important gate-keeping role in terms of confirming voluntariness and capacity (which can be observed in all the AD regimes under discussion), notwithstanding that this gate-keeping role (or aspects of it) might also be performed by trained professionals other than physicians. Accordingly, an interplay between at least two distinct forms of autonomy begins to be revealed – one associated with an exercise of autonomy within the specific context of the medical treatment decision itself and one associated with a right that can expand the scope of medical treatment options available, in this case, to address suffering (as

opposed to dying - as demonstrated by the additional safeguards for those not expected to die in the near future).

The correlative duties also take two forms, the first relating to those that arise from the doctrine of informed consent and the second relating to obligations to give effect to the recognized right. With respect to the latter, the right is given effect by adding to the spectrum of treatment options available to the patient. Because the core of this latter right is in a sense negative, i.e. to be free from or to allow decisions on the basis of one's own personal convictions, the right does not impose a positive duty to provide AD but rather adds AD to treatment options that are to be made available, if and when, the suffering patient makes such a request. The question then is a matter of whether someone will respond to meet the request¹⁶⁰ and then to ensure that safeguards are in place to ensure the voluntariness and sincerity of the request.

Interestingly, the Belgian Law of 2002, despite all of its similarities to the Dutch Law of 2002, does not include a provision that requires physicians to terminate the life with "due care" as is the case under the Dutch law.¹⁶¹ Perhaps such a provision was considered redundant, particularly with respect to the practice of euthanasia which necessarily requires that the physician (with all attendant professional obligations) to be present during the terminating act. However, in the case of PAS, understood to be included under the Belgian law as already discussed, the terminating act itself does not require the physician's presence. The absence of a due care provision regarding the terminating act might also perhaps signal or trigger a conceptual shift in focus and responsibility away from the physician towards the patient. This would be consistent with the conceptual shift from AD as a form of physician defence to AD as a form of patient self-determination. As will be seen later in this discussion, this type of patient-oriented responsibility is reflected in the AD laws of the United States.

¹⁶⁰ See (n 183) below and associated text.

¹⁶¹ Griffiths, et al argue that this omission leaves no statutory basis to impose standards for additional activities such as remaining with the patient until death, the drugs selected and the division of responsibilities between doctor and nurse. See Griffiths, Weyers and Adams (n 2) 322; Note however that there is legislation in place to shield pharmacists from liability. *Wet van 10 November 2005 tot aanvulling van de wet van 28 mei 2002 betreffende de euthanasie met bepalingen over de rol van de apotheker en het gebruik en de beschikbaarheid van euthanatica* [The Law supplementing the Law on Euthanasia with provisions on the role of the pharmacist and the availability of euthanatica of 10 November 2005] *Belgisch Staatsblad* (13 December 2005) <www.lachambre.be/FLWB/pdf/51/1832/51K1832001.pdf> accessed 31 May 2012.

d. Statistics and Trends

Pursuant to the Belgian Law of 2002, the FCEC is responsible for reviewing and reporting euthanasia cases on a biennial basis. To date, the FCEC has issued four biennial reports which cover all reported euthanasia cases up to 2009.¹⁶²

According to the biennial reports, reported cases have been increasing – from 259 in 2002-2003¹⁶³ (.2% of all deaths) to 642 in 2004-2005 (or .36% of all deaths) and 924 in 2006-2007 (.44% of all deaths).¹⁶⁴ In 2008, the FCEC attributed the increase to an increase in physician awareness of the law, taking the position that “clandestine euthanasia” is “dying out”.¹⁶⁵ However, the results of the fourth biennial report (2008-2009) show a much more significant increase in reported euthanasia cases (1526 and .7% of all deaths)¹⁶⁶ and question if that is indeed the case, particularly in light of current research that indicates an ongoing problem with physician underreporting. For example, research conducted on deaths in 2007 by Smets et al, estimated that only 1 out of 2 cases of euthanasia in the Flanders region were being reported to the FCEC and that the incidence of euthanasia in 2007 was closer to 1040 (or 1.9% of all deaths).¹⁶⁷ Regardless, the FCEC maintains that the amount of illegal euthanasia “can only be very low”.¹⁶⁸

While reported cases under the Belgian Law of 2002 have been increasing, the profile of patients requesting euthanasia over the years 2002-2008, has remained fairly

¹⁶² FCEC 2004 Report (n 130), FCEC 2010 Report (n 151), Commission Fédérale de Contrôle et d'évaluation de l'euthanasie, *Deuxième Rapport aux Chambres Législatives (Années 2004 et 2005)* (2006), Commission Fédérale de Contrôle et d'évaluation de l'euthanasie, *Troisième Rapport aux Chambres Législatives (Années 2006 et 2007)* (2008) (FCEC 2008 Report), (the FCEC Reports). For summary of cases reported to the FCEC between 2002-2007 see: T Smets, J Bilsen, J Cohen and others, 'Legal euthanasia in Belgium. Characteristics of all reported euthanasia cases' (2010) 48 *Med Care* 187, 187-192 (Smets, Bilsen and Cohen).

¹⁶³ The Belgian Law of 2002 (n 96) went into effect in September 2002. Thus the data only includes the period from September 22 to December 31, 2003. FCEC 2004 Report (n 130).

¹⁶⁴ The number of reported cases of PAS is small, representing no more than 1% of all cases of reported assisted deaths. The FCEC Reports (n 161).

¹⁶⁵ FCEC 2008 Report (n 161) 21-2.

¹⁶⁶ FCEC 2010 Report (n 151) 21.

¹⁶⁷ Johan Bilsen, Joachim Cohen, Kenneth Chambaere and Geert Pousset, 'Medical End-of-Life Practices under the Euthanasia Law in Belgium' (2009) 361 *New England Journal of Medicine* 1119, 1119-21. "The most important reason given by physicians for not reporting a case to the review committee was that the physician did not perceive the act to be euthanasia (76.7%)." (Bilsen, Cohen, Chambaere and Pousset); Tinne Smets, Johan Bilsen, Joachim Cohen and others, "Reporting of euthanasia in medical practice in Flanders, Belgium: cross sectional analysis of reported and unreported cases" (2010) 341(c5174) *British Medical Journal* (The 2007 Smets Study); See also K Chambaere, J Bilsen, J Cohen and others, 'Physician-assisted deaths under the euthanasia law in Belgium: a population-based survey' (2010) 182(9) *Canadian Medical Association Journal* 895-901 (Chambaere, CMAJ).

¹⁶⁸ FCEC 2010 Report (n 151) 22.

consistent.¹⁶⁹ Of the reported cases, the vast majority come from the Flemish/Dutch-speaking part of Belgium (80%).¹⁷⁰ Further, the majority of patients who receive euthanasia are suffering from cancer (80%)¹⁷¹ with the remainder of the patients suffering from other disorders such as progressive neuromuscular diseases like ALS. Approximately half the number of cases of euthanasia takes place in patients aged 66-79.¹⁷²

From 2002-2007, half the number of euthanasia cases took place in the hospital setting with a smaller number occurring in the home. This trend appears to be shifting with euthanasia now occurring more frequently at the patient's "residence" for the years 2008-2009, with 44% at home and 8% in a nursing or care home.¹⁷³

Almost all of the reported cases of euthanasia were the result of a direct personal request.¹⁷⁴ Euthanasia for unconscious patients by advance request has risen slightly over the years but remains low at approximately .02% of the cases.¹⁷⁵ To date, the FCEC reports that physicians are in compliance with due care criteria; none of the cases reported to the FCEC over the years 2002-2009 have been sent to the public prosecutor, although in some cases, the FCEC made further inquiries.¹⁷⁶

Recently, it has been argued that there is increasing opinion in Belgium that the practice of euthanasia is "normal medical practice" and part of the palliative care

¹⁶⁹ The FCEC data is consistent with results from the EURELD Study (n 107); See discussion in Griffiths, Weyers and Adams (n 2) 331-4.

¹⁷⁰ 83% (2002-2003); 86% (2004-2005); 81% (2006-2007); 80% (2008-2009). The FCEC Reports (n 229). Only 60% of the Belgium population is Dutch speaking, thus this figure appears disproportionate. For discussion as to possible explanations for this difference see Lieve Van den Block, *End-of-Life care and Medical Decision-Making in the last Phase of Life* (Brussels: Brussels University Press, 2008) 151; See also discussion in Lewy (n 10) 80.

¹⁷¹ 83% in 2002-2003; 83% in 2004-2005; 81% in 2006-2007; 79% in 2008-2009. The FCEC Reports (n 161).

¹⁷² 48% in 2002-2003; 49% in 2004-2005; and 55% in 2006-2007. For 2008-2009, 52% of cases were from ages 60-79 and 73% cases occur in ages 40-79. FCEC Reports *ibid*.

¹⁷³ FCEC 2010 Report (n 151) 33.

¹⁷⁴ 99.5% (2002-2003); 98% (2004-2005); and 96% (2006-2007); FCEC 2010 Report *ibid* 15. Note however, the 2007 Smets Study found that "Unreported cases were generally dealt with less carefully than reported cases: a written request for euthanasia was more often absent (87.7% v 17.6% verbal request only). The 2007 Smets Study (n 167) 341. Additionally, a second study regarding nurse involvement in euthanasia (also carried out in 2007) found that of the nurses surveyed in the Flanders area (1678 with 76% response rate), in the case of euthanasia, 12% of nurses administered the drug "and in almost half of the cases without an explicit request from the patient". Els Inghelbrecht, Johan Bilsen Freddy Mortier and others, 'The role of nurses in physician-assisted deaths in Belgium' (2010) 182(9) *Canadian Medical Association Journal* 1 (Inghelbrecht study); See also Chambaere, CMAJ (n 167).

¹⁷⁵ FCEC 2010 Report (n 151) 23; Compare to Inghelbrecht study *ibid*.

¹⁷⁶ The FCEC Reports (n 130).

spectrum,¹⁷⁷ an opinion which would not be inconsistent with the rights-focused underpinnings of the law nor with the language of “natural death” utilized in the Belgian Law of 2002. To a certain extent however, this view is challenged by the evidence of ongoing physician underreporting as well as a possible growing preference in doctors for other end-of-life practices such as palliative or terminal sedation over the practice of euthanasia.¹⁷⁸

Griffiths et al make the further argument that legally speaking, “normal medical practice” cannot include euthanasia.¹⁷⁹ Under the Belgian Law of 2002, the physician is obliged to discuss all options with the patient including palliative care.¹⁸⁰ The Law of Palliative Care 14 June 2002,¹⁸¹ approved by Belgium parliament at the same time as the Belgian Law of 2002 specifically states that “every patient has a right to palliative care at the end of life.”¹⁸² Accordingly, if euthanasia was part of the palliative care spectrum, this would create a right to euthanasia along with a positive obligation for doctors to perform it. This is clearly not the situation – a physician cannot be compelled to perform euthanasia or PAS.¹⁸³ As with the Dutch Law of 2002, the Belgian law only provides the opportunity to *request* euthanasia. Thus under the current scheme, euthanasia (and PAS) in Belgium cannot be considered “normal” medical practice. This position, notwithstanding that it has been arrived at through different pathways, would be consistent with the Dutch perspective, at least as articulated by the KNMG, that euthanasia is to be considered “an *exceptional* medical

¹⁷⁷ See for example, Association of General Practitioners, *Policy Statement on End of Life Decisions and Euthanasia* (4 December 2003) art 2: “Euthanasia is one of the possible choices in terminal care and must be framed by and embedded in total palliative care that transcends individual care” <www2.domusmedica.be/files/PB_euthanasie.htm> accessed 31 May 2012.

¹⁷⁸ “The rate of intensified alleviation of pain increased from 18.4% in 1998 and 22.0% in 2001 to 26.7% in 2007, and the rate of withholding or withdrawing life-prolonging treatment increased from 14.6% in 2001 to 17.4% in 2007. In the case of 14.5% of all deaths, physicians reported using continuous and deep sedation until death, a rate that was substantially higher than that in 2001 (8.2%).” Bilsen, Cohen, Chambaere and Pousset (n 167) 1119-21; See also 2007 Smets Study (n 167); See also Tinne Smets, Joachim Cohen, Johan Bilsen and others, ‘The Labelling and Reporting of Euthanasia by Belgian Physicians: a Study of Hypothetical Cases’ (2012) 22(1) *European Journal of Public Health* 19.

¹⁷⁹ Griffiths, Weyers and Adams (n 2) 313-4.

¹⁸⁰ The Belgian Law of 2002 (n 96) art 2§1.

¹⁸¹ Wet van 14 juni 2002 betreffende de palliatieve zorg. *Belgisch Staatsblad* (22 October 2002) (effective 22 September 2002) (the Belgian Law of Palliative Care). For a discussion of the history of the impetus and development of the Law of Palliative Care along and the idea of a “palliative care filter” implemented by the majority of Flemish Catholic hospitals in Belgium see Griffiths, Weyers and Adams (n 2) 315-6; For discussion on the extent of palliative care in Belgium see Lewy (n 10) 78, 85-7.

¹⁸² The Belgian Law of Palliative Care *ibid* art 2; See also The Law on Patient’s Rights (n 132) art 5, the right to high-quality care. Note: The right to palliative care does not import any obligation; palliative care need not be performed before a patient can demand euthanasia.

¹⁸³ Should the physician refuse however, the physician must inform the patient in a timely manner his/her reasons for refusal and must provide the patient’s medical record to the any new physician designated by the patient. The Belgian Law of 2002 (n 96) art 14.

procedure that inherently entails a dilemma for the physician requested to perform it and will *never become 'standard'*” [author’s emphasis].¹⁸⁴ That said, since 2003, proposals have been introduced into Belgium parliament to amend the law to identify euthanasia as normal medical behavior, though none of these proposals have been successful to date.¹⁸⁵

Furthermore, at the time of writing, the public debate regarding euthanasia for “tired of life” has commenced in Belgium with the publication of a news story of 93-year-old Amelie Van Esbeen. Ms. Van Esbeen went on a hunger strike to hasten her own death after her request for euthanasia was denied.¹⁸⁶ Ms. Van Esbeen was not suffering from a terminal illness but believed her quality of life was not sufficient to warrant living. According to Wim Distelmans, the head of the FCEC, the “ills of the elderly”, such as “poor sight, poor hearing, poor verbal skills and dependence on others,” could amount to unbearable suffering and “the euthanasia law should be changed to enable seniors who are tired of life to be able to request this method.”¹⁸⁷

Ms. Van Esbeen’s request was eventually granted.¹⁸⁸ It should be noted however that the usage of the term “tired of life” by Distelmans was advanced in connection to physical forms of suffering arising out of age-related medical conditions as opposed to less tangible forms of mental suffering unrelated to physical symptoms.

It is also of interest to note that both the Dutch Law of 2002 and the Belgian Law of 2002 rely on the safeguards (substantive or procedural) requiring the existence of a fairly close relationship between the doctor and patient in order to restrict AD to their respective citizens as opposed to setting out an express provision limiting the practice to residents which is the case in the American jurisdictions of Oregon and Washington.

While the potential practice of AD to non-residents has not made Belgium or Netherlands targets of international criticism to the same extent as Switzerland

¹⁸⁴ KNMG 2011 Position Paper (n 19) 7.

¹⁸⁵ Proposal of law, (Senate 2003-04 no. 3-804/1:8) (7 July 2004); See discussion in Griffiths, Weyers and Adams (n 2) 314.

¹⁸⁶ ‘93-year-old Belgian woman on hunger strike’ *Expatica* (Belgium, 24 March 2009) <www.expatica.com/be/news/local_news/93_year_old-Belgian-woman-on-hunger-strike_50901.html> accessed 31 May 2012.

¹⁸⁷ *ibid*; This issue has been recognized in the latest 2010 report of the FCEC although no reforms have been suggested. FCEC 2010 Report (n 151).

¹⁸⁸ ‘Amelie van Esbeen om 12 Uur Overleden’ *De Standaard* (Belgium, 01 April 2009) <www.standaard.be/artikel/detail.aspx?artikelid=dmf20090401_028> accessed 31 May 2012.

(discussed in Chapter III.B.4. below), this is not to say that this practice has not occurred in these jurisdictions.¹⁸⁹

To summarize, the Belgium AD model is premised on the right to self-determination whereby state responsibility to address what is currently understood to be a medical matter (suffering) was to be fulfilled on “the basis of each individual’s convictions.”¹⁹⁰ Accordingly, the Belgium law is advanced primarily on the basis of autonomy and self-determination, but is constrained by the imposition of medically classifiable suffering. Different than the Dutch model where suffering is a key factor to how AD activity becomes justified, the suffering criteria in the Belgian model is the impetus for state response. The justification for AD however arises as an acknowledgement of an extension of the right to self-determination whereby the scope of a physician’s duty to respect and protect life is to be interpreted in relation to the will of the individual.

III.B.3. Luxembourg

In 2009, Luxembourg became the third European country to introduce express legislation to permit euthanasia and PAS. The *Law of 19 March 2009 on Euthanasia and Assisted Suicide* (the Luxembourg Law of 2009)¹⁹¹ not only “draws heavily” on the Belgian Law of 2002¹⁹² it was similarly advanced without any significant consultation with the medical profession.¹⁹³ Prior to the Luxembourg Law of 2009, euthanasia was strictly prohibited under Article 397 of the Luxembourg Penal Code.¹⁹⁴ Assisted suicide on the other hand was not expressly illegal under the Luxembourg

¹⁸⁹ See for example, John Lichfield, ‘Mystery death of cancer patient ignites French euthanasia debate’ *The Independent* (London, 21 March 2008) <www.independent.co.uk/news/world/europe/mystery-death-of-cancer-patient-ignites-french-euthanasia-debate-799029.html> accessed 31 May 2012.

¹⁹⁰ Regeerakkoord [Coalition Agreement](July 1999) para 11; See also Griffiths, Weyers and Adams (n 19) 283;

¹⁹¹ *Loi du 16 mars 2009 sur l’euthanasie et l’assistance au suicide* [Law of 16 March 2009 on Euthanasia and Assisted Suicide] Mémorial A - N°46, 16 mars 2009, 615-9 <www.legilux.public.lu/leg/a/archives/2009/0046/a046.pdf> accessed 31 May 2012 (Luxembourg Law of 2009).

¹⁹² Buiting (n 59) 3.

¹⁹³ Collège Médical Luxembourg, *Communiqué du Collège médical concernant l’euthanasie du 24.04.2008* (24 April 2008).

¹⁹⁴ Code Pénal (Loi du 16 juin 1879) Mém. 1879,589- Pas. 1879,231, art 397: murder by poisoning: the use or administration of a substance, in any manner, that brings death more or less quickly shall be punished with life imprisonment [author’s translation] <www.legilux.public.lu/leg/textescoordonnes/codes/code_penal/CodePenal_PageAccueil.pdf> accessed 31 May 2012 (The Luxembourg Penal Code).

Penal Code but may have been caught by a provision related to the failure to assist a person in danger.¹⁹⁵

a. Historic Overview

Deputy Jean Huss of the Green Party introduced the topic of euthanasia into the Chamber of Deputies in 1994¹⁹⁶ and a full debate was held in 1996.¹⁹⁷ During this debate, a special Parliamentary committee was established to begin preparing the framework for future discussion on death of persons suffering from serious and incurable diseases.¹⁹⁸ In February 1998, the Luxembourg National Commission on Ethics (the “LEC”) issued a special report regarding the issues of palliative medicine, the intensive use of medication and euthanasia.¹⁹⁹ While the LEC demonstrated consensus on a number of points including the importance of palliative care, the inappropriateness of aggressive medical treatment and the relief of suffering that may also have life shortening effect, it did not come to any consensus with respect to the practice of euthanasia.²⁰⁰ Although the LEC considered euthanasia from the same point of view that drove the Dutch AD reform i.e. that at the end of life, there may be medical situations where a physician will not be morally blameworthy, the LEC decided that there was no need to change the current laws or medical code of ethics.²⁰¹

¹⁹⁵ The Luxembourg Penal Code *ibid* art 410-1: failure to assist a person in danger.

¹⁹⁶ The Chamber of Deputies, Luxembourg’s parliament, is comprised of 60 deputies elected under the proportional representation method. *Chambre des Députés du Grand-Duché de Luxembourg*, ‘Travail à la Chambre’ <www.chd.lu/wps/portal/public> accessed 31 May 2012 (Chambre Travail).

¹⁹⁷ Ministry of Health and Ministry of Social Security, *Euthanasia and assisted suicide: 25 questions 25 answers* (2010) 6 <www.sante.public.lu/fr/catalogue-publications/sante-fin-vie/fin-vie/euthanasie-assistance-suicide-25-questions-reponses-de-en/index.html> accessed 31 May 2012 (Luxembourg Euthanasia Guide); See also Jean Huss, ‘Depenalizing Euthanasia in Luxembourg’ (ADMD-L, 29 October 2008) <www.admdl.lu/en/node/57> accessed 31 May 2012 (Huss).

¹⁹⁸ Huss and Err Proposal (n 157); Luxembourg Euthanasia Guide *ibid* 6.

¹⁹⁹ The Luxembourg Ethics Commission opinion serves a fourfold function: 1) to provide information to bodies responsible for the public; 2) to conduct ethical debate and determine legal consequences; 3) to make recommendations to public bodies; 4) initiate ethical and legal debate. *Commission Consultative Nationale d’Ethique pour les Sciences de la Vie et de la Santé, Les Avis de la C.N.E: L’aide au suicide et l’euthanasie* (Avis 1/1998—May 2008) 1 <www.cne.public.lu/publications/avis/1998_1.pdf> accessed 31 May 2012.

²⁰⁰ *ibid* I.

²⁰¹ *ibid* II-III ; See also discussion report by Luxembourg Ethics Commission in Jean-Paul Harpes and Edmond Wagner (eds) *Les Cahiers de la C.N.E. Actes de la Première Journée Nationale d’Ethique 15 mai 1998 L’euthanasie et l’aide au suicide* (Fascicule IV, 15 May 1998).

A second policy debate held in Luxembourg Parliament in the spring of 1999²⁰² however led to the majority support for a possible *a priori* approach to regulating euthanasia whereby doctors would be protected from criminal liability for assisting with the death of a patient if they had first consulted with an ethics committee.²⁰³ This approach was similar to that being considered by the Belgium Senate at the time. Two resolutions related to living wills and the possible modification of the Penal Code to permit euthanasia were considered but later rejected and the possibility of the *a priori* approach was never followed up.²⁰⁴ By 2001 however, Prime Minister Jean-Claude Juncker (head of the majority Christian Social Peoples Party), announced he was ready to reopen the debate, notwithstanding that he himself was personally opposed to any change to the law.²⁰⁵

On February 5th, 2002, “inspired” by developments in Belgium,²⁰⁶ Green Party deputy Huss and Socialist deputy Lydie Err – both members of the Association for the Right to Die with Dignity (ADMD-L)²⁰⁷ – tabled a bill modeled on the Belgian Law of 2002²⁰⁸ (the Right to Die bill).²⁰⁹ Prime Minister Juncker submitted the bill to the Council of State for its opinion.²¹⁰ The discussions on the Right to Die bill provoked parallel discussions on the status and expansion of palliative care services in Luxembourg as well as identified the need to include the Luxembourgish medical community in the euthanasia debate.²¹¹

In an explanatory memorandum accompanying the Right to Die bill, Huss and Err described the debate as centering around two conflicting fundamental human rights – the right to life and the right to self-determination.²¹² Huss and Err re-iterated the Belgian Senate comment that the obligation to protect the right to life must be

²⁰² Huss (n 197).

²⁰³ Huss and Err Proposal (n 157) 6.

²⁰⁴ *ibid*

²⁰⁵ *ibid*

²⁰⁶ Huss (n 197).

²⁰⁷ Association pour le droit de mourir dans la dignité - Lëtzebuerg a.s.b.l. [Association for the right to die with dignity] was established in 1989 <www.admdl.lu/fr> accessed 31 May 2012.

²⁰⁸ Huss and Err Proposal (n 157) 7. See also Jean Huss, *Open Letter to the Prime Minister* (19 June 2002) <www.greng.lu/document_centernew.php?iddownload=278&idusergroup=20Open Letter to the Prime Minister> accessed 31 May 2012 (Huss Letter).

²⁰⁹ *Proposition de loi no.4909 sur le droit de mourir en dignité. Doc. Parl. No.4909, Sess ord. 2001-2002.*

²¹⁰ Notice of State Council (13 July 2007) Nos. 45.786, 47.259 <<http://www.conseil-etat.public.lu/fr/avis/2007/07/45786.pdf>> accessed 31 May 2012 (2007 Notice of State Council).

²¹¹ See Huss Letter (n 208).

²¹² Huss and Err Proposal (n 157) 3.

interpreted in terms of self-determination, meaning that the right to life must also reflect the will of the person.²¹³

The bill was met with strong opposition from the Catholic Church,²¹⁴ palliative care organizations,²¹⁵ and the Luxembourg Medical College (the “College”). In a 2002 opinion statement, the College emphasized its disagreement with the Right to Die Bill²¹⁶ arguing instead for the “ethics of life” to be based on support and symptom relief, “not on the acceptance of killing.”²¹⁷ The College voiced its concern for potential abuses such as patients opting for euthanasia because of feelings of being a burden, including an economic burden, on family and society (demonstrating slippery slope concerns).²¹⁸

The College also took the position that Article 43 of the *Law on Hospitals*²¹⁹ – which required doctors to relieve suffering of terminally ill patients in accordance with the patient’s choice and respect for dignity – respect for human dignity being the absolute duty of the doctor²²⁰ – made any changes to the current law or the 1991 Code of Medical Ethics²²¹ unnecessary.²²² That said, the College further acknowledged that there was always the possibility of the “exceptional” case where a doctor could face a desperate situation and be unable to resist a request evidencing a perspective consistent with the evolution of the Dutch necessity defence (see Figure 2 above).

²¹³ *ibid* 4.

²¹⁴ Michael McCabe, ‘Interview with Professor Erne Gillen – Moral Theologian and Bioethicist from Luxembourg’ (2009) 29 *The Nathaniel Report* 2 <www.nathaniel.org.nz/?sid=215> accessed 31 May 2012 (McCabe); See also *Den Menschen im Sterben würdigen, Stellungnahme der Kirche Luxemburgs zum Thema Euthanasie* (Église Catholique à Luxembourg 2002) <www.cathol.lu/Den-Menschen-im-Sterben-wurdigen.html> accessed 31 May 2012.

²¹⁵ See European Association for Palliative Care, ‘Luxembourg says ‘yes’ to euthanasia’ (2008) <www.eapcnet.org/latestnews/LuxemburgEuthanasia.html> accessed 31 May 2012 (EAPC); See also Omega 90, ‘Position d’Omega 90 sur l’euthanasie arrêtée par le Conseil d’Administration en sa séance du 13 avril 2002’ (2002) <www.omega90.lu/resources/pdf/prises_de_position/Omega_euthanasie.pdf> accessed 31 May 2012.

²¹⁶ Collège médical, *Avis du Collège médical concernant la proposition de loi sur le droit de mourir en dignité* [Medical College Opinion on the Draft Law on the Right to Die in Dignity] (2002) para 1 <www.collegemedical.lu/opsmain/download/droitdemourirendignite.pdf> accessed 31 May 2012 (2002 College Opinion).

²¹⁷ 2002 College Opinion *ibid* para 2.

²¹⁸ *ibid* para 4.

²¹⁹ *Loi du 28 août 1998 sur les établissements hospitaliers* [Luxembourg. Law of 28 August 1998 on hospital establishments] *Mémorial A - N°78*, 18 September 1998, No. 78, 1564-1672 (Law on Hospitals).

²²⁰ See discussion in 2007 Notice State Council (n 210) 5.

²²¹ Arrêté ministériel du 21 mai 1991 approuvant le code de déontologie des professions de médecin et de médecin-dentiste édicté par le Collège Médical, *Mémorial A-N°36*, 21 May 1991, art 45: doctors have no right to cause the deliberate death of their patients. <www.legilux.public.lu/leg/a/archives/1991/0036/a036.pdf> accessed 31 May 2012.

²²² 2002 College Opinion (n 216) para 6.

Under those circumstances, the College recommended that a doctor could make a decision of conscience after multi-disciplinary consultation (doctors, palliative care specialists, ethicists and so forth). If there was any doubt as to the propriety of the doctor's final decision, the matter could be referred to the College for investigation and possible disciplinary action.²²³

The Christian Social Peoples Party ("CSV"), the dominant partner in the governing coalition was opposed to the Right to Die Bill which continued to be held in abeyance awaiting the Council of State's opinion.²²⁴ In the interim, the government began to focus more intensely on its palliative care initiatives.²²⁵ A palliative care bill tabled in 2004 and its revised version tabled in 2006 were both rejected.²²⁶

On June 7, 2006, a new bill on palliative care, advance instructions and end-of-life accompaniment was tabled by the Minister of Health (the "Palliative Care Bill").²²⁷ The Palliative Care Bill was aimed at establishing a right to palliative care for any person in an advanced or terminal phase of a serious and incurable disease, whatever the cause.²²⁸ From that point on, discussions regarding the Right to Die Bill adhered to the discussions concerning the Palliative Care Bill (the "two bills").

The government continued to informally hear from interested parties including the College, private and public employee organizations, professional caregivers, health care and palliative care experts and disability rights groups, among others.²²⁹ During these discussions, public opinion polls showed that the Right to Die Bill was supported by somewhere between 50-70%²³⁰ of the population while the Catholic Church was seen to mount an "aggressive campaign" against it.²³¹

²²³ *ibid* para 8.

²²⁴ Lydie Err, 'De la proposition de loi sur le droit de mourir en dignité à la loi sur l'euthanasie et le suicide assisté' (admd-L, 18 December 2009) <www.admdl.lu/fr/node/161> accessed 31 May 2012 (Err).

²²⁵ For example, in 2004 "the Ministry of Health organised 14 pain relief and palliative care training sessions for physicians - 76 physicians attended these training units". EAPC Task Force on the Development of Palliative Care in Europe, 'Luxembourg' <www.eapcnet.org/download/forPolicy/CountriesRep/Luxembourg.pdf> accessed 31 May 2012; See also Motion de Monsieur Jean-Paul Rippinger: Droit du patient aux soins palliatifs et au traitement de la douleur (I-2002-O-M-2804-01) 21 March 2003.

²²⁶ Doc. parl. no. 5303, Sess. ord. 2003-2004. See 2007 Notice of State Council (n 210).

²²⁷ *De la proposition de loi no.5584 sur le droit relative aux soins palliatifs, à la directive anticipée et à l'accompagnement en fin de vie*, Doc. parl. No. 5584, Sess. Ord. 2005-2006.

²²⁸ The bill also obligated doctors to effectively relieve pain (physical or psychological), described treatment decision-making via advance directives and special leave provisions for family member's providing care, *ibid*.

²²⁹ 2007 Notice of State Council (n 210).

²³⁰ Ellen Verbakel and Eva Jaspers, 'A Comparative Study on Permissiveness Toward Euthanasia Religiosity, Slippery Slope, Autonomy, and Death with Dignity' (2010) 74(1)

On July 13, 2007, the Council of State finally issued an opinion on the Right to Die Bill and advised that a “reserved” approach should be taken. In support of its opinion, the Council of State cited both the 2005 Code of Medical Ethics²³² which prohibited doctors from performing euthanasia and assisted suicide²³³ and the Parliamentary Assembly of the Council of Europe’s 1999 recommendation to maintain a prohibition on the intentional taking of the life of the terminally ill and dying.²³⁴ In a supplementary opinion issued later that same year, the Council of State determined that the Right to Die Bill was not compatible with the Palliative Care Bill because of, among other things, a lack of consistency in terminology and the provisions concerning living wills.²³⁵

Notwithstanding the position of the Council of State, on February 19, 2008, the Chamber of Deputies unanimously passed the Palliative Care bill and also passed the Right to Die Bill but by a much slimmer margin, (30 in favour, 26 against).²³⁶ The Chamber of Deputies requested the Council of State to waive the second vote of the bills.²³⁷ The Council of State refused the request²³⁸ because of the ongoing

Public Opinion Quarterly 109, 111; Rory Watson, ‘Luxembourg is to allow euthanasia from 1 April’ (2009) 338 *British Medical Journal* b1248 (Watson);

²³¹ Watson *ibid*; See discussion in Archbishop of Luxembourg, ‘Une parole de l’Archevêque de Luxembourg sur l’euthanasie’ (7 December 2008) <www.cathol.lu/Une-parole-de-l-Archeveque-de.html> accessed 31 May 2012; See also letter from Mgr Rino Fisichella to Chamber of Deputies, ‘Euthanasie : l’académie pour la vie adresse une lettre au Luxembourg’ (5 December 2008) <www.zenit.org/rssfrench-19623> Archbishop of Luxembourg, ‘Une parole de l’Archevêque de Luxembourg sur l’euthanasie’ (7 December 2008) <www.cathol.lu/Une-parole-de-l-Archeveque-de.html> accessed 31 May 2012.

²³² Arrêté ministériel du 7 juillet 2005 approuvant le code de déontologie des professions de médecin et de médecin-dentiste édicté par le Collège Médical <www.collegemedical.lu/Codededeontologiemedicale.pdf> accessed 31 May 2012 (2005 Luxembourg Code of Medical Ethics).

²³³ *ibid* art 40

²³⁴ See 2007 Notice of State Council (n 210); See also Parliamentary Assembly of the Council of Europe, *Recommendation 1418 (1999) on Protection of human rights and dignity of the terminally ill and dying*, No.8241 (21 May 1999).

²³⁵ Council of State (Supplementary Opinion, 11 December 2007) <www.conseil-etat.public.lu/fr/avis/2007/12/> accessed 31 May 2012.

²³⁶ Julien Ponthus, ‘Luxembourg parliament adopts euthanasia law’ *Reuters* (20 February 2008) <www.reuters.com/article/2008/02/20/us-luxembourg-euthanasia-idUSL2011983320080220> accessed 31 May 2012.

²³⁷ Laws must be passed by an absolute majority of the Chamber of Deputies in two separate votes held at least three months apart. This two vote requirement can be waived by the Council of State. *Chambre Travail* (n 196).

²³⁸ *Chambre des Deputes Session ordinaire 2007-2008, Refus de dispense de second vote constitutionnel par le Conseil d’Etat* (04-March-2008) No 4909(7) <www.chd.lu/wps/portal/public/RoleEtendu?action=doDocpaDetails&id=4909#> accessed 31 May 2012; For reasons for refusal see *Rapport de la Commission de la Santé et de la Sécurité sociale, Discussion générale Motion Vote sur l’ensemble de la proposition de loi et dispense du second vote constitutionnel* (C-2007-O-027-0004).

incompatibilities between the two bills²³⁹ and instead required that the Right to Die bill be amended. The Council of State further stipulated that both bills would have to pass the second reading simultaneously.²⁴⁰ A suspected political calculation behind this move was that if both bills were bound, the Right to Die Bill would be more likely to fail because it had been advanced by only two members of parliament as opposed to the Palliative Care Bill which had been endorsed by a government majority.²⁴¹

Work by the Ministry of Health in consultation with the Council of State culminated in two sets of amendments adopted in June and November 2008 respectively.²⁴² Voting on the bills was delayed however due to the anticipated refusal of the Grand Duke of Luxembourg (who personally opposed the Right to Die Bill) to sign the law into force as required by the Luxembourg Constitution. A vote was thus held to permit an amendment to the language the Luxembourg Constitution so that the Grand Duke would be able to promulgate laws without also having to “sanction” them.²⁴³ The constitutional amendment was passed at the first vote and on December 18, 2008, the Palliative Care and Right to Die Bills were subsequently passed by the Luxembourgish Parliament by 60 out of 60 votes and 30 out of 59 votes (1 abstention) respectively.²⁴⁴ The requirement for the second vote was waived.²⁴⁵ After the second vote in favour of amending the Constitution,²⁴⁶ the Luxembourg Law of 2009 and the

²³⁹ Conseil d'état du Grande-Duché de Luxembourg, 'Motifs du refus de la dispense du second vote constitutionnel des projets n° 4909 (droit de mourir en dignité) et n° 5584 (soins palliatifs, directive anticipée et accompagnement en fin de vie) (10 April 2008) <www.conseil-etat.public.lu/fr/actualites/2008/04/motifrefusdispense/index.html> accessed 31 May 2012.

²⁴⁰ *ibid*; EAPC (n 215).

²⁴¹ McCabe (n 214) 1.

²⁴² Chambre des Deputes Session ordinaire 2007-2008 No 4909(10) *Amendements adoptés par la Commission de la Santé et de la Sécurité sociale* (10 June 2008) and Chambre des Deputes Session ordinaire 2008-2009 No 4909(12), *Amendements adoptés par la Commission de la Santé et de la Sécurité sociale* (5 November 2008); See also Chamber of Deputes, *Rapport complémentaire de la commission de la Sante et de la Securite Sociale* (Supplementary Report of The Board of Health and Social Security) (No 4909/15) (4 December 2008) 2.

²⁴³ Le gouvernement Luxembourg, *Adoption en première lecture du projet de révision de l'article 34 de la Constitution* (Press Release, 11 December 2008) <www.gouvernement.lu/salle_presse/actualite/2008/12-decembre/11-revision-constitution/index.html> accessed 31 May 2012.

²⁴⁴ McCabe (n 214) 1,2.

²⁴⁵ Chambre des Deputes Session ordinaire 2008-2009, No 4909(17), *Dispense du second vote constitutionnel par le conseil d'état* (19 December 2008), <www.chd.lu/wps/portal/public/RoleEtendu?action=doDocpaDetails&id=4909#> accessed 31 May 2012.

²⁴⁶ Le gouvernement Luxembourg, *Adoption en deuxième lecture du projet de révision de l'article 34 de la Constitution* (Press Release, 12 March 2009) <www.gouvernement.lu/salle_presse/actualite/2009/03-mars/12-constitution/index.html> accessed 31 May 2012.

Palliative Care Law²⁴⁷ were promulgated on March 16, 2009.²⁴⁸ Both laws entered into force on April 1st, 2009.²⁴⁹

By implementing discrete legislation, Luxembourgish lawmakers established a distinction between the practice of palliative care and the practice of AD, arguably leaving little scope for any argument that AD formed part of the palliative care spectrum in Luxembourg. On the other hand, it is important to point out that the Luxembourg Law of 2009 and the Palliative Care Law are linked; doctors are required to inform patients who have requested euthanasia or PAS of their palliative care rights and options.²⁵⁰ Likewise, doctors providing palliative care are required to respect and comply with a patient's treatment directions including those that may have the effect of advancing the end of life.²⁵¹

b. Legislative Framework

Euthanasia is illegal and considered to be a form of murder under Article 397 of Luxembourg's Penal Code.²⁵² However, similar to the *ex post facto* regulatory approach taken by the Netherlands and Belgium, Article 397 has been amended by the Luxembourg Law of 2009 by the insertion of Article 397.1 which states that the prohibition will not apply to a physician who, when responding to a request for euthanasia or assisted suicide, has fulfilled the conditions under the Luxembourg Law of 2009.²⁵³ The Luxembourg Law of 2009 exempts a physician from civil liability in addition to criminal liability if certain substantive and procedural conditions are met.²⁵⁴

Article 1 defines both euthanasia – an act performed by a doctor, intentionally ending the life of a person on their express and voluntary request – and assisted suicide – a doctor intentionally assisting another person to commit suicide or providing the means to that end on their express and voluntary request. The “intentional” criteria again

²⁴⁷ Loi du 16 mars 2009 relative aux soins palliatifs, à la directive anticipée et à l'accompagnement en fin de vie et modifiant: 1. le Code de la sécurité sociale; 2. la loi modifiée du 16 avril 1979 fixant le statut général des fonctionnaires de l'Etat; 3. la loi modifiée du 24 décembre 1985 fixant le statut général des fonctionnaires communaux; 4. le Code du travail. Mémorial A - N°46, 16 mars 2009, 615-9 <www.legilux.public.lu/leg/a/archives/2009/0046/a046.pdf> accessed 31 May 2012 (Luxembourg Palliative Care Law of 2009).

²⁴⁸ *ibid.*

²⁴⁹ Watson (n 229)

²⁵⁰ Luxembourg Law of 2009 (n 191) art 2.2.1

²⁵¹ Luxembourg Palliative Care Law of 2009 (n 247) arts 3, 4 and 6.

²⁵² The Luxembourg Penal Code (n 195) art 397.

²⁵³ Luxembourg Law of 2009 (n 191) art 14.

²⁵⁴ *ibid* art 2.1.

operate to exclude other medical practices such as pain relief with life shortening effect, withdrawal or withholding of treatment on the basis of futility or direction of the patient and palliative sedation.²⁵⁵

i. *Due Care Requirements*

Consistent with both the Dutch and Belgian Laws of 2002, the substantive due care conditions (patient qualifiers) that exempt a physician from liability pursuant to the Luxembourg Law of 2009 include that:²⁵⁶

- the patient is competent and conscious;
- the patient is in a hopeless medical situation with constant and unbearable suffering (physical or mental) and without prospect of improvement and arising from a pathological illness or accident;
- the request is made voluntarily, after reflection and does not result from external pressure;
- the request does not necessarily have to be repeated but it must be in writing.²⁵⁷

Unlike the Dutch and Belgian Laws of 2002, the substantive criteria further require that the patient be an “adult”.²⁵⁸ The Luxembourg Law of 2009 also expressly distinguishes the substantive “fundamental” criteria from the “formal and procedural” conditions to be satisfied.

The procedural safeguards include that the doctor must:²⁵⁹

- inform the patient of his or her condition and life expectancy;
- be convinced of the patient’s voluntariness;
- discuss the request and therapeutic alternatives;
- ensure the persistence of suffering and believe that there is no other acceptable solution (from the patient’s point of view) through a series of interviews at reasonable intervals;
- consult an impartial doctor (impartial from patient, treating physician and pathology) who will review the medical file, examine the patient and confirm suffering and lack of improvement; and

²⁵⁵ See for example, Luxembourg Code of Medical Ethics (n 231) art 41 and Law on Hospitals (n 219) art 43; Clarification regarding these practices are contained in the Luxembourg Palliative Care Law of 2009 (n 247) arts 2, 3.

²⁵⁶ Luxembourg Law of 2009 (n 191) art 2.1.

²⁵⁷ If the patient is physically unable to draft and sign the request it may be transcribed and signed by an adult person chosen by the patient, in the presence of a doctor as witness. Luxembourg Law of 2009 *ibid* arts 2.1.4 and 2.2.7; See also interpretation in Luxembourg Euthanasia Guide (n 197) 14.

²⁵⁸ Luxembourg Law of 2009 *ibid* art 2.1.

²⁵⁹ *ibid* art 2.2.

- check to see if the patient has registered a “disposition de fin de vie” (“end-of-life provision”) with the control and assessment authority (discussed further below).

It is interesting to note that the parameters of the doctor-patient relationship are in this case expressly contained within the procedural safeguards as opposed to in the substantive safeguards or in a vague combination of both. This distinction is compelling for at least two reasons. First, it is only non-compliance with the enumerated substantive conditions that warrant notification to the public prosecutor.²⁶⁰ Non-compliance with the enumerated procedural requirements on the other hand only trigger notification to the Medical College for possible disciplinary action.²⁶¹ Placing the details of the patient-physician relationship within the procedural safeguards, as opposed to being a substantive qualifier for AD, arguably demonstrates a viewpoint that is more patient-focused and in turn denotes the emerging primacy of the right to self-determination with physician participation leaning more towards the role of gatekeeper to ensure that the substantive criteria have been met.

Secondly, the distinction is interesting from a non-resident perspective as again there is no express clause regarding residency or nationality under the Luxembourg legislation. Thus, while the law implicitly imposes a close relationship between the doctor and the requesting patient,²⁶² if a doctor is not in compliance with this aspect, as might arise with a non-resident patient, this will be a matter for the Medical College to address, not the public prosecutor.

Like the Netherlands and Belgium, the Luxembourg Law of 2009 permits euthanasia for a patient in an irreversible state of unconsciousness. Under the law, if the patient has drafted, signed and registered an end-of-life provision with the National Control and Assessment Commission (the “CNCE”),²⁶³ a physician may provide euthanasia provided the substantive and procedural conditions have been met.²⁶⁴ Any reiteration,

²⁶⁰ *ibid* art 8.

²⁶¹ *ibid* art 8.

²⁶² A close doctor-patient relationship is inferred because the doctor must know the patient well enough to be able to confirm that the request is made freely and direct because of the obligation to have several interviews and so forth. See Luxembourg Euthanasia Guide (n 197) 26.

²⁶³ Le Commission Nationale de Contrôle et d’Evaluation (the CNCE) is established under Chapter 5 and is to be comprised of 9 members from medicine, law and patient rights representatives. Luxembourg Law of 2009 (n 191) Chpt V.

²⁶⁴ Substantive conditions include: severe and incurable accidental or pathological disorder; state of unconsciousness; and an irreversible situation according to science at the time. As with the Belgian Law of 2002, suffering is not a requirement. Procedural conditions include: consultation with a colleague in respect of the patient’s condition; discussion with the care team; and discussion with the family and appointed person of trust. Luxembourg Law of 2009 *ibid* art 4.

adaptation or withdrawal of the provision must also be registered with the CNCE. However, regardless of any registration, a doctor must always take into account the patient's wishes. Thus, if the doctor becomes aware of a different expression of the patient's wishes, euthanasia must not take place.²⁶⁵

ii. *Reporting and Review*

Doctors must submit a registration document in the appropriate form to the CNCE within eight (8) days of the euthanasia or PAS.²⁶⁶ The CNCE mandate is to examine the document and make a ruling within two months of the submission as to whether the conditions have been met.²⁶⁷ If the CNCE rules that a doctor has not complied with the due care requirements it will notify either the public prosecutor or Medical College depending on whether the breach involves a substantive or procedural condition as described above. The CNCE is also tasked with maintaining a registry for the registration of end-of-life provisions and producing a report every two years for the Chamber of Deputies. The biennial report is to contain statistical data, an assessment of the law and any recommendations for legislative change.²⁶⁸

c. *Compassion and Suffering, Autonomy and Self-Determination*

Some commentators have interpreted the Luxembourg Law of 2009 as only being applicable to those who are "terminally ill". This interpretation is consistent with language used in the English language version of the Ministry of Health Euthanasia Guide (the "Euthanasia Guide") which appends an English translation of the Luxembourg Law of 2009. In this translation, Article 2.1.1, sets out that a patient must be "in a terminal medical situation." The Euthanasia Guide also uses the phrase "terminal state of health" when describing the disorders for which euthanasia may be possible.²⁶⁹ Unfortunately, the guide does not provide a definition of "terminal". However, the Euthanasia Guide does go on to state that the legal conditions could be met by "any severe, incurable and irreversible disorder" in addition to the more common "advanced cancers or neuro-muscular illnesses".²⁷⁰ This description is consistent with the French legislative language "sans issue", which is perhaps more accurately translated as "hopeless" rather than "terminal". The accuracy of the statement that the law is limited to the "terminally ill" is thus dependent on how "terminally ill" is defined. It would appear that in the case of the Luxembourg Law of

²⁶⁵ For further discussion see Luxembourg Euthanasia Guide (n 197) 19-24.

²⁶⁶ Luxembourg Law of 2009 (n 191) art 5.

²⁶⁷ *ibid* arts 7 and 8.

²⁶⁸ *ibid* art 9.

²⁶⁹ Luxembourg Euthanasia Guide (n 197) 13.

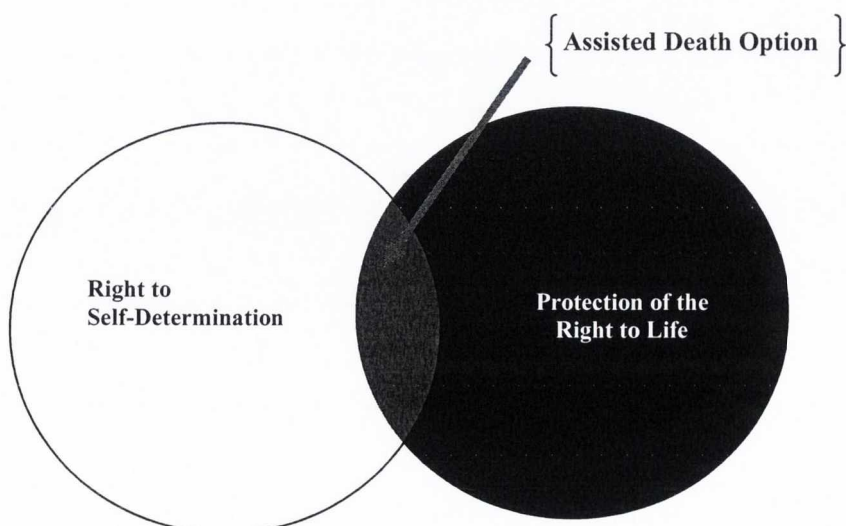
²⁷⁰ *ibid* 13.

2009, the definition of “terminal” is not restricted to illnesses or conditions that result in death but rather extends to any medical disorder considered incurable or irreversible.

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

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

Figure 5: AD advanced as a right to self-determination in conflict with protection of the right to life



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

Indeed, as described earlier, the main catalyst for the change to Luxembourg law came from proponents of the right to die with dignity who justified AD practices in a manner similar to that of Belgium – from the perspective of the autonomous individual. On the other hand, the Luxembourgish medical community took the position that AD law was interfering with the special trust relationship between doctor and patient. To date, the 2005 Code of Medical Ethics has not been adapted to conform with the liberalization of euthanasia and PAS and still maintains a prohibition against both.²⁷¹ Hence a doctor who carries out a request under the requisite conditions will be in compliance with the law but in breach of the current Code of Medical Ethics.

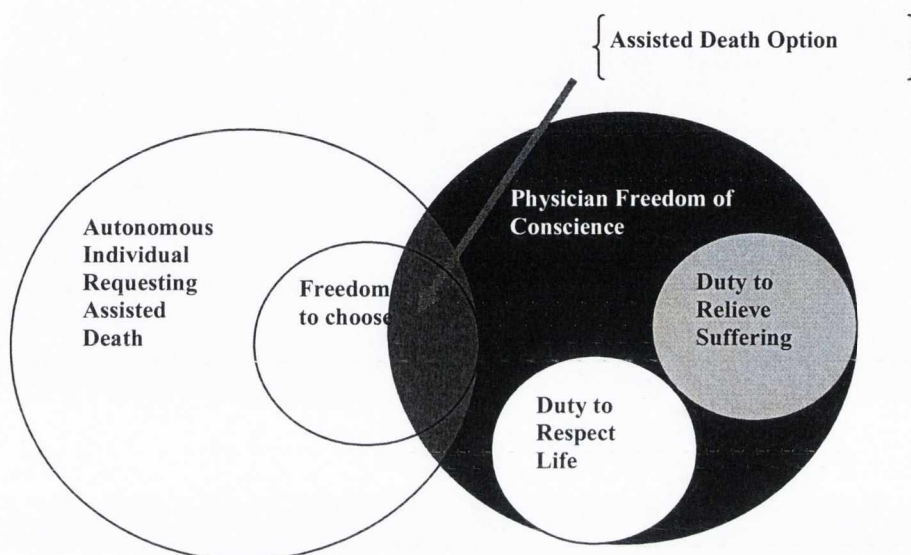
The framing of the conflict at issue in the Luxembourg AD debate is therefore particularly interesting in that it shows a further evolution in thinking with respect to the substance of patient "rights" in terms of accessing AD as well as the balancing of rights as between doctors and their patients. On one hand the language of self-determination within the context of AD includes the idea of a "right to decide on the end of their life in accordance with their beliefs"²⁷² while on the other hand there is greater recognition that the conscience of the physician may be in conflict with that "right". The legalization of AD under the Luxembourg Law of 2009 appears to be grounded on respect for the autonomy of the suffering patient. However, by passing both the Palliative Care Law and the AD Law of 2009 simultaneously and overtly managing their distinction, Luxembourg parliament appears to have equalized, rather than merged, the agendas of the duty to relieve suffering and the duty to protect life,

²⁷¹ 2005 Luxembourg Code of Medical Ethics (n 231) art 40.

²⁷² Luxembourg Euthanasia Guide (n 197) 6.

limiting AD to circumstances where the patient's right to self-determine coincides with the physician's conscience. Within this balance, Luxembourgish lawmakers protect doctors who accede to the individual's request for euthanasia or assisted suicide from criminal or civil liability.²⁷³

Figure 6: AD advanced on basis of the patient's freedom to choose constrained by physician freedom of conscience



But as with the Netherlands and Belgium, there is no absolute right to euthanasia or PAS under the Luxembourg Law of 2009. In the event that a doctor conscientiously objects and does not wish to grant a request for euthanasia or PAS, the doctor is obligated to inform the patient (or their person of trust/spokesperson) within 24 hours and transfer the file to another doctor identified by the patient.²⁷⁴ According to the Ministry of Health Euthanasia Guide, the freedom of conscience to be exercised is an individual one, thus an institution (such as a hospital or retirement home for example) cannot impose an institutional policy against the practice of euthanasia or PAS in order to prevent a doctor from exercising what is his or her individual freedom to grant a request.²⁷⁵

d. Statistics and Trends

The first biennial report of CNCE was released in March 2011. For the years 2009 and 2010, only five (5) declarations of euthanasia were submitted to the CNCE (1 in 2009

²⁷³ *ibid* 10.

²⁷⁴ Luxembourg Law of 2009 (n 191) art 15.

²⁷⁵ Luxembourg Euthanasia Guide (n 197) 30.

and 4 in 2010).²⁷⁶ All five requests were from patients suffering from terminal cancer (3 women, 2 men) and over the age of 60.²⁷⁷ According to the CNCE, all 5 cases were found to be in compliance with the legal requirements and all took place either at the home of the patient concerned or in a hospital.²⁷⁸

Despite the small numbers, which do not provide much information for statistical analysis, the CNCE reached consensus that unbearable suffering must be assessed through thorough consultation between patient and physician. The CNCE did not elaborate on the reasons underlying this statement. Nor did the CNCE offer an opinion as to the relatively small number of cases or the possibility of physician under-reporting. It should be observed however that the population of Luxembourg is itself small and young, estimated in 2010 to be 502,100 of which 86% is less than 65 years of age.²⁷⁹ 43.1% of the 2010 figures belongs to the foreign community.²⁸⁰ The five deaths under the Luxembourg Law of 2009, represents approximately .001% of the total annual deaths in Luxembourg.²⁸¹

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

A 2009 case in Luxembourg is set to provoke further clarification on the scope of the “right” to request euthanasia or PAS under the law. A patient suffering from the terminal stages of cancer was denied euthanasia at a Catholic clinic even though his doctor had authorized the procedure. The board of the clinic refused the request. As described above, while doctors individually have the right to refuse on grounds of

²⁷⁶ Commission Nationale de Contrôle et d'Évaluation, *Commission Nationale de Contrôle et d'Évaluation de la loi du 16 mars 2009 sur l'euthanasie et l'assistance au suicide Premier rapport à l'attention de la Chambre des Députés (Années 2009 et 2010)* (March 2011) 4 <www.sante.public.lu/publications/sante-fil-vie/fin-vie/premier-rapport-loi-16-mars-2009/premier-rapport-loi-16-mars-2009.pdf> accessed 31 May 2012.

²⁷⁷ *ibid* 4,5.

²⁷⁸ *ibid* 12. In all cases, death was obtained by injection of Sodium Pentothal to induce unconsciousness followed by intravenous injection of a paralyzing neuromuscular causing death by cardiopulmonary arrest.

²⁷⁹ Central Service for Statistics and Economic Studies (Statec), *Luxembourg in Figures* (2010) <www.statistiques.public.lu/catalogue-publications/luxembourg-en-chiffres/luxembourg-figures.pdf> accessed 31 May 2012.

²⁸⁰ *ibid*.

²⁸¹ Luxembourg has an estimated annual death rate of approximately 8.43 deaths out of 1000. Central Intelligence Agency, *World Fact Book* (2008) 350 <www.cia.gov/library/publications/the-world-factbook/geos/lu.html> accessed 31 May 2012.

personal conscience, an institution does not share that right. The investigation is currently ongoing.²⁸²

Pursuant to requirements under the Luxembourg Law of 2002, a national debate on the entire issue is anticipated in the near future.²⁸³

To summarize, like Belgium, Luxembourg advances the right to request euthanasia or PAS principally on the basis of the right to self-determination. Physicians can individually refuse a request for AD on the basis of freedom of conscience. The suffering requirement is imposed by the overall state task to respond to irremediable medical suffering and a re-interpretation of physician duty to protect life to include the perspective of the patient's right to self determination.

III.B.4. Switzerland

a. Historic Overview

Article 115 of the Swiss Penal Code²⁸⁴ reads:

Inciting and assisting someone to commit suicide

A person who, for selfish reasons, incites someone to commit suicide or who assists²⁸⁵ that person in doing so shall, if the suicide was carried out or attempted, be sentenced to a term of imprisonment.²⁸⁶

Thus, in Switzerland, assisting someone to commit suicide is not a punishable offence when it is done for “unselfish” reasons. Euthanasia²⁸⁷ on the other hand is illegal under Article 114 of the Swiss Penal Code, albeit is treated as a lesser offence than murder

²⁸² Adam Walder, ‘Denied euthanasia case: a conflict of church and state’ 352 *Lux Magazine* (09 October 2009) <www.352luxmag.lu/index.php?p=edito&id=13090&titleurl=denied-euthanasia-case-a-conflict-of-church-and-state> accessed 31 May 2012.

²⁸³ Luxembourg Law of 2009 (n 191) art 13.

²⁸⁴ Swiss Penal Code (SR 311.0), 21 December 1937, in force since 1 January 1942. The section on homicide was amended by Federal Law of 23 June 1989, in force since 1 January 1990. Unofficial translation by the Federal Authorities of Swiss Confederation, <www.admin.ch/ch/e/rs/3/311.0.en.pdf> accessed 31 May 2012 (Swiss Penal Code).

²⁸⁵ Assists may take the form of providing the lethal means or psychological support. The Swiss National Advisory Commission on Biomedical Ethics, *Assisted Suicide* (Opinion No.9/2005) 7 <www.bag.admin.ch/nek-cne/04229/04232/index.html?lang=en> accessed 31 May 2012 (NEK-CNE Opinion No. 9).

²⁸⁶ In this case, maximum punishment is 5 years of imprisonment (*Zuchthaus*: penitentiary), the minimum punishment is 3 days of imprisonment (*Gefängnis*: prison).

²⁸⁷ The term “Euthanasia” is not used in German-speaking Europe including Switzerland because of its association with Nazi Germany’s “Euthanasie” programme. The term “Sterbehilfe” (literally, “assisted dying”) is preferred and relates to any medical act or omission that foreseeably or intentionally hastens death. Euthansia as it is understood in this paper, is described as “direct active” Sterbehilfe in Switzerland. Georg Bosshard, ‘Switzerland’ in John Griffiths, Heleen Weyers and Maurice Adams (eds), *Euthanasia and Law in Europe* (Hart Publishing 2008) 463,468 (Bosshard, Switzerland).

or manslaughter.²⁸⁸ The practices of increased pain and symptom relief with possible life-shortening effect²⁸⁹ and non-treatment decisions (withdrawal or withholding life sustaining treatment)²⁹⁰ are considered to be acceptable medical practices under both Swiss law²⁹¹ and professional medical guidelines.²⁹²

Assisted suicide practice pursuant to the word “unselfish” in Article 115 does not require that a physician be involved or that the patient be suffering from a particular medical condition, such as a terminal illness. Because of this, Switzerland has been able to develop an open practice of assisted suicide separate from relying on interpretations of the specific duties of the medical profession. Furthermore, the introduction of Article 115 did not arise out of medico-ethical discussions on patient suffering, rather, Article 115 was “inspired by romantic stories about people committing suicide in defence of their own, or their family’s, honour and about suicides committed by rejected lovers.”²⁹³ So although Swiss legislators believed it necessary to include a criminal provision for assisted suicide in order to prevent abuses from occurring (suicide itself not being illegal), they did so in such a way as to not incriminate individuals who had assisted others in committing suicide for “altruistic” reasons.²⁹⁴

²⁸⁸ Article 114, Penal Code: A person who, for decent reasons, especially compassion, kills a person on the basis of his or her serious and insistent request, will be sentenced to a term of imprisonment. Swiss Penal Code (n 284). Under Swiss law, the intentional killing of a person will result in a charge of “intentional killing” under Article 111 of the Penal Code but can be elevated to murder (Article 112 *Mord*) if it is shown that the accused acted with a “reprehensible motive”. Mitigating circumstances on the other hand will lead to charges of manslaughter (Article 113 *Totschlag*), killing on request (Article 114, *Tötung auf Verlangen*) or infanticide (Article 116, *Kinderstötung*). Another provision of potential relevance is Article 117, Negligent Killing (*fahrlässige Tötung*). Christian Schwarzenegger and Sarah J Summers, *Criminal Law and Assisted Suicide in Switzerland*, (Hearing with the Select Committee on the Assisted Dying for the Terminally Ill Bill, House of Lords, 3 February 2005) 2-3, <www.rwi.uzh.ch/lehreforschung/alphabetisch/schwarzenegger/publikationen/assisted-suicide-Switzerland.pdf> accessed 31 May 2012 (Schwarzenegger and Summers).

²⁸⁹ Also known as “indirect active sterbehilfe” whereby person acts with a view to relieve suffering, not to kill. Thus would also therefore include palliative/terminal sedation. Death is considered ‘natural’. Oliver Guillod and Aline Schmidt, ‘Assisted Suicide under Swiss Law’ (2005) 12 *European Journal of Health Law* 25, 26 (Guillod and Schmidt); See also Bosshard, Switzerland (n 287) 466-8.

²⁹⁰ Also known as “Passive sterbehilfe” whereby death is caused by the underlying illness. Guillod and Schmidt *ibid* 26. Passive sterbehilfe is not restricted to end-of-life decisions – a competent patient can refuse treatment at any stage of disease. Death is considered ‘natural’. Bosshard, Switzerland *ibid* 466; See also court decision, *Arbeitsgruppe Sterbehilfe* 1999:15.

²⁹¹ These acts are deemed permissible from the criminal, civil and constitutional law perspectives, civil law perspective and constitutional perspective. For full discussion see Guillod and Schmidt *ibid* 26, fn 6.

²⁹² See discussion in Bosshard, Switzerland (n 287) 466-7.

²⁹³ Guillod and Schmidt (n 289); See also discussion in NEK-CNE Opinion No. 9 (n 285) 28-30, 32.

²⁹⁴ During the 19th century (in Switzerland and other jurisdictions) suicide was examined from a sociological (rather than religious) perspective which called for sympathy and prevention measures rather than criminal punishment. Suicide was thus not included in the criminal codes

As a consequence, over the past two decades, Swiss assisted suicide practice has largely developed through right-to-die organizations²⁹⁵ whereby assisted suicide is more securely held as a human rights issue rather than a medical one; to a great extent existing at the edges of mainstream medical care.²⁹⁶ Having said this, if assistance with a suicide involves a lethal barbiturate, a physician must be involved as a medical prescription is required pursuant to the Narcotics Law²⁹⁷ and the Pharmaceutical Law²⁹⁸ (the “Swiss Narcotics laws”). Because current standard practices by Swiss right-to-die organizations involve the use of barbiturates, the majority of cases of assisted suicide facilitated by these organizations are captured by the Swiss Narcotic laws and can therefore be classified as a form of PAS. Swiss physicians may also independently assist the suicide of a patient without having first been introduced to the patient by a right-to die society, although the latter is usually the case.

PAS in Switzerland has historically been discouraged by the Swiss Academy of Medical Sciences²⁹⁹ (the “SAMW”). Since 2004 however, the SAMW has expressly recognized that a decision to assist a suicide is ultimately a matter of the individual physician’s conscience.³⁰⁰ This development is discussed in further detail below.

In 1982, two right-to-die organizations emerged in Swiss society, Exit Deutsche Schweiz (“Exit DS”) for German-speaking Switzerland (headquartered in Zurich)³⁰¹

of individual Swiss cantons nor in the articulation of the Swiss Penal Code commencing the last decade of the 19th century. Assistance with suicide however was considered a crime in a number of Swiss cantons, and continued to be so considered as the Swiss Penal Code was elaborated, except under particular altruistic circumstances in order to prevent the over-extension of the criminal offence. For further discussion see discussion in NEK-CNE Opinion No. 9 *ibid* 28; See also Guillod and Schmidt (n 289) 28-9; See also NEK-CNE Opinion No. 9 *ibid*.

²⁹⁵ Eliane Pfister and Nikola Biller-Andorno, ‘Physician-Assisted Suicide: Views of Swiss Health Care Professionals’ (2010) 7 *Bioethical Inquiry* 283, 283.

²⁹⁶ Bosshard, Switzerland (n 287) 463.

²⁹⁷ 812.121. *Loi fédérale sur les stupéfiants et les substances psychotropes du 3 octobre 1951* (Etat le 1^{er} janvier 2011) [*Federal Narcotic and Psychotropic Substances Act of October 3, 1951*] (as at January 1 2011) art 11: <www.admin.ch/ch/f/rs/812_121/index.html#fn1> accessed 31 May 2012 (The Narcotics Law).

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

²⁹⁹ In German, Schweizerische Akademie der MweizinischencWissenschaften.

³⁰⁰ Schweizerische Akademie der MweizinischencWissenschaften [Swiss Academy of Medical Sciences] (2004) *Care of Patients in the End of Life*, para. 4.1 <www.samw.ch/en/Ethics/Guidelines/Currently-valid-guidelines.html> accessed 31 May 2012 (2004 SAMW Guidelines).

³⁰¹ EXIT, ‘EXIT – Selbstbestimmung im Leben und im Sterben’ [EXIT-Self-determination in life and death] <www.exit.ch/wDeutsch/> accessed 31 May 2012 (Exit DS Website).

and Exit Association pour le Droit de Mourir dans la Dignité (“Exit ADMD”)³⁰² for French-speaking Switzerland (headquartered in Geneva).³⁰³ Exit DS and Exit ADMD are the largest right-to-die organizations in Switzerland.

In 1997, the executive director of Exit DS and protestant minister, Rolf Sigg, left Exit DS to form Ex-International, “Association for assistance in autonomous dignified death” (“Ex-International”).³⁰⁴ In 1998, a second member of Exit DS (and human rights lawyer), Ludwig A. Minelli, broke away to form a fourth end-of-life organization, Dignitas.³⁰⁵ And in January 2002, psychiatrist Peter Baumann, resigned from Exit DS over the issue of assisted suicide for patients with mental illness – Baumann being in favour. Baumann and 27 other members of Exit DS, formed Suizidhilfe³⁰⁶ which defends the absolute right of individuals to determine their time of death, including individuals who do not suffer from a somatic illness and who have been diagnosed as mentally ill.³⁰⁷ These organizations strongly affirm the absolute right of self-determination and autonomy of the individual, with a limited or no role desired from “paternalistic” medicine.³⁰⁸ While some of these organizations are also active in promoting the use of advance directives for medical treatment, the Swiss AD organizations³⁰⁹ are more widely known for their assisted suicide services.³¹⁰

i. *Swiss AD Organizations*

Exit DS currently has over 50,000 members in Switzerland³¹¹ and is Zurich’s largest right-to-die organization.³¹² The early activities of Exit DS involved the distribution of suicide manuals to its members providing detailed instructions regarding lethal

³⁰² Exit, ‘Exit Association pour le Droit de Mourir dans la Dignité’ [Exit Association for the Right to Die with Dignity] <www.exit-geneve.ch/index.html> accessed 31 May 2012 (Exit ADMD Website).

³⁰³ Lewy (n 10) 89.

³⁰⁴ *ibid*; Ex-International, ‘Ex-International’ <www.exinternational.ch/> accessed 31 May 2012 (Ex-International Website).

³⁰⁵ Lewy (n 81) 110; Dignitas, ‘Dignitas – Menschenwürdig leben - Menschenwürdig sterben’ [Dignitas - Live with dignity - Die with dignity] <www.dignitas.ch/> accessed 31 May 2012 (Dignitas Website).

³⁰⁶ Suizidhilfe, ‘Suizidhilfe’ <Suizidhilfe.ch> accessed 31 May 2012 (Suizidhilfe Website).

³⁰⁷ Lewy (n 81) 109; See also Peter Baumann, ‘Behilfe zum Suizid kann eine ärztliche Handlung sien’ (2001) 82(6) Schweizerische Ärztezeitung / Bulletin des médecins suisses 296, 296-8 <www.saez.ch/pdf/2001/2001-06/2001-06-1091.PDF> accessed 31 May 2012.

³⁰⁸ Lewy (n 10) 89.

³⁰⁹ EXIT, ‘Patientenverfügung – Was ist ein PV?’ <www.exit.ch/wDeutsch/2110006/was_ist_eine_pv.php?navanchor=2110030> accessed 31 May 2012; Note: an advance directive cannot be used to request suicide assistance. See also Lewy (n 10) 93.

³¹⁰ Lewy *ibid*.

³¹¹ Exit DS Website (n 301).

³¹² As of 2010, the annual membership fee is 45 CHF (€35, £29, \$47 CAD). A lifetime membership is 900 CHF (€701, £598, \$948USD). EXIT, ‘Melden Sie sich an’ <www.exit.ch/wDeutsch/2110001/melden_sie_sich_an.php> accessed 31 May 2012.

combinations of drugs and the use of plastic bags for asphyxiation.³¹³ Over the years, Exit DS has increased its activities in respect of assessing and guiding individuals through the suicide process. These activities include: the evaluation of patients by volunteer assistants; the review of requests and medical files by Exit DS officials; the conducting of a second review by an ethics committee in particularly difficult cases; if needed, the facilitation of access to a physician who can prescribe the lethal drug, typically sodium pentobarbital (NaP); the presence of attendant/witness at the terminating act; and the reporting of assisted suicides to the appropriate authorities.³¹⁴ As is the case with all AD in Switzerland, in order to not fall afoul of Article 114, the final step (for example, the taking of the oral medication or the opening the valve of an intravenous line or feeding tube) must be carried out by the individual wishing to die.³¹⁵

Exit DS will assist in a suicide provided the patient is competent, has a persistent desire to die and is suffering unbearably. In accordance with its philosophy which stresses self-determination and autonomy of the individual, Exit DS sanctions assistance to those who are not only terminally ill, but also to those who have severe disabilities or who are experiencing other conditions such as “weariness” or “tired” of life.³¹⁶ Exit DS limits its services to Swiss residents except in exceptional cases.³¹⁷

Exit DS has not been without controversy over the years, particularly with respect to questions of financial gain by its executive, lack of training for volunteers, assisted suicide for patients who lacked mental competence due to psychiatric conditions³¹⁸ and past attempts to obtain lethal medications without a physician’s prescription.³¹⁹ In

³¹³ Bosshard, Switzerland (n 287) 472.

³¹⁴ S Fischer, CA Huber, L Imhof and others, ‘Suicide assisted by two Swiss right-to-die organisations’ (2008) 34 *Journal of Medical Ethics* 810 (Fischer); See also Andreas Frei, Tanja-Anita Schenker, Asmus Finzen and others, ‘Assisted suicide as conducted by a “Right-to-Die”-society in Switzerland: A descriptive analysis of 43 consecutive cases’ (2001) 131 *Swiss Medical Weekly* 375, 375; See also Elke M Baezner-Sailer, ‘Physician-Assisted Suicide in Switzerland: A Personal Report’ in Dieter Birnbacher and Edgar Dahl (eds), *Giving Death a Helping Hand* (vol 38, Part III, International Library of Ethics, Law, and the New Medicine, 2008) 141-3 (Baezner-Sailer).

³¹⁵ Fischer *ibid* 810.

³¹⁶ *ibid* 812; Bosshard, Switzerland (n 287) 478.

³¹⁷ Where foreign patient has a close relationship to Swiss members of the organization. Lewy (n 10) 93.

³¹⁸ See for example, the Basel case- Dr. Meinrad Schär, professor of preventative medicine at Zurich University and member of Exit DS was investigated in 1998 for prescribing lethal medication based on a questionable diagnosis of a 29-year-old woman suffering from a mental illness. Exit DS subsequently issued a moratorium on assisted suicide for individuals with a mental illness and stimulated discussions on types of precautions required. The moratorium was apparently relaxed in 2004. NEK-CNE Opinion No. 9 (n 285) 9; compare Baezner-Sailer (n 314) 146.

³¹⁹ For full discussion see Lewy (n 10) 89-100.

2009, *Exit DS* entered into an Agreement with the Canton of Zurich setting up due care rules to overcome these and other concerns.³²⁰ Two of the more notable provisions in the agreement are Article 2, which identifies NaP as the only authorized medication and Article 4.4.4 which prohibits assisted suicide to persons under age 25 unless they are experiencing severe physical suffering.³²¹

Between 1990-2004, *Exit DS* facilitated 748 assisted deaths among Swiss residents.³²² In the years 2007, 2008 and 2009, *Exit DS* facilitated 167, 175 and 217 assisted suicides respectively.³²³ The majority of the diagnoses were for “fatal” conditions (e.g. cancer, cardiovascular/respiratory, HIV/AIDS, neurological disease) than “non-fatal” conditions (e.g. rheumatoid arthritis/pain syndromes and mental disorders – mostly depression, osteoporosis, blindness or general weakness).³²⁴ The number of *Exit DS* assisted suicides in women and the proportion of older people suffering from non-fatal diseases has been increasing since the 1990s.³²⁵ Current research also indicates that the number of requests overall is increasing every year.³²⁶

Exit ADMD is the second largest Swiss right-to die organization with currently over 15,000 members.³²⁷ *Exit ADMD* restricts membership to persons over the age of 20 years residing in Western Switzerland.³²⁸ *Exit ADMD*’s guidelines, procedures and criteria are similar to *Exit DS*: a prognosis of death or a significant disability;

³²⁰ *Vereinbarung über die organisierte Suizidhilfe*” between Ober staats anwalt schaft des Kantons Zurich and Exit Deutsch Schweiz <www.sterbehilfedeutschland.de/sbgl/files/Medien/PDF%20neu/Vereinbarung%20Zuerich%20Brunner-Exit.pdf> accessed 31 May 2012 (*Exit DS Agreement*). Rules include: a ban on profit - charge for assisted suicide must not exceed 500 Swiss francs (£280; €330; \$470USD); assisted suicide to be provided only in certain conditions (severe suffering due to disease, accident or disability; discussion of alternative treatments with patient including palliative care; counselling over several weeks; examination by physician; in case of psychiatric illness, psychiatrist examination and confirmation that desire for death is not result of the psychiatric disorder); exclusive use of the medical substance sodium-pentobarbital (NaP); written certificates from involved physicians confirming all required procedures have been followed etc. For interpretation of provisions, see Deutsches Referenzzentrum für Ethik in den Biowissenschaften [The German Reference Centre for Ethics in the Life Sciences] (DRZE), *Discussion in the Canton Zurich Concerning Euthanasia* (Module) <www.drze.de/in-focus/euthanasia/modules> accessed 31 May 2012; See also discussion in Lewy (n 10) 100-1.

³²¹ *Exit DS Agreement* *ibid* arts 2 and 4.4.4.

³²² G Bosshard, E Ulrich and W Bär, ‘748 Cases of Suicide Assisted by a Swiss Right-to-Die Organisation’ (2003) 133 *Swiss Medical Weekly* 310, 310 (Bosshard, 748 cases).

³²³ *EXIT, Annual Report of the Control Committee 2009* (2009) <www.exit.ch/> accessed 31 May 2012 (*Exit 2009 Annual Report*).

³²⁴ 78.9% fatal between 1990-2000 and 67.3% fatal between 2001-2004: 67.3%. Bosshard, 748 cases (n 322) 312-3 and Fischer (n 314) 811.

³²⁵ Fischer *ibid* 810.

³²⁶ *ibid* 813; Bosshard, 748 cases (n 322) 100.

³²⁷ *Exit ADMD Website* (n 302).

³²⁸ Annual membership fees as of 2010 are CHF 40 (€30.81, £25.91, \$42USD). *Exit ADMD, ‘Formulaire demande d’adhésion’* <www.exit-geneve.ch/Adhesion.htm> accessed 31 May 2012 (*Exit ADMD Membership Application Form*).

intolerable physical or psychological suffering, a written request, and serious and repeated demand.³²⁹ The moral foundation for providing assisted suicide as expressed by the current president in 2001 is, “the freedom of the individual, limited only to the extent that he/she respects the freedom of others.”³³⁰

It has been reported that 200 assisted suicides were facilitated by Exit ADMD during the years of 2001-2005,³³¹ and 66 in 2007.³³² Exit ADMD’s rate of approval of assisted suicide requests is high at 95% or above during each of the years 2004, 2005 and 2007 and every year the number of requests has been increasing.³³³ The patient profile is also similar to EXIT DS – during the years 2001-2005, 86.5% of diagnoses were for fatal conditions and 13.5% for non-fatal conditions with 10.5% of the latter suffering from a multitude of disabilities encompassing a fear of progressive deterioration.³³⁴ Again, Exit ADMD numbers reveal a higher representation of women³³⁵ and older people.³³⁶

Dignitas is unremarkable in the sense that its guidelines and procedures leading up to assistance with suicide are comparable to those of EXIT DS and Exit ADMD.³³⁷ However, Dignitas is generally perceived as being the most controversial of the Swiss right-to-die organizations because of its openness to providing assisted suicide services to non-residents.³³⁸ According to its founder Ludwig Minelli, it extends its

³²⁹ Exit ADMD, ‘25 ans d’engagement pour le droit de mourir dans la dignité’ [25 years for the right to die with dignity] (February 2007) 15-6 <www.exit-geneve.ch/Exit_56pp.pdf> accessed 31 May 2012 (Exit, 25 years).

³³⁰ Jerome Sobel, ‘Point of View-Assisted Death’ (Exit ADMD) 1, translation from (2001) 121 *Revue médicale de la Suisse Romande* 163, <www.exit-geneve.ch/Exitpointofview.pdf> accessed 31 May 2012.

³³¹ Sandra Burkhardt et al, ‘L’assistance au suicide en Suisse romande: une etude sur cinq ans’ (2007) 50 (1-2) *Journal de Medicine Droit Medicale* 42 (Burkhardt).

³³² Exit ADMD, *Bulletin No.43* (2005), Exit ADMD *Bulletin No. 45* (2006) 9, Exit ADMD, *Bulletin No .49* (2008) 14.

³³³ Burkhardt (n 331) 42; Compare to Exit DS, which had a 86% rate of approval in 1996 and 62% in 2007. Lewy (n 10) 94.

³³⁴ Burkhardt *ibid* 42.

³³⁵ 2001-2005: 59%, 2007: 65%. *ibid* and Exit ADMD, *Bulletin*, No.49 (2008) (n 332) 14.

³³⁶ 2001-2005: 69% over age 70. Burkhardt (n 331) 42.

³³⁷ See Dignitas, *How Dignitas Works: On what philosophical principles are the activities of this organisation based?* (1st edn, Dignitas May 2010) <www.dignitas.ch/> accessed 31 May 2012 (How Dignitas Works).

³³⁸ Stephen J Ziegler and Georg Bosshard, ‘Role of Non-Governmental Organisations in Physician Assisted Suicide’ (2007) 334 *British Medical Journal* 295; Additional factors contributing to Dignitas’ controversial status include its fees, which appear higher than other right-to-die organizations, founder Minelli’s apparent personal remuneration as general secretary, assistance to individuals who were suffering from mental impairment, use of apartments in residential areas and the use of helium gas in the death of 4 patients to avert new requirements in 2008 imposed by the Canton of Zurich (that the member undergo two doctor consultations prior to the issuance of a prescription for NaP). See *How Dignitas Works* *ibid* 15-7; See also discussion in Lewy (n 10) 105-8; Deborah Ball and Julia Mengewein, ‘Assisted-Suicide Pioneer Stirs a Legal Backlash’ *The Wall Street Journal* (6 February 2010)

services to non-residents on the basis of the European Convention of Human Rights which prevents discrimination on any grounds, including on the basis of where one lives.³³⁹

Dignitas' current membership is approximately 5989 from 52 countries. In 2009, the highest membership came from Germany (2971), followed by Switzerland (834) and the United Kingdom (694).³⁴⁰ Over the years 2002-2009, 1041 assisted suicides were reported by Dignitas.³⁴¹ Of these, 88.24% of the persons assisted were foreigners, with the highest number from Germany at 59.14%.³⁴² Dignitas facilitates almost double the number of suicides as Exit DS, which is possibly attributable to its greater "catchment area" i.e. foreigners.³⁴³ In 2011, Dignitas reported 160 assisted suicide deaths, 149 of these by non-residents.³⁴⁴

It is the activity of Dignitas' that has connected Switzerland to the phrase "suicide tourism"³⁴⁵ and international criticism. This criticism has prompted debate within

<online.wsj.com/article/SB10001424052748703414504575001363599545120.html> accessed 31 May 2012 (Ball and Mengewein); Alexandra Williams, 'The penniless founder of Dignitas 'now a multi-millionaire' *The Daily Mail* (London, 25 June 2010) <www.dailymail.co.uk/news/worldnews/article-1289217/Dignitas-founder-Ludwig-Minelli-multi-millionaire.html> accessed 31 May 2012. Current estimates for fees are: entry fees of 100 CHF (€80, £65) and annual fees of 50 CHF (€40, £32) plus the suicide costs estimated at up to 3500 CHF (€2700, £2300) for residents and 3500-9000 CHF (€2700-€7000, £2300-£5900) for non-residents. See Lewy (n 10) 106; See also interview with Ludwig Minelli in 2008 in *Wolfgang Prosinger and Norbert Thomma*, 'Wenn Sie das trinken, gibt es kein Zurück' *Der Tagesspiegel* (Berlin, 29 March 2008) <www.tagesspiegel.de/weltspiegel/wenn-sie-das-trinken-gibt-es-kein-zurueck/1198414.html> accessed 31 May 2012.

³³⁹ European Convention (n 158) art 14.

³⁴⁰ Data issued by Dignitas and available on The Guardian website. 'Assisted suicide statistics: the numbers Dignitas helps to die, by country' *The Guardian Datablog* (London, February 2010) <www.guardian.co.uk/news/datablog/2010/feb/25/assisted-suicide-dignitas-statistics#data> accessed 31 May 2012 (Guardian Datablog).

³⁴¹ Dignitas, *Accompanied Suicides of Members of Dignitas, by Year and by Residency* 2011 (Switzerland Dignitas) <<http://www.dignitas.ch/images/stories/pdf/statistik-ftb-jahr-wohnsitz-1998-2011.pdf>> accessed 31 May 2012 (Dignitas 2011 Report). Dignitas' reported figures are consistent with figures issued by the Zurich City Police for years 2001, 2002 and 2003. NEK-CNE Opinion No. 9 (n 285) 9.

³⁴² Membership breakdown is fairly consistent with number of assisted suicides actually carried out, although UK appears slightly overrepresented. For example, from 2002-2009, the percentage of total assisted suicides is: Germany (59.14%) Switzerland (11.76%) and United Kingdom (14.08%). Guardian Datablog (n 340) In September 2005, Dignitas opened a branch in Germany (Hanover) under the name DIGNITATE. This move has attracted fierce controversy and protests from a variety of doctors, church representatives and German politicians. Annette Tuffs, 'Assisted suicide organisation opens branch in Germany' (2005) 331 *British Medical Journal* 984; See also 'Ein Mann, der dringend sterben wollte' *Die Zeit* (No. 44, Germany, 27 October 2005) <http://www.zeit.de/2005/44/Sterben_und_Tod> accessed 31 May 2012.

³⁴³ Fischer (n 314) 813.

³⁴⁴ Dignitas 2011 Report (n 341).

³⁴⁵ Suicide tourism, where people come from abroad to be helped in committing suicide in Switzerland. Guillod and Schmidt (n 354) 31; See Frontline Documentary, 'The suicide tourist' (2010) <www.pbs.org/wgbh/pages/frontline/suicidetourist/> accessed 31 May 2012; See also,

Swiss government regarding the possible state regulation of right-to-die organizations. Proposed responses range from regulations that restrict assisted suicide to Swiss residents to a complete ban on organized assisted suicide altogether.³⁴⁶ The Dignitas connection with “suicide tourism” also attracts additional international criticism to the issue of assisted suicide for individuals who do not suffer from a terminal illness³⁴⁷ even though both Exit DS and Exit ADMD also provide assisted suicide for non-fatal illnesses³⁴⁸ and the possibility of euthanasia for non-terminal illness also exists in the Netherlands, Belgium and Luxembourg.

Ludwig Minelli, the founder and general secretary of *Dignitas*, is unambiguous with respect to the role that autonomy plays in advancing what he describes as, “the last human right” – the right to decide when and how to end one’s life.³⁴⁹ Like Exit DS, Minelli describes how individuals must be free to pursue their own objectives provided that that pursuit does not harm the “public interest” or the “legitimate interests of a third party.”³⁵⁰

Ex-International also provides suicide assistance to non-residents, but on a much smaller scale than Dignitas.³⁵¹ Membership is approximately 700-800 from various European countries.³⁵² A 2008 estimate of assisted suicide by Ex-International ranged from 12-20 members in the district of Bern.³⁵³ According to Margrit Weibel (the successor of Rolf Sigg³⁵⁴ and current head of the organization), upon receipt of a request, the procedures followed by Ex-International include: establishment of a

Klaus Wille, ‘Suicide Tourists Make Swiss Uneasy as Terminally Ill Seek Death’ *Bloomberg News* (18 January 2011) <www.bloomberg.com/news/2011-01-18/suicide-tourists-make-swiss-minister-uneasy-as-terminally-ill-look-for-death.html> accessed 31 May 2012.

³⁴⁶ See for example, 2002 motion by Dorle Vallender to National Council, *Motion 02.3500*, <www.parlament.ch/f/suche/pages/geschaefte.aspx?gesch_id=20023500> and Swiss Federal Department of Justice and Police, *Organized Assisted Suicide to be regulated* (Press Release, 28 October 2009) <www.ejpd.admin.ch/ejpd/en/home/dokumentation/mi/2009/2009-10-28.html> accessed 31 May 2012.

³⁴⁷ See for example: Daniel Foggo, ‘Why Daniel James Chose to Die’ *The Sunday Times* (London, 19 October 2008) <www.timesonline.co.uk/tol/news/uk/article4969423.ece> accessed 31 May 2012; See also Ball and Mengewein (n 335) and David Brown, ‘Dignitas Founder Plans Assisted Suicide of Healthy Woman’ *The Times* (London, 3 April 2009).

³⁴⁸ A 2001-2004 study has shown that exit ds had a higher rate of assisted suicide for non-fatal diagnosis (32%) than Dignitas (21%). Fischer (n 314) table 1; Study of 200 Exit ADMD cases in years 2001-2005, revealed a rate of 13.5% for non-fatal conditions. Burkhardt (n 331) 42.

³⁴⁹ How Dignitas Works (n 337) 3.

³⁵⁰ *ibid* 22.

³⁵¹ Fischer (n 314) 810; Lewy (n 10) 110. ; To date, Ex-International has not published any data on its activities and practices.

³⁵² Membership fees vary and are based on what individual members can afford Lewy (n 10) 110.

³⁵³ *ibid*.

³⁵⁴ Sigg has been the subject of criminal investigation, particularly with respect to activities concerning German patients. For example, in contravention of German law, he smuggled NaP into Germany to provide to persons seeking assisted death. See *ibid* 111.

relationship between patient and assistant, evaluation of whether the condition is unbearable without any hope of relief; voluntariness; production of doctor's certificate with diagnosis; and examination by a Swiss doctor to ensure patient is "lucid and discerning".³⁵⁵

Suizidhilfe was founded in 2002 by Peter Baumann, a psychiatrist, who defends the individual's "absolute right" to determine the time and circumstances of death.³⁵⁶ Consequently, Suizidhilfe will facilitate assisted suicide in cases where a terminal illness is not present and even in cases where suffering is related to a mental illness.³⁵⁷ Membership fees are minimal.

In 2003, Baumann was arrested in connection to the deaths of three individuals suffering from depression. In 2007 he was found not guilty in one case but guilty in the second for failure to exercise due care and sentenced to 3 years in prison, 2 on probation.³⁵⁸ In the third case, Baumann had permitted the AD to be filmed and broadcast on national television. Baumann was found guilty by a trial court for assisting a suicide for selfish motivations on the basis of a desire for "publicity". Subsequently, Baumann was acquitted of this charge by the Court of Appeal which restored the previous legal understanding of "selfish" motives to that of material gain.³⁵⁹

The main role carried out by physicians is to prescribe the lethal drug NaP which, as discussed, is legally required under the Swiss Narcotics laws. These laws require that the drug be prescribed and dispensed in accordance with the acknowledged rules of medicine and science³⁶⁰ and further mandate their use only to the extent they are necessary in accordance with the acknowledged rules of medicine.³⁶¹ The acknowledged rules of medicine allow doctors to prescribe lethal barbiturates to eliminate pain.³⁶² Through court interpretation, these laws have also come to mean that prior to prescribing a regulated drug, a doctor is obligated to examine the individual

³⁵⁵ *ibid* citing a talk given by Margrit Weibel in Luxembourg in July 2006.

³⁵⁶ Suizidhilfe, 'Statutes' <www.suizidhilfe.ch/> accessed 31 May 2012.

³⁵⁷ Lewy (n 10) 109.

³⁵⁸ Baumann had considered a patient competent, but expert evidence demonstrated that if he had acted with proper care, he would have realised that was not indeed the case. The trial court decision was affirmed by the Court of Appeal. See *ibid* 109.

³⁵⁹ See discussion in *ibid* 110.; According however to the NEK-CNE Opinion No. 9, an individual will be deemed selfish under art 115 if the offender is pursuing "personal advantage" which may be material in nature (securing an inheritance for eg) or non-material or emotional (e.g. gratification of hatred, desire for revenge or spite). NEK-CNE Opinion No. 9 (n 285) 7, 31.

³⁶⁰ The Pharmaceutical Law (n 298) art 26.

³⁶¹ Narcotics Law (n 297) art 11.

³⁶² Schwarzenegger and Summers (n 288) 6.

wishing to die and confirm his or her competence.³⁶³ Failure to do so will result in punishment and possible revocation of the physician's licence.³⁶⁴ Furthermore, according to the courts, if the patient's suffering arises from a mental disorder, the individual must be examined by an expert who can confirm that the desire to die has not arisen from a curable psychiatric disorder, but rather is well-considered, permanent and rational.³⁶⁵

ii. *Medical Guidelines*

As described earlier, the SAMW has maintained fairly strong opposition to PAS, noting in a 1994 guideline, that "assisted suicide is not part of a physician's activities."³⁶⁶ Criticism of this position³⁶⁷ however prompted new SAMW guidelines in 2004, *Care of Patients in the End of Life* [the 2004 SAMW Guidelines].³⁶⁸

The 2004 SAMW Guidelines identify that a doctor can be faced with a conflict: on the one hand, a doctor does not have any duty to assist a suicide because it contradicts the aim of medicine but on the other hand, a doctor has a duty to take the patient's own wishes into account.³⁶⁹ The "solution" to this dilemma is the doctor's personal decision of conscience.³⁷⁰ The position taken by the SAMW appears to be similar to the Luxembourg perspective (see Figure 5), notwithstanding that Luxembourg medical code has not yet been brought into alignment with the Luxembourg AD law. Under the SAMW Guidelines, if a doctor makes a decision to assist, the doctor is obligated to: confirm a terminal diagnosis (a condition that will lead to death within a matter of days or a few weeks); discuss alternatives and, if desired, implement them; confirm decision-making capacity and that the decision is well thought out without external

³⁶³ See Verwaltungsgericht des Kantons Zürich [Zurich Administrative Court], *Entscheid der 3. Kranmer VB Nr 99.00145*, 1999; Verwaltungsgericht des Kantons Aargau [Aargau Administrative Court], *Entscheid BE 2003.00354-K3*, 2005; see also Bosshard, Switzerland (n 287) 473.

³⁶⁴ See Schwarzenegger and Sumners (n 288) 6.

³⁶⁵ Schweizerisches Bundesgericht [Federal Supreme Court of Switzerland], *Entscheid 2A.4812006*, 2006 (The Haas case); See also Bosshard, Switzerland (n 287) 473; See also decision by the Administrative Court Canton of Zurich, which revoked a gynaecologist's authority to prescribe lethal medication because he did not have the necessary psychiatric knowledge in order to judge the patient's wish to die. In doing so, he had violated his duty of care. Verwaltungsgericht des Kantons Zürich [Zurich Administrative Court], *Geschäftsnummer: VB.2009.00559 Endentscheid vom 11.03.2010*.

³⁶⁶ Schweizerische Akademie der MweizinischencWissenschaften [Swiss Academy Medical Sciences] *Medical-ethical guidelines for the medical care of dying persons and severely brain-damaged patients* (1995) <www.samw.ch> accessed 31 May 2012 (1995 SAMW Guidelines).

³⁶⁷ See Guillod and Schmidt (n 289) 27.

³⁶⁸ 2004 SAMW Guidelines (n 300).

³⁶⁹ *ibid* para 41.

³⁷⁰ *ibid*.

pressure; and obtain confirmation by a third party that all requirements have been met. The final step in the suicide must be taken by the patient him/herself.³⁷¹

The 2004 SAMW Guidelines also recognize a right to palliative care for patients in the final phase of life³⁷² but further acknowledge the need to recognize that not all suffering associated with dying and death can be avoided.³⁷³ Euthanasia however remains strictly prohibited under the SAMW Guidelines in accordance with the Penal Code.³⁷⁴

Thus although the SAMW discourages assisted suicide, physicians have the legal discretion like any other Swiss citizen, to altruistically assist suicide,³⁷⁵ with the exception that to be in compliance with the SAMW Guidelines, a physician's discretion can only be exercised with respect to cases of terminal illness.

Different than the Luxembourgish approach whereby exercise of conscience rests solely with the individual physician, if an individual resides in a Swiss health care facility, the individual may also be subject to the views of the particular institution which may not tolerate assisted suicide. Up until the 1990s there was a general understanding that assisted suicide was not permitted in public hospitals and nursing homes.³⁷⁶ Effective 2001 however, Zurich City Council introduced regulations permitting assisted suicide to be conducted in these institutions.³⁷⁷ Similarly, since 2006, hospitals in French Switzerland have permitted Exit ADMD to provide assistance on its premises under specific conditions such as the presence of a terminal diagnosis and consultation with health care teams.³⁷⁸ In 2007, the Geneva University Hospital agreed to allow Exit ADMD to provide assisted suicide on its premises,

³⁷¹ *ibid* 6.

³⁷² *ibid* 4.

³⁷³ *ibid* 8.

³⁷⁴ *ibid*.

³⁷⁵ Samia A Hurst and Alex Mauron, 'Assisted suicide and euthanasia in Switzerland: allowing a role for non-physicians' (2003) 326 *British Medical Journal* 271, 272 (Hurst).

³⁷⁶ Bosshard, Switzerland (n 287) 474. The basis for this understanding was the moral conflict posed by suicide in a medicalized setting: how is the therapeutic mandate reconciled with a patient's intention to commit suicide? See discussion in NEK-CNE Opinion No. 9 (n 285) 13.

³⁷⁷ NEK-CNE Opinion No. 9 *ibid* 9.

³⁷⁸ For example Lausanne University Hospital imposed the conditions that the patient be suffering from a terminal illness; not be able to be transferred; consultation with a psychiatric and palliative care team; and that the final decision whether to grant the request is made by a hospital evaluation committee. Lewy (n 10) 104; Bosshard, Switzerland (n 287) 474; For discussion on physician responses to this initiative, see J Pereira, P Laurent, PB Cantin and others, 'The response of a Swiss university hospital's palliative care consult team to assisted suicide within the institution' (2008) 22(5) *Palliative Medicine* 659 (Pereira).

provided that hospital staff members did not participate.³⁷⁹ Policies on assisted suicide in health care facilities thus vary from institution to institution.³⁸⁰

iii. *Legislative Developments*

Over the years, criticism of suicide tourism issue and concerns of abuse of patients with psychiatric illnesses³⁸¹ has provoked public and political calls to restrict or regulate the practices of right-to-die organizations. The development of a more comprehensive regulatory scheme however has been impeded by: added complexities arising from new initiatives for legalized euthanasia;³⁸² leadership changes in the Federal Department of Justice and Police (EJPD) - the department responsible for reform initiatives;³⁸³ jurisdictional concerns;³⁸⁴ and debates over the appropriate role to be played by physicians³⁸⁵ and health care institutions.³⁸⁶

³⁷⁹ Lewy (n 10) 105; Bosshard, Switzerland (n 287) 474.

³⁸⁰ For example see recommendations by Social/Medical Ethics Committee for the Canton of Vaud: Anne-Laure Jotti-Arnold, François Matt, Janine Diserens, Pr Lazare Benaroyo, 'Assistance au suicide en EMS : Recommandations éthiques et pratiques de la Chambre de l'éthique de l'AVDEMS' (2005) 1 *Revue Medical Suisse* 85; See also recommendations in 2004 SAMW Guidelines (n 300) 9.

³⁸¹ For example, a 2008 protest in the Canton of Zurich collected 8763 signatures demanding that suicide tourism be ceased. The requisite number of signatures for a referendum (6000 signatures) has been exceeded thus the Council of the Canton has to conduct itself according popular vote. See Statistisches AMT de Canton Zürich, 'Nein zum Sterbetourismus im Kanton Zürich' [No to death tourism in the canton of Zurich] <www.wahlen.zh.ch/abstimmungen/initiativen/initiativen_detail.php?id=41> accessed 31 May 2012.

³⁸² See for example, Federal Department of Justice and Police, *Sterbehilfe/Assistance au décès [Assistance to Death]* (Commission Report of the Working Group (March 1999) <www.ejpd.admin.ch/content/dam/data/gesellschaft/gesetzgebung/sterbehilfe/b-bericht-f.pdf> of which a majority recommended that under exceptional circumstances, the court should have the discretion to abstain from imposing criminal punishment under Article 114; See also 2000 initiative by National Councillor Franco Cavalli submitted to the National Council which sought a similar exceptional circumstances judicial discretion and physician immunity for euthanasia, *Cavalli Initiative, 00.441* (27 September 2000) <www.parlament.ch/ab/frameset/f/n/4611/44739/f_n_4611_44739_44740.htm> accessed 31 May 2012 (2000 Cavalli Initiative).

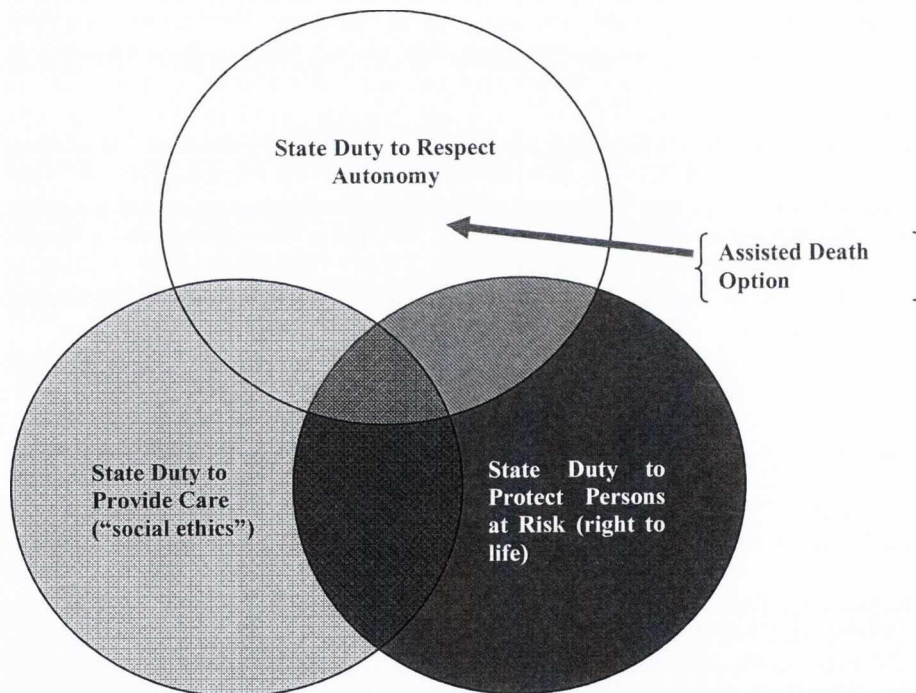
³⁸³ In 2004, Christoph Blocher, the head of the Federal Department of Justice and Police (EJPD) from 2004-2007, stopped a project commenced by previous head of EJPD, Ruth Metzler, aimed at overhauling existing regulations on euthanasia and assisted suicide. Blocher took the position that no additional state action was necessary and that in any event, any regulation on the matter was properly under the jurisdiction of the cantons, not the federal government See NEK-CNE Opinion No. 9 (n 285) 9; See also Federal Department of Justice and Police, *Regulations on prescribing and issuing sodium pentobarbital are sufficient* (Press Release, 29 August 2007); Federal Department of Justice and Police, Supplementary Report, *Ergänzungsbericht zum Bericht 'Sterbehilfe und Palliativmedizin – Handlungsbedarf für den Bund?* (July 2007) 6-8, <www.ejpd.admin.ch/content/dam/data/gesellschaft/gesetzgebung/sterbehilfe/ber-sterbehilfe_ergaenzung-d.pdf> accessed 31 May 2012; See also discussion in Lewy (n 10) 120-1.

³⁸⁴ *ibid.*

³⁸⁵ 2000 Cavalli Initiative (n 382); 2000 Initiative by Dorle Vallender submitted to the National Council which sought to, among other things, prohibit doctors and nurses from participating in assisted suicide, *Vallendar Initiative 01.407* (14 March 2001)

In 2005, the Swiss National Advisory Commission on Biomedical Ethics (NEK-CNE)³⁸⁷ pursuant to a request by Ruth Metzler, the head of the EJPD at the time, issued Opinion No. 9/2005 on Assisted Suicide (Opinion No. 9). The opinion recognized the “twin poles” of the assisted suicide discussion – the conflict between providing care for people at risk for suicide and respecting the autonomy of that person,³⁸⁸ – and identified that while neither should be assigned priority, both should be taken into account. Further, the state’s duty to provide care went beyond the individual desiring suicide to include “social ethics” to make sure that other individuals’ freedom of choice was not restricted by being made to feel like a burden on society and thus opt for suicide or assisted suicide (demonstrating reflection on slippery slope concerns).³⁸⁹

Figure 7: AD restricted by State Duty to Protect Persons at Risk and Duty to Provide Care



<www.parliament.ch/ab/frameset/f/n/4611/44739/f_n_4611_44739_44740.htm> accessed 31 May 2012; For further discussion see NEK-CNE Opinion No. 9 (n 285) 35.

³⁸⁶ See 2000 Cavalli Initiative *ibid*; See also NEK-CNE Opinion No. 9 *ibid* 36, 69.

³⁸⁷ The Swiss National Advisory Commission on Biomedical Ethics (the “NEK-CNE”) was established by the Federal Council in 2001 to advise the federal government and cantonal authorities on issues in bioethics. Federal Office of Public Health, ‘The National Advisory Commission on Biomedical Ethics’ <www.bag.admin.ch/nek-cne/index.html?lang=en> accessed 31 May 2012.

³⁸⁸ NEK-CNE Opinion No. 9 (n 285) 13, 62.

³⁸⁹ *ibid* 62.

Opinion No.9 recommendations included: maintaining Article 115 but regulate right-to-die organizations; prohibiting assisted suicide when suicidality is a manifestation of mental illness; permitting suicide of non-residents but establishing conditions to ensure in-depth knowledge of the patient and the patient's request.³⁹⁰

In 2006, NEK-CNE released Opinion No.13/2006 (Opinion No. 13)³⁹¹ which recommended certain minimal duty of care criteria to be fulfilled by right-to-die organizations³⁹² and directed physicians to follow the 2004 SAMW guidelines.³⁹³

On October 28, 2009, the Federal Council, under Eveline Widmer-Schlumpf the new minister of justice, tabled two (2) alternative amendments to Parliament for changes to Swiss law.³⁹⁴ The first option ("Option 1") contemplated clear duties of care for right to die organizations, the second option contemplated a complete ban on organized assisted suicide altogether.³⁹⁵ Federal Council's preference, Option 1, would: restrict assisted suicide to terminal illness; require two independent physicians to confirm diagnosis and legal capacity; require discussion of alternatives with the patient; limit the lethal drug to a prescription drug; and prohibit commercial gain.³⁹⁶

Upon completion of a consultation process in March 2010, three quarters of the cantons, political parties and interested organizations that took part were in favour of legislative action at the federal level³⁹⁷ although there was no consensus as to precisely

³⁹⁰ *ibid* 61-73.

³⁹¹ Swiss National Advisory Commission on Biomedical Ethics, *Duty-of-care criteria for the management of assisted suicide* (Opinion No. 13/2006) <www.bag.admin.ch/nek-cne/04229/04232/index.html?lang=en> accessed 31 May 2012 (NEK-CNE 2006 Opinion No. 13).

³⁹² Incorporating the "twin poles", NEK-CNE recommendations included: mental capacity assessed over a series of discussions; severe suffering arising out of illness (accident or disease), no assisted suicide when suicidality is a manifestation of mental illness; enduring, consistent and voluntary request; all options to be assessed and exhausted in accordance with the wishes of the person desiring suicide; independent second expert opinion; documentation. NEK-CNE 2006 Opinion No. 13 *ibid* 4-6

³⁹³ *ibid* 2-3; The due care criteria recommended are not concerned with assistance provided by a close family member or personal relation, single acts within the physician-patient relationship nor with the act of suicide. *ibid* 3.

³⁹⁴ Federal Department of Justice and Police, *Organised assisted suicide to be regulated* (Press Release, 28 October 2009) <www.ejpd.admin.ch/content/ejpd/en/home/dokumentation/mi/2009/2009-10-28.html> accessed 31 May 2012 (EDJP 2009 Press Release).

³⁹⁵ "This option rests on the belief that individuals working in assisted suicide organisations are never actually motivated by purely altruistic reasons, and may develop a close relationship with the suicidal person." *ibid*.

³⁹⁶ *ibid*.

³⁹⁷ 35 in favour of setting strict duties of care, 20 in favour of complete ban, 22 called for special licensing scheme or the creation of a supervisory authority. Federal Department of Justice and Police, *Specific regulations for organised assisted suicide in Switzerland* (Press Release, 17 September 2010) <www.ejpd.admin.ch/content/ejpd/en/home/dokumentation/mi/2010/2010-09-17.html>

how the right-to-die organizations should be regulated. For example, limiting assisted suicide to persons with terminal illness was criticized as discriminatory and unlawful,³⁹⁸ a perspective also apparently held by a large percentage of the Swiss public.³⁹⁹ The Federal Council was set to draft a bill based on Option 1 for debate by Swiss parliament. The Federal Department of Home Affairs was also to submit a proposal to the Federal Council on how to strengthen suicide prevention and palliative care.⁴⁰⁰ Palliative care is not yet available to all terminally ill patients in Switzerland.⁴⁰¹

On 1 November 2010 Widmer-Schlumpf was succeeded by Simonetta Sommaruga. Sommaruga⁴⁰² in 2011 announced that the Swiss government will not introduce specific regulations on organized assisted suicide but instead will take measures to boost palliative care and suicide prevention.⁴⁰³ According to Sommaruga, these latter measures are aimed at “strengthening the right of self-determination for people until one’s dying day.” While Sommaruga stated that “[r]evising the current legislation could give an official stamp of approval to organisations offering their services for assisted suicide,” she identified that the existing legislation was sufficient to tackle any abuses of the system and that it was up to cantonal authorities to ensure that the current legislation was strictly observed.⁴⁰⁴

b. Legal Framework

As described earlier, Article 115 permits assistance with suicide if done for altruistic reasons. Mental capacity of the person requesting assistance is also required because

accessed 31 May 2012 (EDJP 2010 Press Release). A June 2006 decision by the Federal Supreme Court held that the regulation of narcotics is a valid state function pursuant to its obligation to protect health and the common good. Thus, the state has a right and duty to regulate the operation of right to die organizations. See discussions in Lewy (n 10) 123 and Bosshard, Switzerland (n 287) 473; See also NEK-CNE Opinion No. 9 which states that inherent in Article 115 is the responsibility of the state to protect those who are the subjects of an individual motivated by personal advantage. NEK-CNE Opinion No. 9 (n 285) 11.

³⁹⁸ EDJP 2010 Press Release (n 397).

³⁹⁹ For example, in a 1999 EXIT ADMD survey of 1000 members of the public, 82% agreed that “a person suffering from an incurable disease and who is in intolerable physical and psychological suffering has the right to ask for death and to obtain help for this purpose.” Hurst (n 375) 272; “A recent study by Zurich University found that most Swiss are in favour of assisted suicide, and would also support direct active euthanasia. However, two-thirds of respondents came out against the practice of “death tourism”.” The World Federation of Right to Die Societies, ‘Swiss Government wants rules for assisted suicide’ (17 September 2010) <www.worldrtd.net/node/1072> accessed 31 May 2012.

⁴⁰⁰ EDJP 2010 Press Release (n 397).

⁴⁰¹ Hurst (n 375) 272.

⁴⁰² EDJP, ‘Federal Councillor Simonetta Sommaruga’ <www.ejpd.admin.ch/ejpd/en/home/die_oe/dv.html> accessed 31 May 2012.

⁴⁰³ Urs Geiser, ‘Cabinet rules out new suicide legislation’ <swissinfo.ch> accessed 31 May 2012.

⁴⁰⁴ *ibid.*

without it, a request will not be legally valid pursuant to the legal capacity provisions in Article 18 of the Civil Code.⁴⁰⁵ Without capacity, the assistor will be criminally responsible for the intentional killing under Articles 111-113 of the Penal Code because the suicide cannot be recognized as a voluntary and free decision.⁴⁰⁶

If a drug like NaP is to be used in an assisted suicide, the Swiss Narcotics laws come into play and the patient must be examined by a physician in order to obtain a prescription. Controversially, right-to-die organizations have previously tried to avoid these laws by using other methods, such as helium gas.⁴⁰⁷ Regardless, death by assisted suicide is considered to be a “unnatural” death in Switzerland and thus requires the authorities to be notified who will conduct an investigation to ensure that a criminal offence has not taken place.⁴⁰⁸

i. *Due Care Requirements*

Due care criteria are, generally speaking, dictated by the internal guidelines of the right-to-die organizations as opposed to legislation. The principal exceptions here are concomitant obligations of prescribing doctors imposed via the Swiss Narcotics laws as well as through the 2004 SAMW Guidelines.

With respect to the substantive criteria pursuant to organization guidelines, the individual desiring assistance must: be competent (as assessed by volunteer assistants), suffering unbearably (physical or mental) and have a voluntary repeated and serious demand. The precise criteria and corresponding thresholds vary from organization to organization. For example, Exit ADMD expressly restricts its membership to persons over 20 years of age⁴⁰⁹ whereas, Exit DS will accept members who are 18 years or older.⁴¹⁰

Organization guidelines notwithstanding, the primary procedural safeguards to ensure that the competency criteria are indeed satisfied appears to be imposed through the Swiss Narcotics laws along with court interpretation as discussed, and obligate

⁴⁰⁵ 210 Swiss Civil Code of 10 December 1907 (Status as on 1 January 2011) art 18: “A person who lacks legal capacity cannot, unless a statutory exception applies, enter into any legal transactions.” Article 16 is also relevant: “A person who lacks legal capacity cannot, unless a statutory exception applies, enter into any legal transactions.” See discussion in Schwarzenegger and Sumners (n 288) 5.

⁴⁰⁶ Note that, a mere omission could amount to criminal responsibility if the individual (such as parents) had a duty to take positive steps to prevent a suicide. Guillod and Schmidt (n 289) 30; See also Schwarzenegger and Sumners *ibid*.

⁴⁰⁷ See How Dignitas Works (n 337).

⁴⁰⁸ *ibid* 21.

⁴⁰⁹ Exit ADMD Membership Application Form (n 328).

⁴¹⁰ Baezner-Sailer (n 314) 142.

physicians to confirm the patient's competence and diagnosis before prescribing the lethal medication. In the case of suffering arising out of a mental or psychiatric condition, extra caution must be taken. This includes expert assessment of the individual to ensure that the desire to die or suicidality is not a manifestation of the illness.⁴¹¹

There is currently however no requirement that doctors get to know the patient well, although this gap is said to be filled by organizational guidelines. According to Exit DS, Exit ADMD and Dignitas, volunteer attendants have numerous conversations and significant contact with their respective members prior to the actual act to discuss alternatives.⁴¹² If the assisted suicide takes place in a public hospital there may be additional procedures to be followed pursuant to hospital rules and regulations.

Two additional and significant procedural safeguards are firstly, that the lethal medication is never handed directly to the individual seeking assistance; it is always handed over to the organization or one of its volunteers in order to prevent abuse.⁴¹³ When the time is determined by the member, the lethal dose is made available to the individual by the volunteer attendant. Secondly, the volunteer attendant and at least one additional witness (alternatively, two attendants) remain with the individual until death.⁴¹⁴ As will be discussed later, these safeguards are not expressly required under the PAS schemes of Washington and Oregon.

Pursuant to the 2004 SAMW Guidelines, the substantive due care criteria or "preconditions" include: a voluntary and well-thought out request, decision-making capacity,⁴¹⁵ terminal illness,⁴¹⁶ and discussion and implementation (if desired) of alternatives.⁴¹⁷ Additionally, for patients in care homes, the SAMW guidelines,

⁴¹¹ See text associated with fn 365.

⁴¹² Baezner-Sailer (n 314) 142, Exit 25 Years (n 329) fn 39; How Dignitas Works (n 337) 7-9, 28; See however criticisms of practice where assisted suicide has been known to occur within only a very short membership time Hurst (n 375) 81; In a 2007 study on Exit DS, the interval between the time between the first visit and the act was 14 days or less in 37% of cases. Lewy (n 10) 98; See also 2001-2004 study by Fischer et al where in 1.5% of Dignitas cases and in 5.4% of Exit DS cases, membership was less than one week. Fischer (n 314) 811.

⁴¹³ See for example Baezner-Sailer *ibid* 142.

⁴¹⁴ For Exit DS see Baezner-Sailer *ibid*. For Dignitas see How Dignitas Works (n 337) 17.

⁴¹⁵ The 2004 SAMW Guidelines elaborate the criteria for assessing decision-making capacity in conformance with Article 16 of the Swiss Civil Code. For example, "the ability to weigh up rationally, information obtained in the context of a coherent system of evaluation;" and "the ability to express his own choice". 2004 SAMW Guidelines (n 300) 7, ad 2.

⁴¹⁶ Patients in a terminal phase are to be distinguished from "patients with incurable, progressive diseases that may persist for several months, or even years." However the SAMW recognizes that there is a certain vagueness in its definition, given that it often coincides with medical decisions regarding the withdrawal or refusal of treatment. 2004 SAMW Guidelines *ibid* 7, ad 1.

⁴¹⁷ 2004 SAMW Guidelines *ibid* 6, ad 4.1.

Treatment and care of elderly persons who are in need of care,⁴¹⁸ must also be taken into account.⁴¹⁹ Among other things, these guidelines recognize the particular vulnerability of elderly persons due to different dependencies, which can increase the risk of suicide⁴²⁰ thus requiring particular attention to providing necessary palliative, therapeutic and/or psychiatric measures and spiritual help if desired.⁴²¹ Death pursuant to PAS is considered an unnatural death and as such must be reported to the authorities.⁴²²

With respect to procedural safeguards, the 2004 SAMW Guidelines require that the “preconditions” have been checked by a third party⁴²³ and that the decision-making process has been documented.⁴²⁴

ii. Reporting and Review

As earlier described, in Switzerland, death pursuant to assisted suicide is considered an “unnatural” death and must be reported to the examining authorities when the death occurs.⁴²⁵ The doctor responsible for the assisted suicide is not permitted to fill out the death certificate.⁴²⁶ Authorities are to conduct a brief investigation to ensure that a criminal offence has not taken place.⁴²⁷ Prosecution for assisted suicide is rare.⁴²⁸

c. Compassion and Suffering, Autonomy and Self-determination

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

⁴¹⁸ SAMW, ‘Treatment and care of elderly persons who are in need of care’ (SAMW 2004) <www.samw.ch/en/Ethics/Guidelines/Currently-valid-guidelines.html> accessed 31 May 2012 (SAMW Care of Elderly Persons Guidelines).

⁴¹⁹ 2004 SAMW Guidelines (n 300) 7, ad 4.

⁴²⁰ SAMW Care of Elderly Persons Guidelines (n 418) 9.

⁴²¹ *ibid* 9.

⁴²² 2004 SAMW Guidelines (n 300) 78, ad 4.1.

⁴²³ *ibid* 8, ad. 4.1.

⁴²⁴ *ibid*.

⁴²⁵ *ibid*.

⁴²⁶ *ibid*.

⁴²⁷ Baezner-Sailer (n 314) 143.

⁴²⁸ NEK-CNE Opinion No. 9 (n 285) 8; See also Hurst (n 375) 271.

by organizations for a broad range of conditions ranging from cancer to paralysis to mental disorders to “weariness of life”.⁴²⁹

This is not to say that the individual’s view on unacceptable physical or mental suffering is the only relevant consideration for assisted suicide in Switzerland. As already described, assistance typically requires a physician prescription which, to a certain extent, constrains the working definition of suffering by imposing a medical construction of physical or mental suffering. Additionally, in the *Haas* case, the Swiss Federal Court limited assisted suicide for psychiatric illness, permitting it only when the desire to die is well-considered, permanent and rational.⁴³⁰ Furthermore, some right-to-die organizations have imposed more stringent limits on qualifying suffering⁴³¹ and under the SAMW guidelines, doctors must balance the patient’s right to self-determination with their duty to support the patient.⁴³²

Equally important is the broader understanding and clear interpretation of the “right” to assisted suicide as a negative right as opposed to a positive right, a position clarified by the Swiss Federal Supreme Court in the 2006 *Haas* case.

In the *Haas* case, Mr. Haas, a Swiss national suffering from a serious bipolar affective disorder was denied a prescription to NaP on several occasions.⁴³³ Mr. Haas applied to the Swiss courts to obtain the drug on the basis of an infringement of his right to privacy under Article 8 of the European Convention of Human Rights arguing “that his right to end his life in a safe and dignified manner had been violated in Switzerland as a result of the conditions that had to be met – and which he had not met – in order to be able to obtain sodium pentobarbital”.⁴³⁴

In denying his application, the Swiss Federal Court found that there was a distinction between the right to decide one’s own death (established under a right to privacy) and the right to commit suicide assisted by another party. The court explained that the “right to die” is only a negative right (a liberty right) in that individuals are to be free from state intervention or prohibitions. A negative right can be restricted if other basic rights are at risk. The *Haas* case was appealed to the European Court of Human Rights .

⁴²⁹ Fischer (n 314) at 811-812.

⁴³⁰ The *Haas* case (n 365); See also discussion in Bosshard, Switzerland (n 287) 473.

⁴³¹ See for example Exit DS moratorium on mental illness. See (n 318) and associated text.

⁴³² 2004 SAMW Guidelines (n 300) 8, ad 4.1.

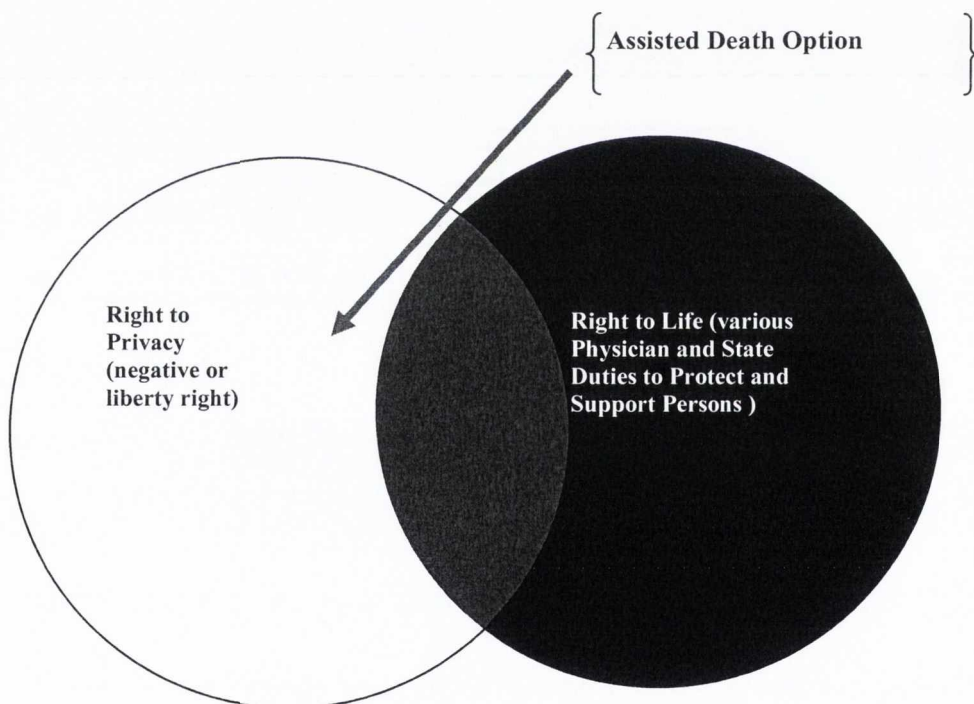
⁴³³ Schweizerisches Bundesgericht [Federal Supreme Court of Switzerland], *Entscheid 2A.4812006*, 2006; See also discussion in Bosshard, Switzerland (n 287) 473.

⁴³⁴ ECHR, ‘Switzerland cannot be criticised for not having assisted a suicide’ (Press Release no. 040, 20 January 2011) 2
<www.selvmordsforskning.dk/filecache/32910/1297608416/chamberjudgmenthaasv.switzerlandd20.01.2011.pdf> accessed 31 May 2012 (ECHR Press Release No. 040).

which confirmed that while an aspect of the right to respect for private life includes the right of an individual to decide the manner and moment at which life should end, this right had not been violated.⁴³⁵ In so doing, the European Court of Human Rights noted that national authorities had a wide “margin of appreciation” in terms of what weight they choose to place on the protection of an individual’s life (Article 2, the right to life) and on the right to end one’s life (Article 8, right to respect for privacy).⁴³⁶

Thus despite Ludwig Minelli’s (founder of Dignitas) frequent assertion that the Federal Supreme Court of Switzerland has recognized the human right to end one’s life and such a right is protected under Article 8 of the European Convention,⁴³⁷ this position is only accurate if it is qualified as a negative right which can in turn be limited by certain state interests.

Figure 8: AD advanced as Privacy Right limited by Various Interests/Duties



⁴³⁵ *Affaire Haas c. Suisse no 31322/07* (ECHR, 20 January 2011); See also ECHR Press Release No. 040 *ibid*.

⁴³⁶ ECHR Press Release *ibid* 3; Thomas A O’Donnell, ‘The Margin of Appreciation Doctrine: Standards in the Jurisprudence of the European Court of Human Rights’ (1982) 4 *Human Rights Quarterly* 474, 475 (“[w]hile difficult to define, the margin of appreciation refers to the latitude allowed to the member states in their observance of the Convention”).

⁴³⁷ Dignitas, *How Dignitas Works* (n 337) 2.

That there is no positive right to AD, only some form of right to request it, is a position consistent in all jurisdictions canvassed. That said, it is the Swiss (and as we shall see also the American) requirement that the last terminating step be taken by the individual alone that appears to be more analytically consistent with the construction of AD as a negative right.⁴³⁸ In other words, the Swiss legal framework is consistent with the liberal ethical view that the exercise of autonomy (formulated as a right to privacy) includes the freedom to control the timing of one's death, including gaining some assistance by another individual(s) in exercising that freedom, but stopping short of allowing that other individual(s) to perform the actual act.

d. Statistics and trends

Because there is no central notification system,⁴³⁹ data on the frequency and extent of assisted suicide is very limited for Switzerland and until the publication of a report by Swiss authorities in March 2012 (the FSO Report)⁴⁴⁰ no official statistics had been previously available.⁴⁴¹

Unofficially, as reported by the NEK-CNE, the frequency of assisted suicide in the 1990s was approximately 100 cases per year.⁴⁴² According to the NEK-CNE, this has risen to over 200 cases per year, in a large part due to increasing numbers of assisted suicide cases for non-residents facilitated by Dignitas. The rate of assisted suicide for Swiss residents though has remained fairly consistent over the past ten years.

For example, based on NEK-CNE figures, in 2001-2002, assisted suicide accounted for 0.4% of all Swiss deaths.⁴⁴³ Assisted suicide specifically handled by right-to-die organizations resulted in a total of 137 cases⁴⁴⁴ accounting for approximately 0.2% of all Swiss deaths in 2001-2002.⁴⁴⁵ If assisted suicide for non-residents reported by Dignitas (59 cases) are included, assisted suicide accounted for approximately 0.5% of all deaths in Switzerland for 2001-2002.⁴⁴⁶ These numbers roughly correspond to the results of an independent 2001 study of doctors involved in assisted suicides which

⁴³⁸ See also interpretation of suicide NEK-CNE Opinion No. 9 (n 285) 8.

⁴³⁹ Fischer (n 314) 810.

⁴⁴⁰ Federal Statistical Office FSO, *Cause of death statistics 2009: assisted suicide and suicide in Switzerland* (March 2012) <<http://www.bfs.admin.ch/bfs/portal/en/index/news/publikationen.html?publicationID=4732>> accessed 31 May 2012 (FSO Report).

⁴⁴¹ Hurst (n 375) 810.

⁴⁴² NEK-CNE Opinion No. 9 (n 285) 26.

⁴⁴³ Out of approximately 62,000 annual deaths NEK-CNE Opinion No. 9 *ibid* 26; and Bosshard, Switzerland (n 287) 477.

⁴⁴⁴ 100 Exit DS, 20 Exit ADMD, 17 Dignitas. NEK-CNE Opinion No. 9 *ibid* 26; See also Guardian Datablog (n 340) 340.

⁴⁴⁵ NEK-CNE Opinion No. 9 *ibid* 26

⁴⁴⁶ Bosshard, Switzerland (n 287) 477.

indicates that Swiss right-to-die organizations have been complying with reporting requirements.⁴⁴⁷

According to the FSO Report, the number of Swiss residents who have died from “assisted suicide” has “increased continuously” over the years 1998-2009. The official numbers indicate that fewer than 50 assisted suicide deaths took place in 1998 compared to just less than 300 assisted suicide deaths occurring in 2009 (representing approximately .48% of all deaths).⁴⁴⁸

According to the FSO Report,⁴⁴⁹

The age distribution is similar for both men and women. From 55 years of age, the absolute number of women resorting to assisted suicide is markedly higher than that for men. Assisted suicide is resorted to when life no longer appears worth living for the person concerned, in particular in the presence of a serious physical illness. In 44% of cases, cancer was reported as the underlying disease, in 19% a neurodegenerative disease, in 9% cardiovascular diseases and in 6% musculoskeletal disorders. “Other diseases” includes pain syndromes, multimorbidity and other pathologies. Depression was reported in 3% of cases and dementia in 0.3%.

While a significant percentage of the Swiss population supports maintaining a liberal scheme for non-residents in Switzerland,⁴⁵⁰ suicide tourism remains a significant and contentious political issue. Aside from a potential Federal Council bill, suicide tourism may end up being addressed by cantonal tax authorities who do not wish to subsidize the practice for non-residents. According to the public prosecutor’s office, administrative costs run between CHF 3000-5000 per assisted suicide, which amounts to CHF 273,000 per year in the canton of Zurich alone.⁴⁵¹

There also appears to be continued support for the practice of euthanasia by the public (71% in 1999)⁴⁵² and some support for it among palliative care physicians (19%) if it

⁴⁴⁷ *ibid* 479.; The EURELD study conducted in 2001, revealed that assisted suicide accounted for .36% of all deaths, of which right to die organizations were involved in 92% of the cases. The studies reviewed 3248 deaths by way of a physician questionnaire, which had a 67% response rate. The EURELD Study (n 107) 347.

⁴⁴⁸ FSO Report (n 440) 1.

⁴⁴⁹ *ibid* 2.

⁴⁵⁰ A 2011 referendum involving over 278,000 voters in Zurich indicated that 78% of voters were against a ban that would prohibit non-residents from accessing assisted suicide in Switzerland. Additionally, 85% of voters rejected an initiative to ban assisted suicide. Staff, ‘Zurich voters reject ban on “suicide tourism”’ (15 May 2012) <swissinfo.ch> accessed 31 May 2012.

⁴⁵¹ Baezner-Sailer (n 314) 145.

⁴⁵² Hurst (n 375) 272 citing survey by Exit ADMD which surveyed 1000 people in 1999, Exit ADMD, ‘Sondage assistance au suicide et euthanasie active’ <<http://www.exit-geneve.ch/Sondage1.htm>> accessed 31 May 2012.

were to be legalized.⁴⁵³ In January 2011, the Swiss euthanasia debate was re-ignited when a regional criminal court in Canton Neuchâtel acquitted a physician who triggered the lethal drip based on the patient's cue – a foot movement.⁴⁵⁴ Despite the prohibition on euthanasia, the court ruled that the doctor had a medical and moral duty to violate the law and had complied with all due care criteria required by suicide assistance.⁴⁵⁵ In addition to calling to mind the necessity justification of the Netherlands, this case is expected to provoke the inclusion of euthanasia in future political discussions regarding assisted suicide as well as new initiatives arguing for reform to the Swiss Penal Code.

To summarize then, the practice of assisted suicide in Switzerland was developed on the basis of the individual's right to self-determination, separate and apart from the medical profession. Over time, concerns about possible abuses of individuals lacking in mental competency, the provision of AD to non-residents and motivations based on financial gain have led to the infusion of medicalized contours to the practice, despite opposition from the Swiss medical profession.

III.B.5. Oregon

a. Historic Overview

On 8 November 1994, Oregon became the first jurisdiction in the United States to explicitly legalize PAS.⁴⁵⁶ The *Oregon Death with Dignity Act*,⁴⁵⁷ in full force by 1997, allows doctors to prescribe lethal medication to Oregon residents suffering from a terminal illness – defined as an illness expected to lead to death within six (6) months.⁴⁵⁸ Euthanasia on the other hand remains strictly prohibited.⁴⁵⁹ Other medical practices such as the withholding or withdrawing of life-sustaining treatment for reasons of futility or by patient direction, pain medication in doses that may have life-shortening effect and palliative sedation are for the most part considered to be within

⁴⁵³ 19% of 90 palliative care physicians surveyed. Hurst *ibid* 272.

⁴⁵⁴ The patient was suffering from amyotrophic lateral sclerosis (ALS) a progressive degenerative condition.

⁴⁵⁵ See media report 'Daphné Berner acquittée' *RTN* (Champs-Montants, 6 December 2010) <www.rfj.ch/rtn/Actualite/Regionale/61210Daphne-Berner-acquittee.html> accessed 31 May 2012.

⁴⁵⁶ Almost every state in the United States criminalizes assisted suicide either expressly or by common law. See discussion in Faith Lagay, 'Physician-Assisted Suicide: The Law and Professional Ethics' (2003) 5(1) *The American Medical Journal of Ethics* <virtualmentor.ama-assn.org/2003/01/pfor1-0301.html> accessed 31 May 2012.

⁴⁵⁷ *Oregon Death with Dignity Act*, Oregon Revised Statute 127.800-127.897 <public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ors.aspx> accessed 31 May 2012 (1994 Oregon Law).

⁴⁵⁸ 1994 Oregon Law *ibid* art 127.805 §2.01.

⁴⁵⁹ *ibid* art 3.14.

the range of acceptable medical practices in the United States and are captured in numerous professional medical codes, case law and statutes.⁴⁶⁰

As of the 1990s there was very little empirical data regarding the number of euthanasia or assisted suicide requests, the motivations behind the requests, the types and degrees of suffering or the numbers of requests granted by health care providers.⁴⁶¹ However, despite the lack of data, there existed considerable public interest in PAS and euthanasia.⁴⁶² This interest had been provoked by a number of developments in the United States including: controversy regarding advances in life-support technologies as illuminated by the U.S. Supreme Court case *Cruzan* which confirmed the legal right to forego medical treatment necessary to sustain life;⁴⁶³ the AIDs crisis which was at its peak (at the time considered to be a terminal illness);⁴⁶⁴ and the highly publicized activities of right-to-die activist Dr. Jack Kevorkian.⁴⁶⁵

⁴⁶⁰ For example see: *The Patient Self-Determination Act (PSDA) of 1991* passed as part of the Omnibus Budget Reconciliation Act of 1990 (Sections 1395cc and 1396a) and The Council on Ethical and Judicial Affairs (CEJA), *Decisions Near the End of Life* (CEJA Report B—A-9, adopted June 1991) 9-10 <www.ama-assn.org/resources/doc/code-medical-ethics/2211a.pdf> accessed 31 May 2012 (1991 CEJA Report). The CEJA develops ethics policy for the American Medical Association (AMA); For Oregon specifically, see Oregon Medical Board, *Statement of Philosophy – Pain Management* (adopted 16 April 1999) <oregon.gov/OMB/SOP_PainManagement.shtml> accessed 31 May 2012. Under the 1994 Oregon Law (n 523) these practices are not reportable. Oregon Public Health Division, *FAQs about the Death with Dignity Act* (OHD, 19 November 2010) 4 <public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/faqs.pdf> accessed 31 May 2012 (OHD FAQs).

⁴⁶¹ 1991 CEJA Report *ibid* 7; Prior to legalization of PAS in Oregon, one report identified that 7% of physicians surveyed had written a prescription knowing that it would be used to end the patient's life. Melinda A Lee, Heidi D Nelson, Virginia P Tilden and others, 'Legalizing Assisted Suicide -- Views of Physicians in Oregon' (1996) 334(5) *The New England Journal of Medicine* 310 (Lee).

⁴⁶² RJ Blendon, US Szalay and RA Knox, 'Should Physicians Aid their Patients in Dying? The Public Perspective' (1992) 267 *The Journal of the American Medical Association* 2658-62.

⁴⁶³ Nancy Cruzan sustained brain injuries from a car accident leaving her in a persistent vegetative state. When it became apparent that there was no chance of recovery, her parents petitioned the courts to permit the hospital to remove the feeding tubes that were keeping her alive. The U.S. Supreme Court upheld the right to refuse life-sustaining treatment on the constitutionally protected autonomy-based liberty interest. In the case of an incompetent person however, their wish to have life-support withdrawn must be proven by clear and convincing evidence. *Cruzan v Director, Mo. Dep't of Health*, 497 U.S. 261, 284 (1990) (*Cruzan*); The Cruzan case was preceded by the 1976 landmark case, *In re Quinlan* 355 A.2d 647 (N.J.) 664 (*Quinlan*) where the New Jersey Supreme Court granted the parents' request to turn off the respirator that was keeping their daughter Karen Ann (who was in a coma) alive. The court held that a patient's constitutional right to privacy could outweigh the state's interest in preserving life particularly as the degree of bodily invasion increases and the prognosis dims.

⁴⁶⁴ Carol A Pratt, 'Efforts to Legalize Physician-Assisted Suicide in New York, Washington and Oregon: A Contrast Between Judicial and Initiative Approaches - Who Should Decide?' (1998) 77 *Oregon Law Review* 1027, 1029-32 (Pratt); In a 1990s study of 228 physicians in the San Francisco area caring for patients with human immunodeficiency virus disease (HIV), 53% reported having granted a request for PAS. LR Slome, TF Mitchell, E Charlebois and others, 'Physician-assisted suicide and patients with human immunodeficiency virus disease' (1997) 336 *The New England Journal of Medicine* 417-21; See also text to footnote 544-552 and discussion regarding cases, *Washington v Glucksberg*, 521 U.S. 702 (1997) and *Quill v*

While the first person to be assisted by Dr. Kevorkian was Oregon resident Janet Adkins who was suffering with Alzheimer's disease,⁴⁶⁶ the initiative to put a ballot measure before Oregon voters to legalize PAS came from another Oregon resident, Elvin Sinnard⁴⁶⁷ whose wife Sara was suffering from chronic heart disease.⁴⁶⁸ With information obtained from the Oregon branch of the Hemlock society, a euthanasia advocacy group,⁴⁶⁹ Mr. Sinnard assisted his wife in taking her own life, though leaving her when she died (at her request) in order to legally protect himself.⁴⁷⁰

In 1990, Mr. Sinnard, along with a group of physicians and lawyers,⁴⁷¹ spearheaded the drafting of *Ballot Measure 16, the Oregon Death with Dignity Act*. On 8 November 1994, this measure was voted into law by a narrow margin of 51 per cent in favour to 49 per cent against⁴⁷² (the 1994 Oregon Law).

The 1994 Oregon Law was scheduled to come into effect 30 days later⁴⁷³ but its implementation was delayed for another three years when a group comprised of patients, physicians and residential care facilities challenged the constitutionality of the law on the basis that it *inter alia* violated terminally ill patients' due process and equal protection rights under the 14th Fourteenth Amendment in *Lee v. Oregon*.⁴⁷⁴ In

Vacco, 521 U.S. 793 (1997) where at least one of the plaintiffs in each case were men dying of Acquired Immunodeficiency Syndrome (AIDS).

⁴⁶⁵ See generally George J Annas, 'The "Right To Die" in America: Sloganeering From Quinlan and Cruzan to Quill and Kevorkian' (1996) 34 *Duquesne Law Review* 875, 891-2 (Annas); See also Pratt (n 464) 1029-32; See also Neil M Gorsuch, 'The Right to Assisted Suicide and Euthanasia' (2000) 23 *Harvard Journal of Law and Public Policy* 599, 600-1.

⁴⁶⁶ Annas *ibid* 891.

⁴⁶⁷ Previous draft bills allowing PAS introduced in the years, 1987, 1989 and 1991 by Oregon Senator Frank Roberts (with the support of the Hemlock Society) were unsuccessful. Lewy (n 10) 127.

⁴⁶⁸ Pratt (n 464) 1032.

⁴⁶⁹ The Hemlock Society was founded shortly after the Quinlan case (n 529) by euthanasia advocate Derek Humphrey. Annas (n 466) 890. See also Andrew M Jacobs, 'The Right to Die Movement in Washington: Rhetoric and the Creation of Rights' (1993) 36 *Howard Law Journal* 185, 186 (Jacobs). The Hemlock Society later evolved into End-of-Life Choices (EOLC) in 2003, eventually merging with Compassion in Dying to form Compassion & Choices in 2005. Compassion & Choices, 'End-of-life Timeline' <www.compassionandchoices.org/page.aspx?pid=278> accessed 31 May 2012.

⁴⁷⁰ Pratt (n 464) 1032.

⁴⁷¹ This group of individuals ultimately formed the Oregon Right to Die political action committee. Pratt *ibid* 1032.

⁴⁷² 627,980 votes in favour, 596,018 votes against. Oregon Blue Book, 'Initiative, Referendum and Recall: 1988-1995' <bluebook.state.or.us/state/elections/elections21.htm> accessed 31 May 2012.

⁴⁷³ See also Oregon Legislative Policy & Research Office, *Basics on . . . Ballot Measure 51* (Legislative Policy & Research Office, October 1997) 1 <www.leg.state.or.us/comm/commsrvs/51final.pdf> accessed 31 May 2012.

⁴⁷⁴ *Lee v Oregon* 891 F. Supp 1429, 1438 (D. Or. 1995) The group also argued that the 2004 Oregon Law violated their free exercise of religion and freedom of Association rights under the

August 1995, the group obtained a permanent injunction from the U.S. District Court of Oregon which found that the law lacked sufficient safeguards to prevent terminally-ill adults who are incompetent (because of depression) from committing suicide. Thus according to the District Court, terminally-ill individuals were deprived of safeguards available to those who were not terminally ill, in violation of the equal protection right.⁴⁷⁵ On appeal to the Ninth Circuit Court of Appeals however, the plaintiffs' claim was dismissed due to various factors including:

- a lack of standing;
- the nature of the plaintiff's injury - the possibility of suicide because of undetected depression was too speculative; and
- the doctors and health care facilities' claim not being "ripe" - the law did not create any penalty for doctors who chose not to participate.⁴⁷⁶

The injunction was lifted on 27 October 1997.⁴⁷⁷

As *Lee v. Oregon* made its way through the courts, two seminal cases, *Washington v. Glucksberg*⁴⁷⁸ and *Vacco v. Quill*⁴⁷⁹ were also being decided with decisions from the United States Supreme Court on 26 June 1997. Both lawsuits had been filed within one year of one another by Kathryn Tucker, the lawyer for Compassion in Dying, a right-to-die organization.⁴⁸⁰ The plaintiffs in each case were terminally ill patients who were challenging Washington and New York state laws that banned assisted suicide respectively on the basis of the constitutionally protected due process and equal protection clauses under the Fourteenth Amendment.⁴⁸¹

In *Washington v. Glucksberg* the plaintiffs made the argument that mentally competent, terminally ill patients have a due process "liberty interest" in the right to choose PAS. PAS, like abortion, was an intimate and personal choice and criminalization interfered with the right to choose. The Supreme Court held that the

First Amendment and their statutory rights under the Americans with Disabilities Act of 1990, the Rehabilitation Act of 1973 and the Religious Freedom and Restoration Act of 1993.

⁴⁷⁵ *ibid.*

⁴⁷⁶ *Lee v Oregon* 107 F.3d 1382 (9th Cir 1997).

⁴⁷⁷ A further petition to the U.S. Supreme Court for certiorari was denied. *Lee v Oregon* 522 U.S. 927(1997).

⁴⁷⁸ *Compassion In Dying v Washington*, 850 F. Supp. 1454 (W.D. Wash. 1994), rev'd, 49 F.3d 586 (9th Cir.), reh'g en banc granted, 62 F.3d 299 (9th Cir. 1995), aff'd, 79 F.3d 790 (9th Cir.), reh'g denied, 85 F.3d 1440 (9th Cir. 1996), rev'd sub nom. *Washington v Glucksberg*, 521 U.S. 702 (1997) (*Washington v Glucksberg*)

⁴⁷⁹ *Quill v Koppell*, 870 F. Supp. 78 (S.D.N.Y. 1994), rev'd sub nom. *Quill v Vacco*, 80 F.3d 716 (2d Cir. 1996), rev'd *Quill v Vacco*, 521 U.S. 793 (1997) (*Vacco v Quill*).

⁴⁸⁰ Pratt (n 464) 1031.

⁴⁸¹ For further discussion see Pratt *ibid* 1029 et seq.

due process clause did not provide a fundamental liberty interest in PAS⁴⁸² and that the law was rationally related to legitimate government interests including: protection of life, prevention of suicide, protection of the ethical integrity of medical doctors, protection of vulnerable people from indifference, prejudice and pressure to end their lives, and protection against the “slippery slope”.⁴⁸³

In *Vacco v. Quill*, the plaintiffs argued that allowing mentally competent terminally ill patients to refuse life-sustaining treatment while prohibiting them from choosing PAS as a way to end their lives violated the Equal Protection clause. The Supreme Court upheld the distinction between the two life ending activities holding that every competent person is entitled to refuse unwanted life-saving treatment but not one is permitted to assist a suicide.⁴⁸⁴ The Supreme Court held that the law did not violate the equality protection and that it was related to a legitimate end, citing the same compelling interests as cited in *Washington v. Glucksberg*.⁴⁸⁵

Thus, although the U.S. Supreme Court refused to recognize a constitutionally protected right to PAS, it left the possibility for legalization of PAS as a matter to be considered by individual states.⁴⁸⁶

In June 1997, before the resolution of the *Lee v. Oregon* litigation, the Oregon legislature authorized a referendum for the November 1997 election to repeal the 1994 Oregon Law - Ballot 51.⁴⁸⁷ The legislature referred Ballot 51 because of questions related to the law’s effectiveness and ongoing concerns regarding the adequacy of safeguards including those related to counseling, residency and reporting requirements.⁴⁸⁸

Both the Oregon Medical Association (OMA) and the Oregon Association of Hospitals and Health Systems (OAHHS) recommended voting in favour of the repeal.

⁴⁸² *Washington v Glucksberg* (n 478) 728.

⁴⁸³ *ibid* 785.

⁴⁸⁴ *Vacco v Quill* (n 479) 801.

⁴⁸⁵ For further discussion see Katherine A Chamberlain, ‘Looking for a Good Death: The Elderly Terminally Ill’s Right to Die by Physician-Assisted Suicide’ (2009) 17 *Elder Law Journal* 61, 69.

⁴⁸⁶ *Washington v Glucksberg* (n 478) 735.

⁴⁸⁷ House Bill 2954-Referred to the Electorate of Oregon by the 1997 Legislature to be voted on at the Special Election, November 4, 1997.

⁴⁸⁸ State of Oregon Secretary of State, *Voters’ Pamphlet, State of Oregon Special Election-November 4, 1997* (1997) 3
<library.state.or.us/repository/2009/200912301518203/sp1997_11_4.pdf> accessed 31 May 2012 (Voters Guide).

⁴⁸⁹ According to the OMA, at the time the law was passed in 1994 the OMA had maintained a neutral position on the law because of a deep division of opinion among its 5,500 members.⁴⁹⁰ By 1997, having had time to study the law in more detail, the OMA stated that it considered the law to have medical deficiencies that would negatively affect the care of seriously ill patients and advocated instead for “compassionate and competent palliative (comfort) care at the end of life”.⁴⁹¹ The OAHHS took a similar position advocating alternatives to PAS including: compassion and comfort care; education for patients, families and health-care providers; and support for aggressive pain relief even if resulting in hastened death. The OAHHS also voiced concerns over the possible failure of a prescription to bring about death, the lack of mandatory psychiatric assessment and the difficulty for physicians to accurately determine when a patient will die.⁴⁹²

Notwithstanding the official positions of the OMA and the OAHHS, a 1995 survey of 2,671 Oregon physicians indicated that 60% of physicians thought that PAS should be legal in some cases,⁴⁹³ with 46% potentially willing to write a lethal prescription for a terminally ill patient if it were legal to do so.⁴⁹⁴ Additionally, a 1996 survey of 321 Oregon psychiatrists showed that 56% were also in favour of implementation of the 1994 Oregon Law.⁴⁹⁵

On 4 November 1997, the Oregon public voted on Ballot 51 and endorsed the 1994 Oregon Law by an even larger margin than before - voting 60 to 40 percent against repeal.⁴⁹⁶ Once in effect however, the law set off yet another complex series of challenges, this time from conservatives at the federal level who sought to nullify the state law through application of the federal 1970 *Controlled Substances Act*.⁴⁹⁷ Efforts

⁴⁸⁹ Voters Guide *ibid* 4. The American Medical Association was also in favour of a repeal and along with the Roman Catholic Church, the Mormon Church and the group Oregon Right to Life, was among the primary funders of the campaign to repeal the legislation. Pratt (n 464) 1098.

⁴⁹⁰ Voters Guide *ibid* 4.

⁴⁹¹ *ibid*.

⁴⁹² *ibid*.

⁴⁹³ Lee (n 461) 311.

⁴⁹⁴ *ibid* 312.

⁴⁹⁵ Linda Ganzini, DS Fenn, MA Lee and others, ‘Attitudes of Oregon Psychiatrists Toward Physician-Assisted Suicide’ (1996) 153 *The American Journal of Psychiatry* 1469; For detailed summary of various United States polls on assisted death see Kathryn L Tucker, ‘In the Laboratory of the States: The Progress of Glucksberg’s Invitation to Address End-of-Life Choice’ (2008) 106(8) *Michigan Law Review* 1593, 1607-8 (Tucker).

⁴⁹⁶ Linda Ganzini, ‘The Oregon Experience’ in Timothy E Quill and Margaret P Battin (eds), *Physician-Assisted Dying: The case for palliative care and patient choice* (Johns Hopkins University Press, 2004) (Ganzini 2004).

⁴⁹⁷ *Controlled Substances Act*, 21 U.S.C. §§ 801-971 (1994 & Supp.II 1996). The *Controlled Substances Act* was enacted to address drug abuse but also served to ensure that legally available drugs could continue to be legally distributed and used.

were aimed at undermining the ability of physicians to prescribe controlled drugs for assisted dying and included: encouraging the U.S. Drug Enforcement Agency to investigate and penalize physicians for prescribing death-hastening drugs;⁴⁹⁸ the introduction of legislation to prohibit the prescribing of federally controlled drugs for purposes related to suicide and euthanasia;⁴⁹⁹ and a 2001 directive from Attorney General John Ashcroft (the “Ashcroft Directive”) which stated that assisted suicide was not a “legitimate medical purpose” within the meaning of the *Controlled Substances Act* thus exposing prescribing physicians to various penalties under the act including suspension and revocation of registration.⁵⁰⁰ Ultimately none of these efforts proved successful. The challenges ended with the 2006 *Gonzales v. Oregon* case, where the Supreme Court upheld an injunction obtained by Oregon’s Attorney General to prevent enforcement of the Ashcroft Directive.⁵⁰¹ The federal authority to issue regulations with respect to controlled substances did not include the authority to define medical practice standards.

In 1997, the U.S. Congress did however enact the *Assisted Suicide Funding Restriction Act* which prohibits the use of federal funding to pay for items and services related to assisted suicide.⁵⁰² Therefore, Oregon patients or physicians in federal health care systems such as veteran or Indian health clinics cannot participate in PAS.⁵⁰³

It should also be briefly noted that the legalization of PAS in Oregon also coincided with substantial improvements in palliative care in Oregon including physician training, pain management, hospice care referrals and increases to the number of

⁴⁹⁸ S Sandy Sanbar and Stuart G Selkin, ‘Physician-Assisted Suicide’ in *Legal Medicine* (6th edn, Mosby, 2001) 317.

⁴⁹⁹ 1999 Pain Relief and Promotion Act (HR 2260 in the House and S1272 in the Senate). While garnering some support by the American Medical Association and the National Hospice Association, there were serious reservations about the ability of federal government to second-guess physicians’ intent and legitimate pain relief and the PRPA failed to reach Senate before its adjournment. Jack P Freer, ‘Congress and the Pain Relief Promotion Act’ (2000) 172(1) *West Journal of Medicine* 2000 5, 5-6 <www.ncbi.nlm.nih.gov/pmc/articles/PMC1070704/#ref1> accessed 31 May 2012; See also SH Johnson, ‘Disciplinary actions and pain relief: analysis of the Pain Relief Act’ (1996) 24 *The Journal of Law Medicine & Ethics* 319; See also proposed legislation, The Lethal Drug Abuse Prevention Act of 1998 (HR4006 in the House and S2151 in the Senate) introduced in the 105th Congress.

⁵⁰⁰ John Ashcroft, *Dispensing of Controlled Substances to Assist Suicide (Memorandum, 6 November 2001) a copy available from Cornell Law* <www.law.cornell.edu/primary_sources/ashcroft_directive.html> accessed 31 May 2012; See also discussion in Ganzini 2004 (n 496) 166.

⁵⁰¹ *Gonzales v Oregon* 546 U.S. 243 (2006).

⁵⁰² Assisted Suicide Funding Restriction Act of 1997 H.R. 1003: Public Law 105-12, 111 Stat. 23-28 *et. seq.* (4/30/97).

⁵⁰³ Department of Human Resources, *Oregon’s Death with Dignity Act: The First Year’s Experience* (Oregon Health Division, 18 February 1999) 9 (1999 Oregon Annual Report).

deaths taking place at home.⁵⁰⁴ However questions continue to be raised regarding the issues of adequate health care coverage and access to medications.⁵⁰⁵

b. Legislative Framework

Under the criminal code in Oregon, causing or aiding another person to commit suicide is a defence to the charge of murder but will be considered manslaughter.⁵⁰⁶ The 1994 Oregon Law does not mention these criminal law provisions except so far as to say that actions in accordance with the 1994 Oregon Law shall not for any purpose constitute suicide, assisted suicide, mercy-killing or homicide under the law.⁵⁰⁷ The 1994 Oregon law protects physicians and others from civil or criminal liability or professional disciplinary action who, in good faith compliance with the law, assist a patient in ending his or her life.⁵⁰⁸

The American Medical Association Code of Ethics (AMA Code) continues to view PAS as being “fundamentally incompatible with the physician’s role as healer.”⁵⁰⁹ Thus an Oregon physician who assists a suicide is at odds with the AMA Code even if in compliance with the 1994 Oregon Law. A similar incompatibility between medical codes and AD law has already been described for Luxembourg as well as, to a certain extent, Switzerland.

i. Due Care Requirements

The substantive requirements, that is, the criteria that qualify a patient to make a request for medication, are that the patient must:⁵¹⁰

- be an adult (18 years of age or older);

⁵⁰⁴ Robert Steinbrook, ‘Physician-Assisted Death — From Oregon to Washington State’ (2008) 359 NEJM 2513-5 (Steinbrook); See also TE Quill, ‘Legal Regulation of physician-assisted death – the latest report cards’ (2007) 356 The New England Journal of Medicine 1911-3.

⁵⁰⁵ See discussion in Andrew R Page, ‘Note: What’s the Cost of Living in Oregon These Days? - a Fresh Look at the Need for Judicial Protections in the Death with Dignity Act’ (2009) 22 Regent University Law Review 233.

⁵⁰⁶ Oregon Revised Statutes § 163.117 provides that: It is a defense to a charge of murder that the defendant’s conduct consisted of causing or aiding, without the use of duress or deception, another person to commit suicide. Nothing contained in this section shall constitute a defense to a prosecution for, or preclude a conviction of, manslaughter or any other crime. Oregon Revised Statutes § 163.125 provides that: (1) Criminal homicide constitutes manslaughter in the second degree when: (a) It is committed recklessly; or (b) A person intentionally causes or aids another person to commit suicide. (2) Manslaughter in the second degree is a Class B felony.

⁵⁰⁷ 1994 Oregon Law (n 457) art 127.880 §3.14.

⁵⁰⁸ *ibid* arts 127.885 §4.01(1) and 127.885 §4.01(2).

⁵⁰⁹ American Medical Association, ‘Code of Medical Ethics Opinion 2.211- Physician-Assisted Suicide’ (2008-2009) <<http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2211.page>> accessed 31 May 2012 (AMA Code of Ethics).

⁵¹⁰ 1994 Oregon Law (n 457) arts 127.805 §2.01 and 127.800§1.01(3).

- be an Oregon resident;⁵¹¹
- be diagnosed with a terminal disease (i.e. expected to lead to death within six months);
- be capable (able to make and communicate decisions about health care); and
- voluntarily express his or her wish to die.

The procedural safeguards that must be fulfilled to ensure that these conditions are met include the following:⁵¹²

- the patient must make a verbal request and a written request, and reiterate the verbal request no less than 15 days after the first verbal request;
- the prescribing (“attending”) physician must confirm diagnosis, capacity and that the voluntary and informed;
- the prescribing physician must ensure the patient is informed by advising patient of diagnosis, prognosis, risks and probable results of taking medication as well as alternatives such as comfort care, hospice care and pain control;
- the prescribing physician must refer the patient to a consulting physician for confirmation of the diagnosis, and for a determination that the patient is capable and acting voluntarily (confirmation must be in writing);
- both the prescribing and consulting physician are to refer the patient to counselling if either believes the patient has depression or other psychiatric or psychological disorder causing impaired judgment;
- the prescribing physician must recommend that patient notify next-of-kin of the prescription request; and
- the written request must be witnessed by two witnesses, at least one of whom does not have any interest⁵¹³ in the patient and who can attest to capacity and voluntariness.⁵¹⁴

It should be re-iterated that the 1994 Oregon Law focuses on the circumstances under which a physician is permitted to prescribe lethal medication. Thus to be in

⁵¹¹ Residency can be shown by driver’s licence, voter registration, property lease or tax return. 1994 Oregon Law *ibid* art 127.860 §3.10; While the patient must be a resident of Oregon, there is nothing in the law that prevents someone from moving to Oregon to participate in the law provided the individual can demonstrate residency. Oregon Health Authority, ‘Frequently Asked Questions About the Death with Dignity Act’ <public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/faqs.aspx> accessed 31 May 2012.

⁵¹² 1994 Oregon Law *ibid* arts 127.800§1.01(7);127.815 §3.01, 127.820 §3.02; 127.825 §3.03; 127.840 §3.06.

⁵¹³ Cannot be a relative or entitled to a portion of the patient’s estate or be employed by the health care facility where the individual resides or is a patient. If the patient is an inpatient at a health care facility, one of the witnesses shall be an individual designated by the facility. *ibid*

⁵¹⁴ 1994 Oregon Law *ibid* art 127.810 §2.02.

compliance with the law the physician cannot directly administer the medication. The requirement that the patient must self-administer the medication is considered implicit in the text of the law.⁵¹⁵

A patient can rescind the request at any time and in any manner⁵¹⁶ and the physician must offer a patient the opportunity to rescind the request at the time of the second verbal request.⁵¹⁷ Furthermore, at least fifteen (15) days must elapse between the initial verbal request by the patient and the writing of the prescription⁵¹⁸ and at least 48 hours must elapse between the patient's written request and the writing of the prescription.⁵¹⁹ The prescribing physician is required to document the fulfillment of all the statutory conditions in the patient's medical record including requests, offers to rescind request, diagnosis, prognosis, consulting physician's verifications as well as the medications prescribed.⁵²⁰

There is neither a requirement that the physician know the patient well⁵²¹ nor a requirement that the physician hold a belief (whether from the physician's or the patient's perspective) that the patient is a situation of unbearable suffering. It would appear that the primary legal responsibility of the physician under the 1994 Oregon law is to confirm the voluntariness of the patient's decision to die in order to provide a prescription for the lethal medication. Along these same lines, the patient can obtain the medication directly from the physician⁵²² or the pharmacist⁵²³ and the physician is not required to be present when the patient takes the lethal medication.⁵²⁴ The physician is not responsible for what happens after the prescription is written,

⁵¹⁵ See for example, *ibid* arts 127.800 §1.01(7)(c) and (d), 127.815 §3.01(g) and §4.01(1), 127.880 §3.14.

⁵¹⁶ *ibid* art 127.845 §3.07.

⁵¹⁷ *ibid* arts 127.815 §3.01 (h) and 127.840 s.3.06.

⁵¹⁸ *ibid* art 127.850 §3.08.

⁵¹⁹ *ibid* art 127.840 §3.06.

⁵²⁰ *ibid* art 127.855 §3.09.

⁵²¹ Note that the average duration of physician-patient relationship for PAS ranged from 10-18 weeks. Department of Human Resources, *Oregon's Death with Dignity Act - - 2010* (Oregon Health Division, 2011) 1, Table 1 (2010 Oregon Annual Report). According to the OHD's summary report for years 1998-2007, 3.4% of Oregon physicians wrote all prescriptions for the 541 patient total during those years. "It is also no secret that right-to-die organization Compassion & Choices helps patients find doctors who in principle are prepared to write prescriptions." Lewy (n 10) 141-2.

⁵²² 1994 Oregon Law (n 457) art 127.815 §3.01(L)(A).

⁵²³ The prescription must however be provided directly to the pharmacist by the physician with the patient's consent. 1994 Oregon Law *ibid* art 127.815 §3.01(L)(B)(ii).

⁵²⁴ As of 2010, prescribing physicians reported their presence on average only 24.2% of the time when the patient ingested the lethal medication. 2010 Oregon Annual Report (n 521) Table 1. A recent news report however cites that volunteers of the organization, Compassion and Choices, have been present in about 85% of the cases. John Iwaski, 'Oregon assisted suicide at record high' *Seattle Post-Intelligencer* (Seattle, 9 January 2009).

although he or she must “counsel the patient about the importance of having another person present when the patient takes the medication” .⁵²⁵

No physician or healthcare provider is obligated to participate in providing medication to end the life of a patient, but the physician or provider must transfer the patient’s records to any new physician or health care provider upon the patient’s request.⁵²⁶

ii. *Reporting and Review*

The Oregon Health Division (OHD) is tasked with monitoring compliance, collecting information on patients and physicians participating in PAS and publishing an annual statistical report.⁵²⁷ Under the administrative rules enacted pursuant to the act, within seven (7) days of writing a prescription for medication to end the life of a qualified patient, the prescribing doctor is to file a prescription report with the OHD documenting compliance with the AD law.⁵²⁸ Further, within ten (10) calendar days of a patient’s ingestion of the lethal medication, the physician is to complete the “Oregon Death with Dignity Act Attending Physician Interview” form prescribed by the OHD.⁵²⁹ Pharmacists are also required to file a dispensing report with the OHD.⁵³⁰

As will be discussed further below, the 1994 Oregon law does not require physicians to be present at the time of death. If present however, the physician is positioned to be able to address death certificate requirements. Alternatively, the physician may make arrangements with the family to be notified of the patient’s death. When these types of arrangements are made, the death certificate originates in the mortician’s office and is then sent for signature by the physician, thus avoiding entry into the medical examiner’s system.⁵³¹ For this same reason, the OHD recommends that physicians

⁵²⁵ 1994 Oregon Law (n 457) art 127.815 §3.01(g).

⁵²⁶ *ibid* art 127.885 §4.01(4).

⁵²⁷ *ibid* art 127.800 -127.897.

⁵²⁸ See Oregon Administrative Rule, *Reporting Requirements of the Oregon Death with Dignity Act*, art 333-009-0010 <public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/oars.aspx> accessed 31 May 2012 (Oregon Admin Rules) and 1994 Oregon Law *ibid* art 127.865 §3.11(2).

⁵²⁹ Oregon Department of Human Services Reporting, *The Oregon Death with Dignity Act: A Guidebook for Health Care Professionals* (December 2008) para 14 <www.ohsu.edu/xd/education/continuing-education/center-for-ethics/ethics-outreach/upload/Oregon-Death-with-Dignity-Act-Guidebook.pdf> accessed 31 May 2012 (2008 Oregon Guidebook).

⁵³⁰ 1994 Oregon Law (n 457) art 127.865 (1)(b) and Oregon Admin Rules (n 528) art 333-009-0010 (3).

⁵³¹ 2008 Oregon Guidebook (n 529) para 14; The Medical Examiner must investigate any death that occurred under suspicious or unknown circumstances ORS 146.090 <www.leg.state.or.us/ors/146.html> accessed 31 May 2012.

record the underlying terminal conditions as the cause of death and mark the manner of death “natural”.⁵³²

The OHD reviews a sample of the reports⁵³³ and contacts physicians for any missing data. The OHD cross-references reports with patient death certificates held by Vital Records to confirm deaths and obtain additional demographic information such as age and education. The OHD also conducts in-person telephone interviews with prescribing physicians after receipt of the patient death certificates to obtain further information not available from the prescription reports or death certificates such as: insurance status; end-of-life care; medical and functional status at the time of death; the physician characteristics (age, sex, years in practice, medical specialty); and so forth.⁵³⁴

The OHD destroys all source documentation approximately one year after the publication of each Annual Report.⁵³⁵

c. Compassion and Autonomy, Self-Determination and Suffering

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

The 1994 Oregon Law does not include suffering as a requirement for access to PAS. This is distinct from the laws of the Netherlands (unbearable and lasting, palpable to the physician), Belgium (persistent and unbearable – from the conscious patient’s perspective), Luxembourg (unbearable and hopeless) and even Switzerland (unbearable or unacceptable). The Oregon legislation replaces the suffering justification with the requirement that patients are diagnosed with a terminal disease i.e. incurable, irreversible and which will produce death within six months.⁵³⁶ In so doing, legal access to PAS is denied to persons experiencing suffering related to chronic but not terminal diseases or disabilities and to persons experiencing prospective suffering in connection with the early stages of diseases like ALS, dementia and Alzheimers. Furthermore, while some diagnoses might eventually meet the terminal requirement, diseases such as dementia and Alzheimers will continue to

⁵³² *ibid.*

⁵³³ Note under the 1994 Oregon Law, the Oregon Health Division is only required to review a “sample” of records submitted but has developed administrative rules and the practice of reviewing all records submitted 1994 Oregon Law (n 457) *ibid* arts 127.865§3.11(1)(a) and Oregon Admin Rules (n 528) *ibid* 333-009-0020 (1).

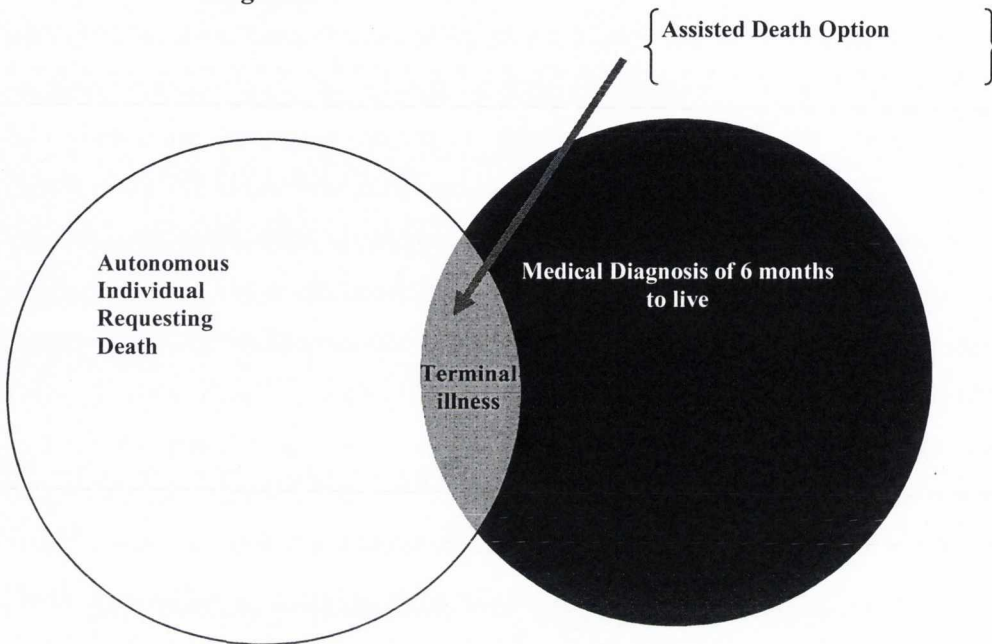
⁵³⁴ 1999 Oregon Annual Report (n 503) 3.

⁵³⁵ OHD FAQs (n 460) 2.

⁵³⁶ 1994 Oregon Law (n 457) arts 127.800 §1.01 and 127.805 §2.01.

be excluded because of the additional requirement that a patient be capable and able to make an informed decision.

Figure 9: AD advanced on basis of autonomy but limited by terminal diagnosis



Oregon thus stands apart from the other jurisdictions discussed by requiring that a terminal medical illness be present in lieu of the suffering criteria and has to a certain degree been criticized because of the difficulty in making an accurate prediction as to when a patient will die.⁵³⁷

Furthermore, the Oregon law is subject to the ongoing criticism that limiting assisted suicide to persons with terminal illness is discriminatory, a concern reflected in the current Swiss debate as described earlier. The strict terminal diagnosis requirement is interesting because the language of the 1994 Oregon law emphasizes “death with dignity”, (the name of the law) and the ending of life in a “humane and dignified manner.”⁵³⁸ As put by John B. Mitchell however, “...neither of the two primary metaphors weaving in and out of the current PAS dialogue - “death with dignity” and “unbearable suffering” - correlate strongly with six months to live.”⁵³⁹ Indeed, the

⁵³⁷ Herbert Hendin and Kathleen Foley, ‘Physician-Assisted Suicide in Oregon: a Medical Perspective’ (2008) 106 Michigan Law Review 1613, 1633-4 (Hendin and Foley). RA Pearlman, ‘Inaccurate prediction of life expectancy: dilemmas and opportunities’ (1988) 148 Archives Internal Medicine 2537-8; A Vigano et al, ‘The relative accuracy of the clinical estimation of the duration of life for patients with end of life cancer’ (1999) 86 Cancer 170-61; E Chow et al, ‘How accurate are physicians’ clinical predictions of survival and the available prognostic tools in estimating survival times in terminally ill cancer patients? A systematic review.’ (2001) 13(3) Clinical Oncology 209-18.

⁵³⁸ 1994 Oregon Law (n 457) art 127.805 §2.01.

⁵³⁹ John B Mitchell, ‘Physician-Assisted Suicide and Dementia: The Impossibility of a Workable Regulatory Regime’ (2009) 88 Oregon Law Review 1085, 1086.

European schemes draw attention to the distinction between pain and suffering (the former more tangibly treatable than the latter) and have thus created more intricate legal frameworks pursuant to which physicians must exercise their conscience and compassion in response to a request to die.

Some commentators have also criticized the Oregon PAS scheme as being more oriented towards the protection of physicians than patients⁵⁴⁰ – medical malpractice and litigiousness being a peculiarly American attribute.⁵⁴¹ On the other hand, it must be observed that in all AD schemes examined thus far, legalized AD practice is expressed as or incorporates a form of physician immunity. Furthermore, the terminal diagnosis requirement embodies a certain logic if the 1994 Oregon Law is perceived as a statutory extension of the common law regarding non-treatment decisions and an amendment to the result in the cases *Washington v. Glucksberg* and *Vacco v. Quill* which failed to convince the courts that the right to forego life-sustaining treatment should, on the basis of equality, extend to the right to seek life-ending medication for the terminally ill. In other words, the quasi-bright line established by the “six months to live” requirement is perhaps an incremental step in a medical treatment framework, consistent with and particularly reliant on the line of cases sanctioning the professional practice of “letting die”.⁵⁴²

When taken together however with what appears to be a reduced legal expectation (comparatively speaking) for physician involvement in the patient’s decision-making⁵⁴³ and for physician attendance when the patient ingests the medication, it might also be argued that the Oregon PAS scheme is more significantly consistent with the expressions of autonomy and self-determination in the Switzerland approach than the other schemes discussed, again despite the fact that PAS schemes are arguably the most narrow of the AD schemes (in terms of AD options available to the

⁵⁴⁰ See discussion in Hendin and Foley (n 537) 1626 et seq; See also discussion in Margaret P Battin, ‘Euthanasia: The Way We Do It, The Way They Do It’ (1991) 6(5) *Journal of Pain and Symptom Management* 298, 304 (Battin, Way).

⁵⁴¹ Battin, Way *ibid* 304.

⁵⁴² For a full treatment of this perspective see Neil M Gorsuch, *The Future of Assisted Suicide and Euthanasia* (Princeton University Press 2006) chpt 4.

⁵⁴³ This is not to imply that physicians do not take steps to introduce palliative measures. Virtually all patients who request assisted suicide are offered hospice care. In a 1999 study by Ganzini et al, it was found that the physician implemented substantive palliative interventions (e.g. pain control, hospice program referral, anti-depressant medication trial, consultation) for 68 patients (including 11 who received prescriptions of which 8 died). L Ganzini, HD Nelson, TA Schmidt and others, ‘Physicians’ experiences with the Oregon Death with Dignity Act’ (2000) 342(8) *The New England Journal of Medicine* 557-63 (Ganzini 2000). See also Ganzini 2004 (n 496) 176; Other studies have shown that with the introduction of the 1994 Oregon Law, physicians have been more willing to refer to patients to hospice care and have been improving their knowledge in palliative care. For summary of studies see Tucker (n 495) 1605-6.

patient). Perhaps limiting assisted death to PAS is the more consistent expression of an exercise of autonomy – PAS retains the decision for death as a future decision of the patient whereas euthanasia directly militates against the patient’s exercise of the right to choose by ending autonomy.

d. Statistics and Trends

Consistent with its legal mandate, the OHD only gathers and reports information concerning the use of the law, meaning, circumstances where a prescription for lethal medication has been written. Thus the data available from the OHD does not consider the possibility or extent of physician under-reporting (although failure to report is a legal violation) or indeed the overall frequency or nature of PAS requests. A 1999 survey of Oregon doctors however reported that only 1 in 6 requests for a prescription for a lethal medication are granted and that 1 in 10 requests result in suicide.⁵⁴⁴

Data from the OHD annual reports⁵⁴⁵ indicates that the number of physician-assisted deaths under the 1994 Oregon Law has gradually increased over the years from 15 (5 out of every 10,000 deaths or .05%) during 1998 to 59 (20.9 out of every 10,000 deaths or .21%) during 2010 to 71(22.5 out of every 10,000 deaths) during 2011 . As of the end of 2011, a total of 935 prescriptions have been written and 596 patients⁵⁴⁶ have died from medication prescribed under the law.⁵⁴⁷

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

Of the 596 cases to date, the most frequently mentioned end-of-life concerns for Oregon patients, were: loss of autonomy (88.7%), decreasing ability to participate in

⁵⁴⁴ 29 out of 221 requests reduced to 165 requests to account for duplication of requests and incomplete information. Ganzini 2000 *ibid* 558; See also DS Fenn and L Ganzini, ‘Attitudes of Oregon Psychologists toward Physician-Assisted Suicide and the Oregon Death with Dignity Act’ (1999) 30 *Professional Psychology Research And Practice* 235, 235-44.

⁵⁴⁵ 1999 Oregon Annual Report (n 503) 5, 2010 Oregon Annual Report (n 521) 1 and Oregon’s Public Health Division, *Oregon’s Death with Dignity Act -- 2011* (Oregon Health Division, 2012) (the 2011 Oregon Annual Report).

⁵⁴⁶ 2011 Oregon Annual Report *ibid* 2.

⁵⁴⁷ Based on protocols established by the Oregon State Pharmacy Association, the barbituates being prescribed are either secobarbital or pentobarbital. Non-lethal medications are also provided to increase stomach emptying and to prevent nausea and vomiting. 1999 Oregon Annual Report (n 503) 5.

activities that made life enjoyable (90.1%) and loss of dignity (74.6%).⁵⁴⁸ The concerns regarding loss of autonomy and participation in enjoyable activities have been trending upward since 1998 (from 75% in 1998 to 88.7% in 2011 and 69% in 1998 to 90.1% in 2011 respectively).⁵⁴⁹ Inadequate pain control or concern about pain was significantly of less concern (22.6% of the total 596 deaths to date).

Notwithstanding the overall upward trends with respect to loss of autonomy and participation in enjoyable activities from 1998 and 2011, both these concerns decreased from 2010 to 2011: from 93.8% to 88.7% and from 93.8% to 90.1% respectively. Similarly, concern over the loss of dignity also dropped from 84.1% (1998-2010) to 74.6% (2011).⁵⁵⁰ Conversely, concern about being a burden on family, friends or caregivers increased from 26.2% in 2010 to 42.3% in 2011.⁵⁵¹ The concern over inadequate pain control also increased from 15.4% in 2010 to 22.6% in 2011.⁵⁵²

Regardless of the trends between 2010 to 2011, these statistics have overall been interpreted to mean that for Oregon patients, the issue of main concern is the desire to control the manner in which they die and that the use of PAS is not about a lack of good end of life care. Indeed, the vast majority of PAS patients die at home and the vast majority are enrolled in hospice care – the most comprehensive form of end-of life care available.⁵⁵³ That said, these concerns also suggest that prospective or anticipatory suffering could be playing a fairly significant role in the Oregon patient's wish to die, which, given the difficulty in accurately predicting death to within 6 months, in the author's opinion warrants deeper examination, as do the recent trends with respect to concerns about being a burden and adequate pain control.

During the years 1998-2010, patients with ALS have had the second highest rate of requests granted (8.0%).⁵⁵⁴ This has led to some concern regarding the ability of the Oregon AD scheme to accommodate these patients particularly if they have difficulty swallowing. To date, only oral medications have been prescribed under the legislation and some commentators question whether the legislation as written could allow for

⁵⁴⁸ 2010 Oregon Annual Report (n 521) Table 1.

⁵⁴⁹ Oregon Public Health Division, *Oregon's Death with Dignity Act: Thirteen Years* (CD Summary, Vol.60, No.06 15 March 2011) 1 (OHD Thirteen Year Summary) and 2011 Oregon Annual Report *ibid*.

⁵⁵⁰ 2011 Oregon Annual Report *ibid*.

⁵⁵¹ 2010 Oregon Annual Report (n 521) Table 1 and 2011 Oregon Annual Report *ibid*.

⁵⁵² *ibid*.

⁵⁵³ For example in 2011, 94.1% of patients died at home and 96.7% were enrolled in hospice care. 2011 Oregon Annual Report *ibid* 2.

⁵⁵⁴ *ibid* Table 1.

self-administration of a medication using an intravenous line.⁵⁵⁵ At face value however, as long as the patient controls every aspect of the decision, timing and the final act causing death, it should be permissible. Current studies on the other hand indicate that many Oregon physicians do not wish to be present when the patient takes the lethal medication,⁵⁵⁶ and the number of prescribing physicians present at the time of death trended downward to 8.5% in 2011, from a high of 48% in 1999. This suggests that the trend of prescribing oral medications will likely continue into the future.

The non-compulsory attendance of physicians when a patient is ingesting the lethal medication has raised the further issue of responsibility for addressing possible complications upon ingestion, such as vomiting and regurgitation, seizures or the regaining of consciousness. To date, complications are known to have occurred in at least 3.7% of the 596 Oregon cases thus far.⁵⁵⁷

It should be noted 1998–2010, chronic lower respiratory disease was the underlying illness associated with the third-highest rate of requests granted (3.8%). However, in 2011, it had bypassed ALS to become the illness associated with the second-highest rate of requests granted at 7.4%; ALS ranked third, at 2.9% of requests granted.⁵⁵⁸

Another ongoing area of concern is the possibility that, contrary to the 1994 Oregon Law, patients with depression are receiving prescriptions for lethal medication.⁵⁵⁹ As discussed, a referral for psychological evaluation only becomes necessary if the prescribing or consulting physician forms the opinion that the patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment. A 2008 study of 58 Oregonians with terminal illness who requested PAS or contacted an aid-in-dying advocacy organization found that out of the 18 patients who had received a lethal prescription, 3 met the criteria for depression and died from lethal ingestion.⁵⁶⁰ The suspicion has intensified as the number of patients referred for a psychological evaluation has continued to decrease over time from 43.5% in 1999 to

⁵⁵⁵ Lewy (n 10) 131.

⁵⁵⁶ *ibid* 140.

⁵⁵⁷ 2011 Oregon Annual Report (n 545) Table 1; See generally discussion in Pereira regarding Swiss physicians' sense of confliction and the non-abandonment on the patient. Pereira (n 378).

⁵⁵⁸ 2011 Oregon Annual Report *ibid* Table 1.

⁵⁵⁹ Erin Hoover Barnett, 'Is Mom Capable of Choosing to Die?' *The Oregonian* (Oregon, 17 October 1999) G1-2; Hendin and Foley (n 603) Parts II and III.

⁵⁶⁰ Linda Ganzini, Elizabeth R Goy, Steven K Dobscha, 'Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross sectional survey' (2008) *The British Medical Journal* 337:a1682.

1.5% (1 out of 65 patients in 2010⁵⁶¹ notwithstanding that the primary condition associated with PAS requests is a terminal cancer diagnosis – known to have a strong correlation with depression disorders.⁵⁶²

In March 2011 House Bill 2016 was put before the Oregon legislature but subsequently died in committee⁵⁶³ The bill sought to impose mandatory counseling of all individuals requesting a prescription for medication to end their lives. Proponents of PAS in Oregon considered the bill an attempt to create barriers to “death with dignity”, designed to burden patients and physicians with needless procedures and paperwork.⁵⁶⁴ This critique is particularly interesting in that it implicitly suggests that there should be a presumption that depression is not present in those suffering from terminal illness unlike the Dutch AD scheme, which makes every medical attempt to rule out depression.⁵⁶⁵

The above contrast regarding how possible depression is addressed can serve to illustrate how the limits to autonomy-based AD might begin to be drawn: in addition to potentially being drawn to respond to undesirable consequences that have or have not played out (i.e. safeguards), limits can also be drawn in the first instance in relation to the perceived foundations or underpinnings of the particular assisted death law at issue. In the case of Oregon, the idea of “death with dignity” pushes the limits that might be imposed by mandatory depression filters outwards while in the case of the Netherlands, the concept of physician-conflict necessarily pulls them in. This in turn provides a glimpse into a subsequent task - to determine whether the heterogenous foundations of the respective AD laws are being analytically diluted in such a way that will minimize the limits to AD and maximize AD to its fullest expression pursuant to a generalized appreciation of the idea of autonomy.

⁵⁶¹ OHD Thirteen Year Summary (n 549) 2.

⁵⁶² See discussions in William Breitbart et al, ‘Depression, Hopelessness, and Desire for Hastened Death in Terminally Ill Patients With Cancer’ (2000) 284 *Journal of the American Medical Association* 2907, 2910; Hendin and Foley (n 537) 1630; See also recent study on depression and grief, Juliet C Jacobsen, Baohui Zhang, Susan D Block and others, ‘Distinguishing Symptoms of Grief and Depression in a Cohort of Advanced Cancer Patients’ 2010 34(3) *Death Studies* 257; But see study by Ganzini where alleviation of depression had no impact on patient end of life decisions when decision based on long held beliefs and morals. Ganzini 2000 (n 543) 560.

⁵⁶³ A Bill for an Act Relating to the Oregon Death with Dignity Act; amending ORS 127.800, 127.815, 127.825, 127.855 and 127.865.7: a1682 <www.leg.state.or.us/l1reg/measpdf/hb2000.dir/hb2016.intro.pdf> accessed 31 May 2012; House Bill 2016, <<http://www.leg.state.or.us/cgi-bin/searchMeas.pl>> accessed 31 May 2012.

⁵⁶⁴ Compassion & Choices Oregon, ‘Supporters of death with dignity hail failure of House Bill 2016’ (12 April 2011) <<http://www.compassionforegon.org/2011/04/supporters-of-death-with-dignity-hail-failure-of-hb-2016/>> accessed 31 May 2012.

⁵⁶⁵ Battin, Way (n 540) 299-300.

III.B.6. Washington

a. Historic Overview

With the passing of the Washington Death with Dignity Act in 2008 (the 2008 Washington Law),⁵⁶⁶ Washington became the second state in the United States to legalize PAS by statute. The 2008 Washington Law substantively mirrors the 1994 Oregon Law with a few minor exceptions.

Washington's first attempt at legalization of assisted death came in November 1991 with an Initiative advanced by the Hemlock Society of Washington State - Initiative 119 (I-119).⁵⁶⁷ In addition to collecting 223,000 signatures (50% more than required for a referendum), surveys of the Washington public indicated that approximately two out of three voters were in favour of euthanasia.⁵⁶⁸

I-119, among other things, would have allowed both PAS and euthanasia for competent adults with a terminal medical condition (i.e. death anticipated within six months).⁵⁶⁹ Proponents of I-119, emphasized autonomy as the primary value, the right to choose and the importance of quality of life.⁵⁷⁰ Opponents emphasized the sanctity of life as the primary value.⁵⁷¹ I-119 was also opposed by a number of Washington State physicians and the medical association who in response to I-119, mailed out thousands of brochures urging physicians to "vote no".⁵⁷²

I-119 only garnered 46% of the 1.5 million votes cast.⁵⁷³ The lack of voter support in favour was attributed to the initiative's failure to provide adequate safeguards against misuse such as the absence of psychological evaluations and waiting periods as well

⁵⁶⁶ Chpt 70.245 RCW, The Washington Death with Dignity Act <wei.secstate.wa.gov/osos/en/Documents/I1000-Text%20for%20web.pdf> accessed 31 May 2012 (2008 Washington Law).

⁵⁶⁷ Rob Carson and Bette-Jane Crigger, 'Washington's I-119' (1992) 22 *The Hastings Center Report* 7 (Carson); At the time, Hemlock founder and executive director Derek Humphrey's suicide manual, "Final Exit" was on the New York Times bestseller list. Jacobs (n 469) 187.

⁵⁶⁸ Carson *ibid* 7.

⁵⁶⁹ Office of the Secretary of State, 'Complete Text of Initiative Measure 119' in *Voters: Pamphlet: State General Election* (5 November 1991) (I-119).

⁵⁷⁰ Jacobs (n 469) 189-94; Carson (n 567) 7.

⁵⁷¹ Jacobs *ibid* 194-199.

⁵⁷² Jacobs *ibid* 202; Ruth C Stern and J Herbie DiFonzo, 'Terminal Ambiguity: Law, Ethics and Policy in the Assisted Dying Debate' (2007) 17 *Boston University Public Interest Law Journal* 99, 122.

⁵⁷³ Carson (n 567) 7.

as the inclusion of the more controversial practice of euthanasia.⁵⁷⁴ Others have attributed the failure to external circumstances including the wealth of the Catholic Church and the negative impact from the “excesses” of Dr. Kevorkian.⁵⁷⁵

Notwithstanding the failure of I-119, the position taken by the Washington Medical Association (WMA) and AD’s illegality, some Washington physicians were providing PAS and euthanasia. A 1996 study of 1453 Washington physicians (828 responded) reported that 12% of physicians received one or more requests for PAS (156 requests) and 4% received one or more requests for euthanasia (58 requests).⁵⁷⁶ Twenty-four per cent of patients who requested PAS, received prescriptions, twenty-one of whom died, and 24% of patients who requested euthanasia received medication by injection and died.⁵⁷⁷ The report concluded that the most common patient concern at the time of the requests was non-physical (loss of control, being a burden, loss of dignity) but that physicians were more inclined to grant the requests of patients who had physical symptoms.⁵⁷⁸

Between the years 1996 and 2006, the path towards a state regime for PAS was mapped out:

- it was appropriate for states to create PAS legislation (*Washington v. Glucksberg* and *Quill v. Vacco*);
- Oregon had developed a scheme that could withstand constitutional scrutiny (*Lee v. Oregon*); and
- the federal right to control restricted substances utilized in PAS did not extend to regulating state medical practices (*Gonzales v. Oregon*).

With this and the benefit of Oregon’s ten years of experience, in January 2008, Booth Gardener (a former Washington Governor)⁵⁷⁹ filed Initiative Measure No. 1000 (I-1000)⁵⁸⁰ which was modeled on the Oregon law.

⁵⁷⁴ Arthur G Svenson, ‘Death with Dignity’s Emerging Conceit: Could *Vacco v. Quill* be Losing its Appeal?’ (2009) 31 *University of La Verne College of Law Review* 45, 55 (Svenson).

⁵⁷⁵ Carson (n 567) 7.

⁵⁷⁶ Conditions were mainly associated with cancer, neurological disease and AIDS. Anthony L Back, Jeffrey I Wallace, Helene E Starks, Robert A Pearlman, ‘Physician-Assisted Suicide and Euthanasia in Washington State’ (1996) 275(12) *The Journal of the American Medical Association* 919, 919 (Back).

⁵⁷⁷ *ibid* 919.

⁵⁷⁸ *ibid*.

⁵⁷⁹ Governor Booth Gardener headed up the Washington initiative, announcing his support of legalized assisted suicide shortly after the Supreme Court decision in *Gonzales v Oregon* (n 501). David Postman, ‘Ex-governor backs initiative to legalize assisted suicide *The Seattle Times* (Seattle, 7 February 2006).

The I-1000 debate centred on arguments similar to those heard throughout the years of debate in Oregon: for proponents – the issues of pain that cannot be alleviated, the limitations of end-of-life practices such as terminal sedation, and the ability to control the time, place and manner of one’s death; for opponents – the destruction of doctor-patient trust relationship; financial and insurance pressures to choose a “cheaper” death; and the slippery slope leading to euthanasia of society’s most vulnerable members such as those with disabilities and the elderly.⁵⁸¹

I-1000 (the “2008 Washington Law”) was passed by voters on 4 November 2008 by a margin of 58% (1,715,219 votes in favour) to 42% (1,251,255 votes against)⁵⁸² and went into effect on March 5, 2009.⁵⁸³

The WMA continues to oppose the 2008 Washington Law but not to the extent of taking repeal efforts.⁵⁸⁴

b. Legislative Framework

In Washington, assisted suicide is prohibited under Washington’s criminal code provisions whereby a person is guilty of “promoting a suicide attempt” when he or she knowingly causes or aids another person to attempt suicide.⁵⁸⁵ Like the 1994 Oregon Law, the 2008 Washington Law identifies that actions taken in accordance with the AD law will not constitute suicide, assisted suicide, mercy killing or homicide under the law and protects physicians and others from criminal and civil liability as well as professional disciplinary action.⁵⁸⁶ As with the Oregon law, the Washington law is not to be construed as authorizing the practice of euthanasia.⁵⁸⁷

⁵⁸⁰ Initiative Measure No. 1000, The Washington Death with Dignity Act <www.secstate.wa.gov/elections/initiatives/text/i1000.pdf> accessed 31 May 2012.

⁵⁸¹ Svenson (n 574) 59.

⁵⁸² Ballotpedia, ‘Washington “Death with Dignity Act”, Initiative 1000 #2008#’ (Ballotpedia, 14 June 2012) accessed 31 May 2012; See also Steinbrook (n 504) 2513.

⁵⁸³ 2008 Washington Law (n 566) art 70.245.903; Washington State Department of Health, ‘Washington Death with Dignity Act’ (Centre for Health Statistics, 2011) <www.doh.wa.gov/dwda/> accessed 31 May 2012.

⁵⁸⁴ Kevin B O’Reilly, ‘51 died under Washington’s assisted suicide law in 2010’ *American Medical News* (28 March 2011) <www.ama-assn.org/amednews/2011/03/28/prsb0328.htm> accessed 31 May 2012 (O’Reilly).

⁵⁸⁵ Wash Rev Code 9A.36.060(1) 1988. Promoting suicide is classified as a Class C felony punishable by imprisonment for up to five years and by a fine of \$1000. Wash. Rev. Code 9A.36.060(2), 9A.20.020(1)(c). Although this prohibition has been in place since 1854 in one form or another, it was rarely enforced. Melvin I Urofsky, ‘Justifying Assisted Suicide: Comments on the Ongoing Debate’ (2000) 14 *Notre Dame Journal of Law, Ethics and Public Policy* 893, 903.

⁵⁸⁶ 2008 Washington Law (n 566) arts 70.245.180 and 70.245.190(1)(a).

⁵⁸⁷ *ibid* art 70.245.180.

i. *Due Care Requirements*

The substantive due care requirements mirror those stipulated under the 1994 Oregon law. In order to qualify for PAS, the patient must be a competent⁵⁸⁸ adult suffering from a terminal disease (death within six months) who has voluntarily expressed his or her wish to die.⁵⁸⁹ The patient must also be a Washington resident.⁵⁹⁰

The procedural safeguards are also virtually identical to the Oregon safeguards: two oral requests, one witnessed written request, initial determination by prescribing physician of terminal illness, competency and voluntariness, confirmation by consulting physician, possible counseling referral, waiting periods, the right to rescind, record keeping and so forth.⁵⁹¹

It should be noted that the 2008 Washington Law goes a little farther than the 1994 Oregon law by expressly including in the definition of “qualified” patient, that the patient self-administer the medication which in turn is defined as the act of “ingesting” the medication.⁵⁹² Thus the Washington law provides physicians with a much clearer image in terms of which patients will be qualified under the law as well as a more distinct threshold between the practice of PAS and the practice of euthanasia.

ii. *Reporting and Review*

The reporting requirements under the 2008 Washington Law are again virtually identical to the 1994 Oregon Law. The Washington Department of Health (WDH) is charged with the annual review of all records, the collection of information and the publishing of an annual report.⁵⁹³ The law does however provide slightly longer time periods under which Washington physicians and pharmacists are to file the required documentation.⁵⁹⁴

Additional administrative rules have been adopted to further facilitate the implementation of the law particularly with respect to form of reporting and confidentiality.⁵⁹⁵

⁵⁸⁸ The definition of “competent” is the same definition as “capable” under the 1994 Oregon Law (n 457). 2008 Washington Law *ibid* art 70.245.010(3).

⁵⁸⁹ *ibid* arts 70.245.020 and 70.245.010(13).

⁵⁹⁰ *ibid* art 70.245.020.

⁵⁹¹ *ibid* arts 70.245.020 *et seq.*

⁵⁹² *ibid* arts 70.245.010(11)-(13).

⁵⁹³ *ibid* art 70.245.150.

⁵⁹⁴ For example, physicians and pharmacists have thirty (30) days after prescribing or dispensing the medication within which to send the required documentation and physicians have thirty (30) days after the death of the patient to send additional required document to the Washington Department of Health. *ibid* art 70.245.150.

⁵⁹⁵ Chpt. 246-978 WAC, *Death with Dignity Act Requirements*.

c. Compassion and Suffering, Autonomy and Self-Determination

Like Oregon, the Washington Law only creates a right to request PAS. Participation by health care providers is not mandatory, and if a health care provider is unwilling to participate he or she is only obligated to transfer a copy of the patient's medical records to the new health care provider upon the patient's request.⁵⁹⁶

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

Under both schemes as described, actions taken in compliance with the law are not to be construed as "suicide" or "assisted suicide" under the law.⁵⁹⁷ However, the 2008 Washington Law also requires that state reports refrain from utilizing suicide terminology and instead refer to the "obtaining and self-administering life-ending medication".⁵⁹⁸ While this shift away from what tends to be perceived as provocative value-laden language (particularly from the North American perspective) might be viewed as advancing the principle of autonomy to a certain extent, it is likely more accurate to perceive the terminology shift as advancing a more finessed descriptor for the ending of life through PAS – many authorities have pointed out that there are fundamental differences in the reasoning underlying the PAS act of a competent terminally ill person and the reasoning underlying the "suicide" act of a clinically depressed person.⁵⁹⁹

What is even more significant however to the advancement of the autonomy concept in the 2008 Washington Law is the express provision: "The attending physician may sign the patient's death certificate which shall list the underlying terminal disease as the cause of death."⁶⁰⁰ This is particularly compelling because in reality, it would be very difficult to assert an argument that the actual cause of death was anything other but poisoning from the ingestion of a lethal compound. What it does demonstrate however is an importation of the law's perspective on autonomy from the angle of a

⁵⁹⁶ 2008 Washington Law (n 566) art 70.245.190.

⁵⁹⁷ 1994 Oregon Law (n 457) art 127.880 § 3.14 and 2008 Washington Law *ibid* art 70.245.180.

⁵⁹⁸ 2008 Washington Law *ibid* art 70.245.180. Note: since 2007, the Oregon Department of Health annual reports use the terminology, "death with dignity option". Svenson (n 574) 61.

⁵⁹⁹ Rhea K Farberman, 'Terminal Illness and Hastened Death Requests: The Important Role of the Mental Health Professional' (1997) 28(6) *Professional Psychology: Research and Practice* 544; David M Smith and David Pollack, 'A Psychiatric Defense in Aid in Dying' (1998) 34(6) *Community Mental Health Journal* 547; Tucker (n 495) 1595.

⁶⁰⁰ 2008 Washington Law (n 566) art 70.245.040(2).

patient's right to refuse life-sustaining treatment – that it may not be properly viewed as a form of suicide,⁶⁰¹ rather it is the underlying illness that ends the patient's life.⁶⁰²

d. Statistics and Trends

According to the WDH 2010 Annual Report, from January 1 to December 31, 2010, 87 people requested and received lethal doses of medication.⁶⁰³ This is an increase from 2009, where 65 prescriptions were reported.⁶⁰⁴ However it is not possible to conclude whether participation increased as the 2009 year only covered a 10 month period, the law having been implemented on 5 March 2009. The number of deaths under the Washington law is approximately one/tenth of 1% of all deaths in Washington.⁶⁰⁵

Of the 87 prescriptions dispensed, 51 people died after ingesting the medication and 15 died without having ingested the medication (ingestion status of 1 was unknown and pending for the other 5).⁶⁰⁶ Of the 72 participants who died, their ages ranged between 52 and 99 years and like Oregon, the majority of patients were suffering from cancer (78%), with neuro-degenerative diseases (including ALS) and heart disease or "other" at 10% and 12% respectively. Referrals for psychological evaluation occurred 3% of the cases down from 7% in 2009.⁶⁰⁷

Similar to Oregon, the primary end-of-life concerns of the 72 participants were recorded as loss of autonomy (90%), loss of ability to participate in enjoyable activities (87%) and loss of dignity (64%). Inadequate pain control or concern about it was a significantly less concern at 36%. Of the 51 people who ingested the medicine and died, 90% were at home and 84% were enrolled in hospice care.⁶⁰⁸

⁶⁰¹ Maria T Celocruz, 'Aid-in-Dying: Should we Decriminalize Physician-Assisted Suicide and Physician-Committed Euthanasia?' (1992) 18 American Journal of Law and Medicine 369, 371.

⁶⁰² The 1994 Oregon Law does not contain a similar mandate although, as noted, in reporting guidelines from the Oregon Health Division, it is recommended that the prescribing physician complete the death certificate with the underlying terminal condition(s) as the cause of death, and the manner of death as "natural". The Task Force to Improve the Care of Terminally-Ill Oregonians, *The Oregon Death With Dignity Act: A Guidebook for Health Care Professionals* (first published March 1998, Task Force 2007) Chpt 7 <www.wsha.org/files/Death%20with%20dignity%20guidebook.pdf> accessed 31 May 2012.

⁶⁰³ Washington State Department of Health, *Washington State Death with Dignity Act* (2010) 2 <www.doh.wa.gov/dwda/forms/DWDA2010.pdf> accessed 31 May 2012 (2010 Washington Annual Report).

⁶⁰⁴ See also 2010 Washington Annual Report *ibid* 4; Washington State Department of Health, *Washington State Death with Dignity Act* (2009) <www.doh.wa.gov/dwda/forms/dwda_2009.pdf> accessed 31 May 2012.

⁶⁰⁵ O'Reilly (n 584).

⁶⁰⁶ 2010 Washington Annual Report (n 603) 7.

⁶⁰⁷ *ibid* 8.

⁶⁰⁸ *ibid* 9.

The duration of the patient-physician relationship ranged from 3 weeks to 10 years, with 51% of cases ranging from a 3-24 week relationship and 36% of cases with a relationship of 1 year or more.⁶⁰⁹ The prescribing physician was present only 4% of the time and other providers 53% of the time when the medicine was ingested.⁶¹⁰ No complications related to the ingestion of medicine however were reported.

Before turning to the overall analysis of this chapter, it should be noted that a proposed ballot initiative, “Mass. Petition 11-12: *An Initiative Petition to establish An Act Relative to Death with Dignity*”⁶¹¹ was filed with the Massachusetts Office of the Attorney General on 2 August 2011. The requisite number of signatures were obtained and accordingly, it is anticipated that the initiative petition will be printed and included on the 6 November 2012 ballot.⁶¹² The proposed legislation follows the same general pattern as the Oregon and Washington PAS statutes.

III. C. COMPARISON OF LIMITS TO ASSISTED DEATH UNDER CURRENT LAWS

III.C.1. Netherlands and the states of Oregon and Washington

In the Netherlands as discussed, AD regulation originally evolved in response to a perceived conflict in physician duties – the duty to protect life and the duty to relieve suffering (Figure 2). This conflict of professional duties was resolved by allowing physicians to provide AD pursuant to the defence of *overmacht* or necessity. Thus the essence of AD law in the Netherlands’ is the regulation of a medical activity. This formulation possesses distinct intrinsic conceptual constraints on AD – legalized AD must connect to a medical condition; it is an exceptional medical procedure that can only be implemented by the physician as a measure of last resort.

Thus in order to “qualify” for AD in the Netherlands, suffering has to be grounded in a medical condition and it must be lasting and unbearable as determined by, that is, “palpable” to the doctor within the doctor-patient relationship. Furthermore, in keeping with the professional duty ideology, once a decision to proceed with AD has been made, the doctor must remain with the patient until his or her death. Implicitly within this particular construction, the expression of autonomy and self-determination

⁶⁰⁹ *ibid* 8.

⁶¹⁰ *ibid* 9.

⁶¹¹ Massachusetts Petition 11-12: *An Initiative Petition to establish An Act Relative to Death with Dignity* (2 August 2011).

⁶¹² Secretary of the Commonwealth (Mass), ‘Secretary Galvin Sets Order of 2012 Ballot Questions’ (22 July 2012).

can be interpreted as fairly narrow, supporting the view that autonomy operates only as a necessary pre-condition to the doctor's activities as described above. The interpretation of autonomy as a pre-condition to physician activities is re-enforced by KNMG statements in its 2011 position paper that there must always be a medical basis in order to come within the Dutch euthanasia law.⁶¹³

One of the most significant outcomes of the physician conflict-of-duties underpinning is the broad scope of the Netherlands AD scheme, justifying euthanasia or PAS and justifying access to those suffering from medical conditions beyond those strictly considered "terminal". That said, it should be re-iterated that the trigger for what some may perceived to be an expansive approach to AD was not rooted in a similarly expansive version of self-determination, being instead grounded in a medical professional assessment of suffering.

Conversely, because a patient can legally refuse treatment that might otherwise address a condition and/or its symptoms, the notion of an operative "necessity" defence could be considered somewhat misleading as it is arguably the patient – the autonomous individual – who controls whether or not the conditions of necessity have been met. An echo of this apparent incongruity between the co-existence of the necessity defence and autonomy is reflected in certain comments made by the judge in the U.K. case *Nicklinson* regarding the plaintiff's lines of argumentation which will be discussed later in Chapter IV.C.2.ii. Granted, even where conditions of necessity unquestionably exist from a strictly medical point of view (i.e. no treatment exists), the physician cannot legally be compelled to provide AD. However, the point is, that without the necessity defence underpinning, logically speaking, there seems to be little basis for filtering the suffering criteria through a medical lens apart from the gate-keeping role regarding patient voluntariness and competency. When combined with the inherent subjectivity of suffering and the expansive "remedies" (i.e. euthanasia and PAS) available in the Netherlands, it is not much of a stretch to contemplate a demand for euthanasia or PAS for any form of suffering, particularly when elderly individuals, who are closer to the death event temporally speaking, are involved, a demand that is already being heard in the Netherlands as discussed (Figure 2).

Even with this apparent weakness in the cogency of the necessity defence underpinning, what is also essential here is that the necessity defence underlying the development of AD in the Netherlands has served to justify the act of euthanasia, that is, lethal injection. Without this association, the practice of euthanasia would have to

⁶¹³ KNMG 2011 Position Paper (n 19) 7.

be justified on an alternative principle, perhaps autonomy or self-determination. In that regard however, it can also be observed that the American (Oregon and Washington) AD model – a model which is overtly associated with the principles of autonomy and self-determination – does not permit euthanasia, only allowing PAS in the case of patients with 6 months or less to live (Figure 9). Indeed, the American AD laws not only simplify the physician's legal obligations regarding the assessment of a patient's suffering – the “6 months or less to live” bright line – but also appear to direct the primary responsibility for the AD act towards the patient.

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

This particular interpretation of the scope of the expression of autonomy in the American AD schemes demonstrates consistency with the particular way in which AD practice has evolved in the United States. As described earlier, the American AD schemes evolved under the influence of legal arguments seeking to extend the legal right to refuse life-saving treatment (even if resulting in the death of the patient) to include an analogous medicalized result for all “dying” patients on a basis ideologically linked to constitutional rights protecting liberty, privacy and/or equality. Indeed it might be said that American AD laws, as developed thus far in Oregon and Washington, emerged out of politico-legal dialogue regarding the *right-to-die qua right to refuse treatment* and as such, might be seen to be a controlled extension of that right-to-die. Given this influence, the appropriateness of citing the cause of death as the underlying terminal disease, as is the case under the 2008 Washington Law and the OHD directive in Oregon, is perhaps more logically consistent than it might at first appear.

The progression of American AD law on this foundation, that is, autonomy interpreted through the ideology of rights to liberty, privacy and/or equality in turn serve to confine AD development to a negative, as opposed to a positive, right. That is, the opportunity to request assisted death viewed as a right to refuse, a right to be free of unwarranted interference or a right to equal treatment for those who are dying does not compel any particular right to assisted death. Such foundations do not oblige a physician to perform AD; participation in AD remains the physician's choice. At best,

it seems that AD advanced on these principles only warrants the provision of immunity to the physicians who voluntarily agree to assist. Thus, we see the result in the 2009 Montana case *Baxter v. Montana* (discussed in more detail in Chapter IV.C.1.ii.) where the Montana District Court's view that a right to die with dignity was established on the basis of rights to human dignity as well as privacy was reversed by the Montana Supreme Court which limited "legal" AD to a less complex statutory defence to homicide.⁶¹⁴

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

With respect to the processes of legal reform, it can be observed that the Netherlands experience was incremental and evolutionary, seeing a particular practice by some physicians being transformed over time into express regulation. The American experience on the other hand involved political lobbying initiatives as well as varied court challenges seeking to connect constitutionally protected rights such as liberty and equality to assisted dying *qua* self-determination. The American AD laws ultimately succeeded however not through nuanced constitutional human rights arguments but through the process of ballot initiative, a rather blunt democratic instrument able to resolve contentious debate by exceptionally narrow margins.

⁶¹⁴ *Baxter v Montana* 2009 MT 449; 354 Mont. 234; 224 P.3d 1211 (SC).

III.C.2. Belgium and Luxembourg

As earlier described, the AD schemes of Belgium and Luxembourg are quite similar to that of the Netherlands. However it also appears that through the process of bringing the respective laws to fruition, both jurisdictions shed the “necessity” underpinning (and so too potentially associated intrinsic policy constraints) in favour of a human-rights approach, with both euthanasia and PAS being justified primarily on the basis of the patient’s free and informed request. From this rights perspective, the physician duty to protect life (as imposed by or in alignment with the right to life) is to be interpreted pursuant to the right to self-determination and reflect the will of the patient (as imposed through the right to privacy) (Figure 6). In other words, the patient’s right to control treatment supersedes the doctor’s obligation to protect life and expands the scope of options available to the patient.

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

The rules of this negotiation require recourse to individual personal convictions and conscience, not only of the patient, but also of the physician as the individual tasked by the state to carry out the practice of AD. Thus what emerges is the regulation of AD based on a construction of autonomy also located within a patient-physician nexus, whereby it is legal for a patient to request AD and legal for a physician to respond to that request in the affirmative or the negative (Figure 6). Furthermore, the patient-physician nexus necessarily imposes a medical dialogue, again positioning suffering as the element common to both parties (Figure 4). The result is the inclusion of unbearable and/or hopeless/constant medical suffering as pre-requisite for AD but understood first and foremost from the patient’s perspective.

It might thus be argued that pursuant to these underpinnings, the Belgium and Luxembourg AD laws envision a more expansive view of autonomy than the Netherlands Law of 2002. This is particularly so given that physician’s role under the Belgium and Luxembourg AD laws is increasingly oriented towards ensuring the voluntariness, capacity and/or competency of the requesting patient. Reflections of this orientation can be seen in the added safeguards imposed on the physician when

the patient is “not expected to die in the near future” under the Belgian Law of 2002 and the provisions related to “dispositions de vie” under the Luxembourg Law of 2009. On the other hand it could also be argued that the net effect of these additional procedural obligations is an increased burden on the patient which in turn serves to create additional barriers to self-determination, an argument similar to that described earlier with respect to the rejection of proposals to impose mandatory counseling under the Oregon AD scheme.

Regardless, the formulation of autonomy as a type of negotiation based on the freedom of choice of the patient and the freedom of conscience of the doctor does not provide a ready basis upon which to expand AD into a positive right, an expansion contemplated by the KNMG, the Dutch Medical Association as discussed earlier.⁶¹⁵

As discussed, unlike the KNMG, the Belgian and Luxembourgish medical associations had little input into the development of AD laws in their respective jurisdictions, taking a position that AD had been imposed upon the medical profession and represented an intrusion into the trust relationship between doctor and patient. Indeed, it was not until the Belgian Law of 2002 was passed when the Belgian Deontological Code was amended to permit physicians to inform the patient of all possible end-of-life options. Furthermore, under the current Luxembourg Code of Medical Ethics, euthanasia is still prohibited.⁶¹⁶ The sense of being imposed upon by the medical professions of Belgium and Luxembourg is not that surprising if one considers the progression of AD laws in terms of shaping rights and corresponding duties. The Dutch approach demonstrates the evolution of professional duty which subsequently articulated the shaping of a “right”, whereas under the Belgium and Luxembourg approaches, the “right” was first identified and then followed by steps to impose a corresponding professional duty consistent with that right.

Thus the Belgium Law of 2002 and the Luxembourg Law of 2009 demonstrate a greater disconnect with the respective medical professional associations than their Dutch counterpart, despite the fact that these laws have been structured almost entirely in the same manner as the Dutch Law of 2002. Accordingly, the appreciation of autonomy under the Belgium and Luxembourg schemes is different than the Dutch construction. On one hand, this construction of autonomy might be seen as less expansive than the Netherlands’ construction in the sense that AD did not have the extensive support from the medical community in these jurisdictions. This in turn

⁶¹⁵ See (n 69) and associated text.

⁶¹⁶ See (n 271) and associated text.

augurs against the further expansion of AD as a medicalized activity from a negative to a positive right as previously discussed.

Paradoxically, the construction of autonomy in Belgium and Luxembourg might be viewed as being *more* expansive than the Netherlands' construction for the very same reason. AD laws were introduced without requiring significant support from the respective medical associations. As described earlier, the idea of the freedom to choose was advanced largely as an appreciation and outgrowth of the right to privacy. As a result, any dilemma involving physician conflict of duty was subordinated to the concept of physician freedom of conscience to facilitate a response to a patient's request for AD. Euthanasia or PAS are both permissible responses, justified not by a conflict of professional duties but rather by the patient's freedom to choose. Furthermore, because the mode of AD also advances directly from the patient's right to choose as opposed to advancing from the physician conflict, the Belgium and Luxembourg AD regimes can be viewed as some form of hybrid of the Netherlands and the American approaches in terms of the construction of autonomy.

To summarize, even though the regulatory frameworks of AD in the Netherlands, Belgium and Luxembourg are almost externally identical, there are subtle differences in the ways in which the principle of autonomy has been translated into the respective laws and in turn, how an AD decision is both justified and directed. Furthermore, while all three (3) jurisdictions experienced legal reform via standard legislative processes, the elements of the underlying legislative discussion were quite distinct with Belgium and Luxembourg advancing AD as a derivative of a human rights perspective from the outset as opposed to derivative of professional medical practice and duty. It thus also becomes apparent that there is an emerging ambiguity as to the precise function of physicians in "qualifying" patients for AD under these latter laws.

III.C.3. Switzerland

Of all the schemes canvassed, the Switzerland AD scheme is the one that has been most consistently advanced as a human-rights issue and on-medicalized concern. The Swiss AD scheme therefore makes more evident, that there is a distinction between regulating the act that brings about death and regulating care of the dying.

Because of the unique formulation of assisted suicide under Article 115 of the Swiss Penal Code, the moral crux of AD in Switzerland is autonomy and self-determination of the individual; the decision for AD belongs to the individual and the assisting individual granted immunity under the law is not required to render any judgment on

the reasons behind that autonomous decision. Critical to this construction is that immunity will only extend to the provision of the means or the information for death; the autonomous individual must carry out the final step that causes death.

Over time however, concerns regarding possible abuses of individuals lacking mental competency, material gain by assistors and pressure from international criticism regarding the provision of AD to non-residents have led to a number of attempts to reign in the Swiss scheme. In particular, the Swiss AD scheme was infused with medicalized contours of suffering despite general reluctance towards AD from factions of the Swiss medical profession and opposition to limiting the scope of AD by certain individuals in right-to-die organizations. Thus while AD is technically legal for any “condition”, whether physical or mental, fatal or non-fatal, AD has been restricted through policies and agreements between right-to-die organizations and the government which, for example: i) prohibit assisted suicide to younger persons who are not experiencing severe physical suffering; and ii) impose the use of specific barbiturates to trigger narcotics regulations which in turn increase physician involvement. Physician guidelines impose further restrictions on physicians specifically, for example, by requiring the existence of a terminal or “fatal” condition, that is, one that will lead to death within a few days or weeks.

Because the Swiss experience with AD is one associated with the narrowing of an expansive scheme as opposed to the expansion of a narrow scheme, the AD conflict in Switzerland has been framed in a number of different ways. For example, the Swiss National Advisory Commission on Biomedical Ethics, the NEK-CNE, described the “twin poles” of the conflict as one between providing care for the person at risk for suicide on the one hand, and respecting the autonomy of that same person on the other. The conflict is thus appreciated at the level of the individual him- or her- self and that particular individual’s interaction with the state and the state’s duty to protect the individual. The NEK-CNE however also described a second clash akin to a practical slippery slope concern, that in the provision of care of the individual desirous of AD, the state must ensure that the freedom of choice of other individuals to not opt for assisted suicide is not restricted or impinged upon (Figure 7). In other words, in permitting AD, the state must not – and must not be seen to – impose AD on those who would not otherwise be inclined to consider AD as an option. Thus while the state perceives an obligation to protect the individual in the sense of ensuring that an individual’s decision is truly autonomous (via physician assessment), AD has been rationalized in Switzerland in such a way as to presuppose assisted suicide as a form of inherent right.

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

When the above perspectives are added to the varied guidelines of the right-to-die organizations as discussed as well as the lessons from the *Haas* case (which expressed the wide margin of appreciation available to states when balancing the right to life with the right to respect for privacy⁶¹⁷), the Swiss perspective describes the scope and function of autonomy in a variety of different ways. Indeed it demonstrates commonalities with the other AD schemes. For example, under the Swiss perspective there is a general acceptance that autonomy and self-determination underpin the practice of AD. There is also a sense that AD might be in contradiction to the aim of medicine but it stands that a patient's wishes must always be taken into account. Thus physician conscience and the assessment of suffering both have roles to play in a negotiation that involves patient autonomy and physician assistance in death. And, similar to the American schemes, while autonomy may support or justify assisted suicide, it does not necessarily justify the practice of euthanasia.

Because the Swiss AD approach is grounded in autonomy ideology and does not extend to the practice of euthanasia, the regulation of AD in Switzerland seems to exhibit the most commonality with the current approach in the states of Oregon and Washington. However, it must also be kept in mind that the American version of autonomy-based AD attaches only to the patient who is dying as opposed to the Swiss version which legally attaches to any competent individual seeking death. Thus the similarity between the two constructions of autonomy appears to end with the identification of the mode of delivery of death and does not include how third party involvement comes to be justified. In the case of the American AD laws, it is the

⁶¹⁷ ECHR Press Release No. 040 (n 434) 2.

dying criteria that justifies third party (the physician) involvement in carrying out the individual's desire for death. In the case of the Swiss AD scheme, it is the individual's desire for death that alone justifies third party involvement who then may go on to assist with impunity if done for unselfish reasons.

III.C.4. SUMMARY OF LIMITS TO ASSISTED DEATH UNDER CURRENT LAWS

Based on the foregoing discussion, it can be observed that depending on how assisted death has been justified, constructed or achieved, a number of different constraints or limits, whether internal or external to the AD law, can be encountered. Without repeating the discussion immediately above, it is helpful to briefly recap three of the more obvious of these constraints.

With respect to internal constraints, the two that stand out in this regard are the necessity defense and the right to self-determination when politically constructed as a logical extension of the "right to die" via a reflection of constitutionally protected rights. As discussed, the necessity underpinning justifies both the practices of euthanasia and PAS. However it also has the practical effect of constraining autonomy expression to the realm of medicine and medical practice, which is significant to restricting requisite suffering to suffering rooted in a medical condition. Assisted death established as a logical extension of the right to die (i.e. withholding or withdrawing life-sustaining treatment) via constitutional protections such as privacy, liberty or equality appears to constrain the conceptual construction of AD to a form of negative right. This in turn points to the additional limits on an autonomy-based assisted death namely that assisted death be limited to cases of terminal illness (patient's who are imminently dying) and limited to PAS only.

In terms of external constraints, it becomes fairly clear that the available avenues for democratic reform are significant to the resolution of contentious matters which might otherwise result in stalemate. The best example here is the availability of ballot initiative in Oregon and Washington, which resulted in the legalization of assisted suicide by margins of 51 to 49 per cent and 58 to 42 per cent respectively.⁶¹⁸ The availability of ballot initiatives to resolve "death with dignity" issues provides an alternative to the development and launching of more nuanced and sophisticated constitutional arguments based on entrenched human rights such as the rights to privacy, liberty, security and equality within the court system.

⁶¹⁸ See (n 472) and (n 582) and associated text.

An appreciation of the limits and constraints is more readily achieved when jurisdictional variations are approached from the perspective of factors that support or challenge a vision of assisted death more expansive than that currently experienced within each of these individual jurisdictions. For example, perspectives or factors that would support a broad construction of assisted death include:

- i. *The nature of conflict aligned with the Belgium or Luxembourg approach:* if the conflict is described as being established on the patient's free and informed request or alternatively, the right to life interpreted from the patient's perspective, the physician necessity underpinning can be avoided. This provides greater opportunity to depart from a medical construction of assisted death and in turn avoid the further requirement that suffering be rooted in a medical condition. Physician involvement might thus be limited to confirming competency and voluntariness but might also be imposed in order to address any complications that arise during an AD procedure.
- ii. *Suffering aligned with the Switzerland approach:* Because Swiss law only prohibits assisted death if done for selfish reasons, Swiss law currently provides the most latitude with respect to the suffering requirement because the nature or presence of suffering does not technically form part of the legal assessment. On the other hand, it must be kept in mind that if prescription medication is required, then limits as to the nature of requisite suffering can be imposed through laws that regulate physician duty with respect to prescribing activities. Additionally, the Swiss law does not permit the practice of euthanasia, thus to incorporate the Swiss perspective on suffering and the practice of euthanasia there needs to exist an analytical decoupling of a right to choose death based on autonomy from the mode of assisted death permissible under the law.
- iii. *Mode of assisted death aligned with the Benelux countries:* The Benelux countries permit both euthanasia and PAS whereas Washington, Oregon and Switzerland only permit PAS. This is significant in terms of an expansive approach to assisted death because, apart from the lack of choice, PAS can be problematic for patients with conditions that cause difficulty with swallowing medication. Because it is only the Netherlands that has demonstrated consistency in terms of how the practices of euthanasia and PAS come to be medically justified (i.e. the necessity defence), it can be observed that some collapse of boundaries between the Benelux regimes has already occurred.

- iv. *Obligation to refer to physician who will participate aligned with the Netherlands:* Notwithstanding that a physician can refuse to participate, the Netherlands has already begun moving to a position whereby physicians are becoming increasingly obligated to refer the requesting patient to another doctor who will participate in AD.

- v. *Characterization of slippery slope in alignment with autonomy:* The construction of the slippery slope argument that permits the broadest approach to assisted death is one that focuses primarily on the free and informed request of the autonomous individual. Pursuant to this logical distinction, the ability to avoid practical slippery slope concerns such as non-voluntary (unable to consent) and involuntary (do not consent) euthanasia appears very straightforward – simply establish safeguards to ensure that the individual is capable, informed and acting voluntarily when expressing the request to die. This construction does not inherently carry with it any implications or limits regarding how assisted death is practiced (euthanasia or PAS) or the nature of requisite suffering.

Similarly, the factors that merit against a broad construction of assisted death are as follows:

- i. *A focus on the inverse relationship between autonomy expression and mode of death:* The Swiss AD model which is held more securely as a rights model and not a medical model does not permit euthanasia. It is the individual who must always take the last step. This perspective is consistent with the philosophical argument that ending an individual's life runs contrary to that individual's expression of autonomy.

- ii. *A focus on the construction of assisted death as a negative human right:* When demand for assisted death is tethered to the rights to privacy, security or liberty it points to the construction of assisted death as a negative human right – the right to be free from interference or the right to choose the timing and manner of one's death. This construction refutes a positive right to assisted death and implies at minimum, limiting the practice to assisted suicide with no extension to euthanasia. The use of an equality argument on the basis of availability of death by withdrawal or withholding of treatment further imports limiting assisted death to situations where the individual has been diagnosed with a terminal illness.

- iii. *A focus on the distinction between regulation of death and the regulation of dying:* Similar to the latter part of point ii. immediately above, arguments constructed on

the basis of medical treatment decisions available to patients who are dying, limits suffering to situations where there is a diagnosis of terminal illness within a medical framework.

- iv. *A focus on the medical basis for assisted death:* As can be observed from the “tired of life” discussion in the Netherlands, the medical framework acts as a mechanism of stabilization to prevent expansion to non-medical situations. On the other hand, it should be recalled that the necessity defence justifying physician involvement in assisted death extends the practice to both euthanasia and PAS.
- v. *A focus on the psycho-social processes leading to desensitization or coercion:* This practical slippery slope argument arguably presents the greater challenge in terms of competently addressing future shifts in the political, economic and psychological conditions that might evolve out of a decision to legalize assisted death. On the other hand, the psycho-social processes argument might be more difficult to advance as it could be simply refuted on the basis that pursuing such a detailed exercise is so overly technical as to make it irrelevant and inadequate for resolving the ethical dilemma at hand.

CHAPTER IV CONSTRUCTION OF ASSISTED DEATH BY THE COURTS

Carve every word, before you let it fall.
Oliver Wendell Holmes Sr.¹

IV.A. INTRODUCTION TO CHAPTER IV

The discussion now turns to the examination of AD as it is being constructed in current debate in the jurisdictions of Montana in the United States, England and Canada. These three jurisdictions have been selected because they have recently or are presently in the process of adjudicating the assisted death controversy before the courts.

Specifically, the state of Montana has been selected because although AD remains a criminal offence, the recent decision *Baxter v. Montana* has recognized patient consent as a physician defence for assistance with suicide distinct from the necessity defence observed in the Dutch experience.² England has been selected because despite having affirmed the illegality of assisted death in the 2002 case of *Pretty*³ (a case which challenged AD prohibitions on the basis of human rights protections), it subsequently developed, following the 2009 *Purdy* case,⁴ prosecutorial guidelines which in addition to providing an alternative mechanism of reform, signal a unique non-physician approach to assisted death. Additionally, despite the *Pretty* and *Purdy* decisions, the High Court of England and Wales has recently set the stage to fully revisit the legalization question in the case of *Nicklinson*⁵ which seeks to advance AD on, among other things, a modified necessity defence.

Canada is included in this discussion because a June 2012 court decision from the province of British Columbia, *Carter*,⁶ has declared the assisted death prohibitions in the Canadian Criminal Code to be unconstitutional despite the Supreme Court of

¹ Oliver Wendell Holmes Sr, *Urania: A Rhymed Lesson* (William D. Ticknor & Co, 1846) 22.

² *Baxter v Montana* 2009 MT 449; 354 Mont. 234; 224 P.3d 1211 (SC) (*Baxter v Montana* SC). Georgia recently struck down its assisted suicide prohibition. This case has not been included in this discussion as the statutory prohibition was struck on the basis that it was unconstitutional under the free speech clauses of federal and state constitutions. The case did not consider other constitutional challenges or the substantive aspects of the prohibition in terms of it being a ban on assisted suicide per se and is therefore not particularly relevant to the discussions herein. See *Final Exit Network, Inc. et al v State of Georgia* (2012) S11A1960.

³ *Case of Pretty v the United Kingdom* App no 2346/02 (ECHR, 2002) (*Pretty*).

⁴ *R (on the application of Purdy) v Director of Public Prosecutions* [2009] UKHL 45 (*Purdy*).

⁵ *Nicklinson v Ministry of Justice & Ors* [2012] EWHC 304 (QB) (*Nicklinson Motion*). See addendum for update on the *Nicklinson* case.

⁶ *Carter v Canada (Attorney General)* 2012 BCSC 886 (*Carter*); Amended Notice of Civil Claim, *Lee Carter, Hollis Johnson, Dr. William Shoichet, the British Columbia Civil Liberties Association and Gloria Taylor v AG Canada and AG British Columbia* (No. S112688 Vancouver Registry) para 10 <<http://bccla.org/wp-content/uploads/2011/10/20110812-BCCLA-Legal-Case-Amendment-to-Carter-et-al..pdf>> accessed 31 May 2012 (*Carter Amended Notice of Civil Claim*).

Canada having previously rejected an almost identical constitutional challenge in the 1993 *Rodriguez* case.⁷ The *Carter* declaration of constitutional invalidity has been suspended for one year in order to provide Canadian Parliament with time to decide whether or how to respond.⁸

The aim of this chapter is to assess the AD debate in these “second generation” jurisdictions against the construction of AD schemes in “first generation” jurisdictions (where AD has been legalized by statute) in order to identify: alignment or non-alignment with the AD models in the first generation jurisdictions; whether similar or different AD models are emerging from the court; distinctions in the construction of autonomy and the limits that might arise thereto; any signs or pathways that indicate possible collapse or convergence towards one homogenous model of AD; and the extent to which potential collapse or convergence is connected with the principle of autonomy – the principle at front and centre of the current assisted death debate.

As described in the Introduction, before turning to specifically to consider the case law developments in the jurisdictions of Montana, England and Canada, this Chapter begins with an overview of the persistent legislative trend to prohibit or maintain AD prohibitions in the “western democracies” of the United States,⁹ the United Kingdom as well as Australia. As will be described in Chapter IV.C, legislative trends from these jurisdictions have been used by earlier courts contemplating AD reform as evidence relevant to the judicial task of striking a balance between individual and state interests and demonstrate that maintaining a prohibition on assisted death is a justified and appropriate outcome. Conversely, recent courts have used the evidence of the legislative reluctance in Western democracies to reform assisted death law in order to establish the legitimacy of judicial entry into the resolution of this critical social policy dispute. Given the relevance to judicial decision-making in this area, and given that courts have utilized and applied the evidence of the consistent overall legislative trend against assisted death evidence in different ways, a brief summary of these trends¹⁰ is provided prior to turning to the case law.

⁷ *Rodriguez v British Columbia (Attorney General)* [1993] 3 SCR 519 (*Rodriguez*).

⁸ *Carter* (n 6) para 1411.

⁹ With respect to the United States in particular, it might be useful to note that over the years, several bills in favour of the legalization of assisted death have been introduced into numerous state legislatures but have failed without significant debate. For this reason, details of these states are not included in the overall discussion. For comprehensive list of bills introduced into State legislatures see Appendix, Chart 2, ‘Rejections of Proposals to Legalize Assisted Suicide in the United States: 1991-2012’ adapted from Mary J Shariff, ‘Expert Report of Mary J. Shariff in Connection with *Carter et al. v. Attorney General of Canada (Assisted Suicide Litigation)*’ (September 2011) Exhibit G (Chart 2).

¹⁰ Chapter IV.B has been adapted from Mary J Shariff, ‘Expert Report of Mary J. Shariff in Connection with *Carter et al. v. Attorney General of Canada (Assisted Suicide Litigation)*’ (September 2011).

IV.B. LEGISLATIVE TRENDS REGARDING ASSISTED DEATH IN NON-PERMISSIVE JURISDICTIONS

Throughout the common law world, the prohibition of assisted suicide is widespread.¹¹ The overwhelming majority of countries, states, provinces, territories in Europe, North America and Australia have not legalized the practices of euthanasia or assisted suicide.

IV.B.1. The United States

i. Overview

The practice of PAS is illegal in the majority of states in the United States by either statute or common law. At the time of writing, 38 out of the 50 states currently have statutes that prohibit physician-assisted suicide.¹² The practice of euthanasia continues to be illegal in every state and is classified as murder/homicide.¹³ To date, no court of final jurisdiction in the United States has recognized a right to physician-assisted suicide or euthanasia under federal or state constitutional protections.¹⁴

Thus far, Washington and Oregon are the only states in the United States that have passed statutes legalizing PAS by ballot initiative in 1994 and 2008 respectively as discussed in Chapter III. Montana has not legalized assisted suicide. However in the recent case *Baxter v. Montana*, the Montana Supreme Court has recognized that the consent of a terminally ill patient to physician aid in dying can constitute a statutory defense to a charge of homicide against a physician.¹⁵ *Baxter v. Montana* is discussed in more detail in Chapter IV.C.1.ii. below

ii. Legalization Initiatives

From 1991 to the present, no less than 25 state legislatures considered proposals to legalize physician-assisted suicide but none of these proposals were adopted.¹⁶ After

¹¹ *Carter* (n 6) para 361.

¹² See Appendix, Chart 1, “Statutory Prohibitions on Assisted Suicide in the United States” adapted from Mary J Shariff, ‘Expert Report of Mary J. Shariff in Connection with *Carter et al. v. Attorney General of Canada (Assisted Suicide Litigation)*’ (September 2011) Exhibit F (Chart 1).

¹³ Canada, Special Senate Committee on Euthanasia and Assisted Suicide, “Assisted Suicide and Euthanasia in Foreign Jurisdictions” in *Of Life and Death: Report of the Special Senate Committee on Euthanasia and Assisted Suicide* (A-149-A-173, 1995) <<http://www.parl.gc.ca/Content/SEN/Committee/351/euth/rep/lad-tc-e.htm>> accessed 31 May 2012 (1995 Canadian Senate Report).

¹⁴ See discussion with respect to Oregon and Washington respectively in Chapter III.B.5 and Chapter III.B.6 above and Montana Chapter IV.C.1 below.

¹⁵ *Baxter v Montana* SC (n 2).

¹⁶ See Chart 2 (n 9).

Washington legalized PAS in 2008, 17 similar bills were introduced into 10 state legislatures.¹⁷ None of these were successful.¹⁸

PAS and/or euthanasia ballot initiatives taken in the states of California, Michigan and Maine in the years 1992, 1998 and 2000 respectively were also all unsuccessful.¹⁹ As mentioned in Chapter III, a proposed ballot initiative, *Mass. Petition 11-12: An Initiative Petition to establish An Act Relative to Death with Dignity*, was filed with the Massachusetts Office of the Attorney General on August 2, 2011.²⁰ The proposed legislation follows the same general pattern as the Oregon and Washington PAS statutes. The petition has received the requisite number of signatures and a vote is anticipated for November 2012. Bills very similar to the provisions in the ballot initiative were previously introduced into the Massachusetts legislature in 2009 and 2011 but again were unsuccessful.²¹

At present, in addition to the ballot initiative in Massachusetts, there are two PAS bills pending in the states of Hawaii and Pennsylvania.²²

iii. Initiatives to Prohibit or Strengthen Prohibitions already in place

After Oregon legalized PAS in 1994, a number of states enacted statutes prohibiting PAS or took other action to reaffirm or strengthen their laws or policies prohibiting PAS. These states include: Rhode Island (1996), enacted law to prohibit assisted suicide; Michigan (1998), enacted law to prohibit assisted suicide; Ohio (2003), legislated that assisting suicide is against public policy of Ohio; Idaho (2011), enacted law to prohibit assisted suicide; and Connecticut (2011), proposed Bill No. 356 to impose mandatory minimum imprisonment term of 2 years for assisting suicide the

¹⁷ Specifically, Arizona, Connecticut, Hawaii, Massachusetts, Montana, New Hampshire, New Mexico, Pennsylvania, Vermont. See Chart 2 *ibid*.

¹⁸ See Chart 2 *ibid*.

¹⁹ *ibid*.

²⁰ Massachusetts Petition 11-12: An Initiative Petition to establish An Act Relative to Death with Dignity (2 August 2011).

²¹ House Bill 2233, An Act Relative to Death With Dignity; House Bill 1468, An Act Relative to Death With Dignity.

²² Hawaii: Proposed companion bills, House Bill 1383, A Bill for an Act Relating to Death with Dignity and House Bill 1165, A Bill for an Act Relating to Compassion in Passing. Bills are currently before Committee; Pennsylvania: Proposed bill, Senate Bill 431, An Act amending Title 20 (Decedents, Estates and Fiduciaries) of the Pennsylvania Consolidated Statutes; Vermont: Proposed Bill H 274, S103: An Act Relating to Patient Choice and Control at End of Life; See Appendix, Chart 3, "Pending Legislation and Ballot Initiatives on Assisted Suicide in the United States" adapted from Mary J Shariff, 'Expert Report of Mary J. Shariff in Connection with Carter et al. v. Attorney General of Canada (Assisted Suicide Litigation)' (September 2011) Exhibit G (Chart 3).

status of which is pending; and Georgia (2012) enacted a law to prohibit assisted suicide.²³

IV.B.2. The United Kingdom

i. England and Wales

Euthanasia and PAS are illegal in England and Wales. Euthanasia constitutes the crime of murder under the common law of England,²⁴ while the offence of assisting or encouraging a suicide is made illegal pursuant to Section 2(1) of the *Suicide Act 1961*,²⁵ as amended by the *Coroners and Justice Act 2009*,²⁶ which makes encouraging or assisting a suicide a crime punishable by up to 14 years imprisonment.²⁷

Committing or attempting suicide itself is not illegal under the *Suicide Act 1961* and, for competent individuals with a terminal illness, the right to refuse life-prolonging treatment (including nourishment and hydration) is established in law and is not considered assisted death.²⁸

The 2002 case of *Pretty*²⁹ established among other things, that “no right to die, whether at the hands of a third person or with the assistance of a public authority” can be derived from Article 2 (*the right to life*) of the European Convention for the Protection of Human Rights and Fundamental Freedoms (the European Convention).³⁰

²³ See Chart 2 (n 9) and Chart 3 *ibid*.

²⁴ See *R v Cox* (1992) 12 BMLR 38; *R v Brown* [1994] 1 AC 212; But see *R v Moor* (1999) Crim LR 568.

²⁵ An Act to amend the law of England and Wales relating to suicide, and for purposes connected therewith, Suicide Act 1961, 9 and 10 Eliz.2, chapter 60 (Suicide Act 1961).

²⁶ An Act to amend the law relating to coroners, to investigation of deaths and to certification and registration of deaths; to amend the criminal law; to make provision about criminal justice and about dealing with offenders; to make provision about the Commissioner for Victims and Witnesses; to make provision relating to the security of court and other buildings; to make provision about legal aid and about payments for legal services provided in connection with employment matters; to make provision for payments to be made by offenders in respect of benefits derived from the exploitation of material pertaining to offences; to amend the Data Protection Act 1998; and for connected purposes, 2009, Chapter 25, Section 59 (Coroners and Justice Act 2009).

²⁷ Suicide Act 1961 (n 25) s 2(1).

²⁸ *Re T (Adult: Refusal of Treatment)* [1993] Fam 95; *Law Hospital NHS Trust v Lord Advocate* 1996 SC 301; See also discussion in Attorney General, *Assisted Dying for the Terminally Ill Bill* (Memorandum, 2005) <<http://www.publications.parliament.uk/pa/ld200405/ldselect/ldasdy/86/5012004.htm>> accessed 31 May 2012; See also discussion in Select Committee on the Assisted Dying for the Terminally Ill Bill [HL], *Volume I: Report* (The Stationary Office, 2005) paras 48-62 (Assisted Dying for the Terminally Ill Bill [HL] 2005 Report). For best interest test in case of non-competent patients see *Airedale NHS Trust v Bland* [1993] AC 789, 2 WLR 316, 866.

²⁹ *Pretty* (n 3).

³⁰ Convention for the Protection of Human Rights and Fundamental Freedoms as amended by Protocols No. 11 and No. 14 Rome, 4.XI.1950 (European Convention).

The case also describes how Article 8(2)³¹ of the European Convention can justify interference with the right to respect for private and family life conferred under Article 8(2) in order to protect the rights of others in a democratic society.

Following *Pretty*, private member bills to enable PAS and euthanasia for terminal illness were introduced into the House of Lords in 2003³² and 2004³³ but did not proceed past second reading.³⁴ In November 2005, a bill seeking to enable only PAS for the terminally ill³⁵ was introduced but was defeated on Second Reading on 12 May 2006, by 142 votes to 100.³⁶

Following the 2009 *Purdy* case, which challenged the lack of clarity in the prosecution policies regarding assisted suicide, the Director of Public Prosecutions for The Crown Prosecution Service (the “DPP”) released its *Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide* (the “DPP Policy”).³⁷ The DPP policy identifies the criteria that the DPP will take into account when determining whether it is in the public interest to proceed with the prosecution of an alleged assisted suicide. Different from the assisted death laws from other jurisdictions as discussed in Chapter III above, the DPP Policy discourages medical involvement in assisted death.

In January 2012, the House of Commons considered but rejected a motion to put the DPP Policy on statutory footing. However, a new challenge brought by the 2012

³¹ibid art 8(2): “There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.”

³² HL Bill 37, The Patient (Assisted Dying) Bill [HL] (2003) 53/2 <<http://www.publications.parliament.uk/pa/ld200203/ldbills/037/2003037.pdf>> accessed 31 May 2012 (HL Bill 37).

³³ HL Bill 17, Assisted Dying for the Terminally Ill Bill (2004) 53/3 <<http://www.publications.parliament.uk/pa/ld200304/ldbills/017/2004017.pdf>> accessed 31 May 2012 (HL Bill 17).

³⁴ Hansard HL Deb 6 June 2003, vol 648, cols 1585-1690; Select Committee on the Assisted Dying for the Terminally Ill Bill [HL] Volume I: Report (London: The Stationary Office, 2005).

³⁵ HL Bill 36, Assisted Dying for the Terminally Ill Bill (2005) 54/1 <<http://www.publications.parliament.uk/pa/ld200506/ldbills/036/06036.i.html>> accessed 31 May 2012 (HL Bill 36).

³⁶ House of Lords, *House of Lords Annual Report 2006/07* (HL Paper 162, 2007) 1 <<http://www.publications.parliament.uk/pa/ld200607/ldbrief/162/162.pdf>> accessed 31 May 2012.

³⁷ Director of Public Prosecution, *Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide* (February 2010) <http://www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.html> accessed 31 May 2012 (DPP Policy). The DPP Policy was released in 2010 following the 2009 release and public-wide consultation of an interim policy which included the participation of over 4,800 individuals and organizations. The Crown Prosecution Service, *Public Consultation Exercise on the Interim Policy for Prosecutors in respect of Cases of Assisted Suicide Summary of Responses* (February 2010) <http://www.cps.gov.uk/consultations/as_responses.pdf> accessed 31 May 2012.

Nicklinson case is set to raise the issue of physician assisted death once again before the English courts. *Purdy, Pretty*, the DPP Policy and *Nicklinson* are discussed more fully in Chapter IV.C.2.ii. below.

ii. Northern Ireland

In Northern Ireland, committing or attempting to commit suicide ceased to be a crime by virtue of the *Criminal Justice Act (Northern Ireland), 1966* (the “*Criminal Justice Act*”).³⁸ However, euthanasia and PAS remain illegal.

Euthanasia is considered murder or manslaughter, while assisted suicide is captured under the offence of “criminal liability for complicity in another’s suicide” under Section 13 of the *Criminal Justice Act* and carrying with it a maximum penalty of 14 years imprisonment.³⁹ Under Section 13 the consent of the Director for Public Prosecutions for Northern Ireland is required before an individual may be prosecuted.

Following the *Purdy* case, the issuance of interim guidelines and extensive public consultation, the Public Prosecution Service (PPS) for Northern Ireland published its final *Policy on Prosecuting the Offence of Assisted Suicide*⁴⁰ identifying the criteria that the PPS will take into account when determining whether it is in the public interest to proceed with the prosecution of an alleged assisted suicide. The policy is virtually identical to the DPP Policy for England and Wales, the latter of which is discussed further in Chapter IV.C.2.ii. below.

The PPS Policy applies to alleged acts of encouraging or assisting suicide committed in Northern Ireland, but the suicide may take place in any jurisdiction, including Northern Ireland.⁴¹

iii. Scotland

In Scotland, while suicide or attempting suicide is not punishable under the law, both euthanasia and assisted suicide are potential criminal activity pursuant to the offence of homicide. Murder requires intent, but if provocation or diminished responsibility applies, the crime of murder can be reduced to culpable homicide. Once this is determined, the prosecutor can take into consideration the public interest test, whereby

³⁸ *Criminal Justice Act* (Northern Ireland) 1966, c20, s 12.

³⁹ *ibid* s 13.

⁴⁰ Public Prosecution Service for Northern Ireland, *Policy on Prosecuting the Offence of Assisted Suicide*, (February 2010).

⁴¹ *ibid* para 1.8.

the prosecutor will look at the nature and gravity of the crime. The more serious the crime, the more likely it is that public interest will require a prosecution.⁴²

Acts connected with assisted dying may also be relevant to other offences under common law or statute including the common law offences of assault, reckless endangerment and breach of the peace, as well as possible offences under the *Misuse of Drugs Act 1971* (c.38).⁴³

With respect to assisted suicide and criminal liability, under Scots law, consent of the victim does not provide a defence. Similarly, other factors considered irrelevant to the charge include the state of the victim's health, voluntary ingestion of the drug and motive of the assistor.⁴⁴

In 2010, Scotland considered a bill that sought to decriminalize both euthanasia and PAS – SP Bill 38, *The End of Life Assistance (Scotland) Bill* (“SP Bill 38”).⁴⁵ The purpose of SP Bill 38 was “to enable persons whose lives have become intolerable and who meet certain conditions to “legally access assistance” to end their lives.”⁴⁶ SP Bill 38 fell after the first stage debate in December 2010. The majority on the committee established to consider and report on the bill was not persuaded to decriminalize the law of homicide as it applied to assisted suicide and euthanasia and did not recommend the general principles of the bill to the Scottish Parliament.⁴⁷

Submissions to the Committee's call for evidence in May 2010, showed that overall, 521 (86.89%) of respondents were opposed to the bill, 39 (6.49%) were supportive of the bill or the principles behind the bill and 41 (6.82%) had no position on the bill. Respondents included submissions from private individuals, medical professionals which comprised of doctors and doctors in training, voluntary organizations, academic, and humanist organizations.⁴⁸

⁴² End of Life Assistance (Scotland) Bill Committee, *End of Life Assistance (Scotland) Bill Committee Report* (SP Paper 523, ELA/S3/10/R1, 2010) vol 1, paras 12-25 (Scotland Committee 2010 Report). See also discussion in Scottish Parliament Information Centre, *End of Life Assistance (Scotland) Bill* (Briefing, 2 September 2010) 8 (SPICe Briefing 2010).

⁴³ SPICe Briefing 2010 *ibid* 8, 10-1.

⁴⁴ Scotland Committee 2010 Report (n 42) vol 1, paras 15-7.

⁴⁵ SP Bill 38, An Act of the Scottish Parliament to permit assistance to be given to persons who wish their lives to be ended; and for connected purposes (as introduced) (SP Bill 38).

⁴⁶ Scotland Committee 2010 Report (n 42) vol 1, para 3; SP Bill 38 *ibid* preamble.

⁴⁷ For edited transcript of the Parliamentary debate see Scottish Parliament, *Official Report* (Col 31001, 1 December 2010) (Scottish Parliament, Official Report).

⁴⁸ SPICe Briefing, 2010 (n 42) 5, 57.

On 1 December 2010 after a debate which tracked overall concerns raised in Committee report, the majority of the Scottish Parliament voted against SP Bill 38, 85-16 with 2 abstentions.⁴⁹ The Committee was disbanded on December 2, 2010.

On 23 January 2012, MP Margo MacDonald lodged with the Scottish Parliament, a draft proposal as part of the first stage in the process of introducing a new member's bill. Eligibility criteria under the draft proposal are similar to SP Bill 38, however the 2012 proposal is limited to PAS.⁵⁰ Consultations on the draft proposal closed 30 April 2012. As of the time of writing, no bill based on the draft proposal has been introduced into Scottish Parliament.⁵¹

IV.B.3. Australia

Euthanasia and PAS are currently illegal in all Australian jurisdictions either pursuant to the common law or statutory codification depending on the state/territory.⁵²

The withdrawing or withholding of life-sustaining treatment by a mentally competent adult in Australia however is legally permitted pursuant to Australian common law and in some cases, by statute pertaining to advance directives, again dependent on the state/territory.⁵³

Many bills have been introduced at the state and territory level but have failed. The vast majority of the initiatives aimed at the legalization of assisted death in Australia have included both euthanasia and PAS for individuals suffering from terminal illnesses.

⁴⁹ Scottish Parliament, Official Report (n 47).

⁵⁰ Margo MacDonald MSP, 'A proposal for a Bill to enable a competent adult with a terminal illness or condition to request assistance to end their own life, and to decriminalize certain actions taken by others to provide such assistance' (2012) <http://www.scottish.parliament.uk/S4_MembersBills/Final_version_as_lodged.pdf> accessed 31 May 2012.

⁵¹ Scottish Parliament, 'Proposed Assisted Suicide Scotland Bill' (Parliamentary Business) <<http://www.scottish.parliament.uk/parliamentarybusiness/Bills/46127.aspx>> accessed 31 May 2012.

⁵² A victim's consent can be immaterial to criminal responsibility: Western Australian Criminal Code s 261; Queensland Criminal Code s 284; Tasmanian Criminal Code s 53(a).; In other jurisdictions consent may reduce culpability reducing murder to manslaughter or to aiding or inciting suicide: See Crimes Act 1958 (Vic) s 6B(1); Criminal Law Consolidation Act 1935 (SA) s 13A(2); New South Wales Crimes Act 1900 (NSW) s 31B(1); For assisting or encouraging suicide, see for example, Crimes Act 1900 (NSW) s 31C(1) and (2); Crimes Act 1958 (Vic) s 6B(2); Criminal Law Consolidation Act 1935 (SA) s 13A(5); Western Australian Criminal Code s 288; Queensland Criminal Code s 311; Tasmanian Criminal Code s 163; Northern Territory Criminal Code s 168; Crimes Act 1900 (ACT) s 17(1) and (2).

⁵³ See discussion in Parliament of Australia, *Euthanasia Laws Bill 1996*, (Bills Digest No 45, 1996-1997) 3,8-9, <<http://www.aph.gov.au/library/pubs/bd/1996-97/97bd045.htm>> accessed 31 May 2012.

Of the bills introduced at the state and territory level, one successfully passed in the Northern Territories, *The Rights of the Terminally Ill Bill 1995 (RTI Act, 1995)*.⁵⁴ The *RTI Act, 1995* was however later made inoperative in 1997 with the passage of the Commonwealth *Euthanasia Laws Act, 1997* (Cth). During the time that the *RTI Act, 1995* was in force, four (4) patients allegedly died pursuant to the act.⁵⁵ The *RTI Act, 1995* is described in more detail below.

i. The Northern Territory, Australian Capital Territory and Norfolk Island

Under the former *RTI Act, 1995*, terminal illness was defined as “an illness which, in reasonable medical judgment will, in the normal course, without the application of extraordinary measures or of treatment unacceptable to the patient, result in the death of the patient.”⁵⁶ Safeguards under the *RTI Act, 1995* included: the patient be 18 years old; capacity and voluntariness; confirmation by a second practitioner of diagnosis, prognosis, lack of depression; no palliative care options reasonably available that would alleviate suffering to an acceptable level; waiting periods; a right to rescind request; record keeping; and so forth.⁵⁷

When passed, the *RTI Act, 1995* was described as causing, “a furore nationally and internationally, with both extensive criticism and extensive support from politicians, health care professionals, religious groups, 'pro-life' and 'pro-choice' pressure groups, academics, the media and members of the general public.”⁵⁸

As mentioned, the *RTI Act, 1995* was made inoperative by the *Euthanasia Laws Act, 1997* (Cth), introduced and passed by a conscience vote by both Houses of the Commonwealth Parliament in December 1996, and March 1997 respectively.⁵⁹

In addition to impacting the Northern Territory, the *Euthanasia Laws Act, 1997* prohibits the respective legislative assemblies of the Australian Capital Territory

⁵⁴ Rights of the Terminally Ill Bill 1995 (Northern Territory) <<http://www.nt.gov.au/lant/parliamentary-business/committees/rotti/serial67.pdf>> accessed 31 May 2012.

⁵⁵ Parliament of Australia, *Restoring Territory Rights (Voluntary Euthanasia Legislation) Bill 2010* (Bills Digest No 36, 10 November 2010) 3 (2010 Australia Bills Digest No 36).

⁵⁶ *ibid* s 3, definition of “terminal illness”.

⁵⁷ *ibid* parts 2 and 3.

⁵⁸ Parliament of Australia, *Euthanasia - The Australian Law in an International Context* (Research Paper 4, 1996-07, 1996) 2.

⁵⁹ The vote to carry the bill was 88-35 in the House of Representatives and 38-33 in the Senate; The validity of *RTI Act, 1995* had been previously but unsuccessfully challenged. See for example, the case *Wake and Gondorra v The Northern Territory of Australia*, No.112 of 1996 (24 July 1996).

(ACT) and Norfolk Island from making laws in relation to euthanasia or assisted suicide.⁶⁰

ii. South Australia

While the upper and lower houses of South Australia legislature have considered numerous bills aimed at the legalization of euthanasia and PAS, none have been successful to date. There are currently three bills pending before the legislature.

Numerous bills for euthanasia/PAS were introduced into the South Australian Parliament during the years, 1995,⁶¹ 1996⁶², 2001,⁶³ 2002,⁶⁴ 2006,⁶⁵ 2008⁶⁶, 2010.⁶⁷ All either failed or lapsed, the majority without significant debate.

The most recent bill, Bill No. 11, *The Voluntary Euthanasia Bill*, was introduced on 1 March 2012 into the House of Assembly.⁶⁸ The bill was defeated at second reading on 14 June 2012.⁶⁹ Bill No. 11 set out a procedure for “voluntary euthanasia” for adults in a terminal phase of a terminal illness (the phase of the illness likely to result in death when there is no real prospect of recovery or remission of symptoms on either a permanent or temporary basis)⁷⁰ subject to appropriate safeguards. Bill No. 11 was

⁶⁰ The Commonwealth Parliament is permitted to override territorial legislation pursuant to Section 122 of the Commonwealth Constitution which grants plenary powers in respect of the Territories. Parliament of Australia, *Bills Digest 45, 1996-1997* (Bills Digest 45, 1997) 6-7. In addition to Section 122, there is also judicial authority for the view that in the case of conflict between the Commonwealth and a Territory Law, the Commonwealth will prevail. *Attorney-General (Northern Territory) v Hand* (1989) 90 ALR 59.

⁶¹ Voluntary Euthanasia Bill 1995 presented to House of Assembly by J. Quirke. Rejected without debate.

⁶² Voluntary Euthanasia Bill 1996 presented by A. Levy to Legislative Council was referred to Select Committee in July 1997 after second reading. The bill lapsed due to election, then referred to Social Development Committee for inquiry on 25 March 1998 but was not reintroduced.

⁶³ A Dying in Dignity Bill 2001 was presented to both the Legislative Council and the House of Assembly. was voted into committee but later defeated.

⁶⁴ The Dying in Dignity Bill 2002 presented in the Legislative Council went to committee but was later defeated. The Dying in Dignity Bill 2003 presented to the House of Assembly was withdrawn in 2005 due to a pending election.

⁶⁵ The Voluntary Euthanasia Bill 2006 was presented by Hon Bob Such again in 2007 after parliament prorogued and presented for a third time in 2008, as Voluntary Euthanasia Bill 2008 after Parliament prorogued for a second time in 2008.

⁶⁶ In addition to the Voluntary Euthanasia Bill 2008, a second bill Consent to Medical Treatment and Palliative Care (Voluntary Euthanasia) Amendment Bill 2008 was presented into the Legislative Council. Both bills were carried into 2009. The Voluntary Euthanasia Bill 2008 lapsed and the Consent to Medical Treatment and Palliative Care (Voluntary Euthanasia) Amendment Bill 2008 failed in December 2009 in an 11-9 vote.

⁶⁷ The Medical Treatment and Palliative Care (Voluntary Euthanasia) Amendment Bill, 2010; The Voluntary Euthanasia Bill 2010.

⁶⁸ Bill No 11, The Voluntary Euthanasia Bill 2012 (Bill No 11).

⁶⁹ House of Assembly Deb 14 June 2012, No 27, para 7 <<http://www.parliament.sa.gov.au/HouseofAssembly/BusinessoftheAssembly/RecordsandPapers/VotesandProceedings/Votes%20and%20Proceedings/27%20Thursday%2014%20June%2012.pdf>> accessed 31 July 2012.

⁷⁰ Bill No 11 (n 68) s 4.

preceded by a similar bill which was introduced in June 2010, *The Voluntary Euthanasia Bill 2010*.⁷¹

On 10 March 2011, Bill No. 88, the *Criminal Law Consolidation (Medical Defences – End of Life Arrangements) Amendment* was introduced into the House of Assembly (“Bill No. 88”).⁷² Bill No. 88 sets out amendments to the *Criminal Law Consolidation Act 1935*, to create a number of physician defences for euthanasia and PAS. The defence requires the person assisted to be an adult of sound mind suffering from a medical condition that has irreversibly impaired the person's quality of life so that life had become intolerable to that person.⁷³

The approach taken by Bill No. 88 is very different to the approaches taken towards the legalization of euthanasia and PAS in all previous bills introduced into the South Australia legislature. The bill passed second reading and was still in committee as of fall 2011.⁷⁴ No further action has been taken.

iii. New South Wales

Unsuccessful bills for euthanasia/PAS were introduced in the New South Wales legislature in the years 2001,⁷⁵ 2003,⁷⁶ and 2010.⁷⁷

Most recently, *the Rights of the Terminally Ill Bill, 2011* was introduced in Legislative Council in August 2011. The current status of this bill was unavailable at the time of writing.

iv. Tasmania

There are currently no euthanasia/PAS bills before the Parliament of Tasmania at the time of writing although the introduction of a bill is anticipated for 2012.

The most recent bill to be defeated was the *Dying with Dignity Bill 2009*⁷⁸ which was introduced in the Lower House of the Tasmanian parliament. Similar to most of the Australian bills, the bill would have permitted both euthanasia and PAS for persons suffering from a terminal illness (one that in the normal course would result in death)

⁷¹ Bill No 23, *The Voluntary Euthanasia Bill 2010*.

⁷² Bill No 88, *Criminal Law Consolidation (Medical Defences—End of Life Arrangements) Amendment Bill 2011* (Bill No 88, 2011).

⁷³ *ibid* part 2.

⁷⁴ House of Assembly 20 October 2011, No 73.

⁷⁵ *Rights of the Terminally Ill Bill 2001*, introduced by I. Cohen.

⁷⁶ *Rights of the Terminally Ill Bill 2003* introduced by I. Cohen, withdrawn.

⁷⁷ *Rights of the Terminally Ill Bill 2010*, introduced by C. Faerhmann, lapsed and reintroduced. Lapsed.

⁷⁸ Bill No. 37, *Dying with Dignity Bill 2009*, introduced by McKim.

and, is experiencing pain, suffering and/or distress to an extent unacceptable to the sufferer.⁷⁹

v. Victoria

The most recent attempt to legalize euthanasia and PAS in Victoria was the *Medical Treatment (Physician Assisted Dying) Bill 2008*⁸⁰ which was defeated at second reading on 10 September 2008.⁸¹

The Medical Treatment (Physician Assisted Dying) Bill 2008 would have permitted an expanded form of PAS (information, prescribing, provision or provision of assistance to ingest a drug) but not euthanasia (assistance by injection through a needle), to mentally competent individuals who are suffering intolerably with a terminal (death is foreseeable) or advanced incurable illness.⁸²

vi. Western Australia

Six (6) bills aimed at the legalization of euthanasia and/or PAS were introduced into the Parliament of Western Australia during the years 1997⁸³, 1998,⁸⁴ 2000,⁸⁵ 2002,⁸⁶ 2003⁸⁷ and 2010⁸⁸ but none were successful.

vii. Queensland

At the time of writing, no euthanasia or PAS bill has been tabled in the Queensland Parliament. Queensland is the only jurisdiction in Australia to never have considered euthanasia or PAS legislation.⁸⁹

⁷⁹ *ibid* Sections 3 and 5.

⁸⁰ *Medical Treatment (Physician Assisted Dying) Bill 2008 (561PM12B.I-26/5/2008) (Victoria Bill 2008)*.

⁸¹ *Parliament of Victoria, Medical Treatment (Physician Assisted Dying) Bill 2008 (Current Issues Brief No 2, 2008)*.

⁸² *Victoria Bill 2008 (n 80) paras 1 and 3*.

⁸³ *Bill No 87, The Voluntary Euthanasia Bill 1997* introduced by N. Kelly, went to second reading but no further action was taken.

⁸⁴ *Bill No 8, The Voluntary Euthanasia Bill 1998* introduced by N. Kelly, went to second reading but no further action was taken.

⁸⁵ *Bill No 121, The Voluntary Euthanasia Bill 2000 and Bill No 2, The Voluntary Euthanasia Bill 2000, Bill No 2*, both introduced by N. Kelly, went to second reading but no further action was taken.

⁸⁶ *Bill No 149, The Voluntary Euthanasia Bill 2002* introduced by R.H. Chapple went to second reading but no further action was taken; *Voluntary Euthanasia Trial (Referendum) Bill 2002* (to hold a referendum to determine with people of NSW would approve in principle, an 18 month supervised trial of euthanasia) notice of motion.

⁸⁷ *Voluntary Euthanasia Trial (Referendum) Bill 2003*, negatived on division at second reading.

⁸⁸ *Bill No 149, The Voluntary Euthanasia Bill 2010* introduced by R.H. Chapple did not go to second reading.

⁸⁹ *2010 Australia Bills Digest No 36 (n 55) 9*.

IV.B.4. Summary

While the overall objective of Chapter IV is to examine AD as it is being constructed in current debate in the jurisdictions of Montana in the United States, England and Canada, it is important to consider this snapshot of the overall legislative reluctance to reform assisted death prohibitions. Based on the foregoing review it can be summarized that there is a consistent and persistent legislative trend to maintain AD prohibitions in the “western democracies” of the United States, the United Kingdom as well as Australia. However, as will be seen in the section that follows, while earlier courts have applied evidence of this legislative trend to justify the yielding of individual rights to broader state interests, current court behaviour, particularly in England and Canada, points to a shift in the significance and interpretation of this evidence – one that views such trends as the justification for judicial entry into assisted death reform.

IV.C. REFORM OF ASSISTED DEATH PROHIBITION BY THE COURTS

IV.C.1. Montana

At present Montana has not legalized assisted suicide. Rather, the Montana court has recognized that the consent of a terminally ill patient can constitute a statutory defence to a charge of homicide against an aiding physician.

i. Legislative Prohibition

Aiding or Soliciting Suicide is an offence under Section 45-5-105 of Montana Criminal Code and punishable by imprisonment up to 10 years, a fine up to \$50,000 or both. This Section only applies when suicide has not occurred.⁹⁰ According to the Commission Comment to Section 45-5-105 (Aiding or Soliciting Suicide), if the conduct of the offender made him the agent of death, the offense will be criminal homicide, *notwithstanding the consent or solicitations of the victim*.⁹¹ Therefore if death occurs pursuant to PAS, the relevant offence will be homicide.

⁹⁰Title 45, Criminal Code of Montana, Section 45-5-105 (1) A person who purposely aids or solicits another to commit suicide, but such suicide does not occur, commits the offense of aiding or soliciting suicide. (2) A person convicted of the offense of aiding or soliciting a suicide shall be imprisoned in the state prison for any term not to exceed 10 years or be fined an amount not to exceed \$50,000, or both (Montana Criminal Code).

⁹¹ Montana Criminal Law Commission, *Commission Comments*, s 45-5-105 (Commission Comments).

There are three categories of homicide in Montana’s Criminal Code, defined by the degree of moral fault that can be attributed to the defendant. Under Section 45-5-102, a person commits the offence of *deliberate homicide* if the person purposely or knowingly causes the death of another human being. Under Section 45-5-103, a person commits the offence of *mitigated deliberate homicide* when the person purposely or knowingly causes the death of another human being but does so under the influence of extreme mental or emotional stress for which there is reasonable explanation or excuse. Under Section 45-5-104, a person commits the offence of *negligent homicide* if the person negligently causes the death of a human being.

In all three cases, conduct will be considered the legal cause of death if, without that conduct, the death of the person would not have occurred.⁹² Thus a physician who provides assistance to a terminally ill patient who then dies and the circumstances are such that the patient would not have otherwise died without that assistance, the physician may be charged with homicide.

Under Montana law, the consent of a victim to conduct or the result of conduct can be considered a defence to a criminal charge.⁹³ However, consent will be ineffective if it is “against public policy to permit the conduct or the resulting harm, even though consented to.”⁹⁴

The 2009 Supreme Court appellate judgment in *Baxter v. Montana* (discussed in more detail below) established that the consent of a terminally ill patient to PAS was not made ineffective under the Criminal Code because according to the court, nothing in court precedent or statute identified that physician aid in dying was against public policy. Accordingly, since *Baxter v. Montana*, under Montana law, physicians, as well as nurse practitioners and other defined health care practitioners who have caused the death of a patient pursuant to PAS, can raise the patient’s consent as a defence to a subsequent charge of homicide.

ii. Case law challenge: *Baxter v. Montana*

In 2007, the Plaintiffs in *Baxter v. Montana* brought a motion challenging the constitutionality of the Montana homicide statutes with respect to PAS. The Plaintiffs in the case were Mr. Baxter, a terminally ill patient with lymphocytic leukemia, four physicians who treated terminally ill patients in the state of Montana, and the non-profit organization Compassion & Choices. The Plaintiffs alleged that the equal

⁹² Montana Criminal Code (n 752) s 45-2-201(1)(a).

⁹³ *ibid* s 45-2-211(1).

⁹⁴ *ibid* s 45-2-211(2)(d).

protection, dignity and privacy clauses of the Montana Constitution provided competent terminally ill patients and their physicians, rights to aid in dying.⁹⁵

In December 2008, 31 days after the passage of the Washington AD law, the Montana District Court rendered its decision. With respect to the equal protection argument which was advanced on the basis of similarity of PAS to the legal practices of withholding or withdrawing life-sustaining treatment,⁹⁶ the District Court held that the equality protection could not protect the Plaintiffs from the Montana homicide laws. According to the District Court, the refusal of life-sustaining treatment, continued to be “dissimilar” to physician assistance in hastening death by self-administering drugs.⁹⁷ This finding was consistent with the decision *Vacco v. Quill*⁹⁸ as earlier discussed in Chapter III.B.5.

The District Court did however find that there was a “right to die with dignity” pursuant to Sections 10 and 4 of Article II in the Montana Constitution, respectively, the rights of privacy and dignity and which read as follows:⁹⁹

Section 10: Right of privacy. The right of individual privacy is essential to the well-being of a free society and shall not be infringed without the showing of a compelling state interest.

Section 4: Individual dignity. The dignity of the human being is inviolable. No person shall be denied the equal protection of the laws. Neither the state nor any person, firm, corporation, or institution shall discriminate against any person in the exercise of his civil or political rights on account of race, color, sex, culture, social origin or condition, or political or religious ideas.

According to the District Court, the “Montana constitutional rights of individual privacy and human dignity, taken together, encompass the right of a competent terminally ill patient to die with dignity.”¹⁰⁰ The court concluded that the state homicide laws were unconstitutional with respect to a physician aiding a competent, terminally ill patient in dying. In other words, the court held that “the right to die with dignity” included the protection of the physician who prescribed life-ending

⁹⁵ *Baxter v Montana* No ADV-2007-787 (Mont. 1st Dist, 5 December 2008) 1-2 (*Baxter v Montana* DC)

⁹⁶ The Constitution of the State of Montana, Article II, Section 4. The basic rule of equal protection is that “persons similarly situated with respect to a legitimate governmental purpose of the law must receive like treatment. (Montana Constitution); *Hoberson v U.S. Dept. of Agriculture*, 2007 MT 293, 342 Mont 85, 179 P 3d 524, para 11.

⁹⁷ *Baxter v Montana* DC (n 95) 13.

⁹⁸ *Quill v Koppell*, 870 F. Supp. 78 (S.D.N.Y. 1994), rev'd sub nom. *Quill v Vacco*, 80 F.3d 716 (2d Cir. 1996), rev'd *Quill v Vacco*, 521 U.S. 793 (1997) (*Vacco v Quill*).

⁹⁹ Montana Constitution (n 96) art II, ss 4 and 10.

¹⁰⁰ *Baxter v Montana* DC (n 95) 23.

medication to competent terminally ill patients from liability under the State's homicide statutes.¹⁰¹

In December 2009, on appeal, the Montana Supreme Court upheld the result but vacated the District Court's ruling on the privacy and dignity constitutional grounds, instead resolving the matter at the statutory level. In examining the culpability of a physician for homicide when extending aid in dying, the Supreme Court noted that consent could indeed shield a physician provided that the patient's consent was not rendered ineffective by virtue of the conduct or resultant harm being against public policy.¹⁰²

After reviewing Montana law, the Supreme Court held that "sheer physical aggression that breaches public peace and endangers others is against public peace".¹⁰³ Physician aid in dying, described by the court as the patient – not the physician – committing the final death-causing act by self-administration of a lethal dose, did not satisfy this definition.¹⁰⁴ Furthermore, the Supreme Court did not find any language in the homicide statute to indicate that killing "oneself" as opposed to another is a punishable offence – there was no statute criminalizing suicide.¹⁰⁵ Notably, the court also described physician aid in dying i.e. making available lethal doses of medicine, as a "lesser end-of-life physician involvement" than the withdrawal or withholding of treatment by the physician, the latter in respect of which physicians have been provided an explicit shield from liability.¹⁰⁶

Accordingly, the majority of the Supreme Court concluded that there was "nothing in Montana Supreme Court precedent or Montana Statutes indicating that physician aid in dying is against public policy"¹⁰⁷ notwithstanding the contradictory view in the Commission Comment that a physician acting as the agency of death may not raise "consent or even the solicitations of the victim" as a defense to criminal culpability.¹⁰⁸ The Supreme Court thus held that a terminally ill patient's consent to physician aid in dying will constitute a "statutory defense to the charge of homicide against the aiding physician when no other consent exceptions apply."¹⁰⁹

¹⁰¹ *ibid.*

¹⁰² *Baxter v Montana* SC (n 2) para 12.

¹⁰³ *ibid* para 21.

¹⁰⁴ *ibid* paras 23-38.

¹⁰⁵ *ibid* para 26.

¹⁰⁶ *ibid* para 32; See Uniform Rights of the Terminally Ill Act (1989), 92 ULA 311, 312 (2001) codified at Title 45, Montana Criminal Code (n 752) Sections 50-9-03, -204.

¹⁰⁷ *Baxter v Montana* SC (n 2) para 49.

¹⁰⁸ Commission Comments (n 91); See also *Baxter v Montana* SC *ibid* para 43 per Rice J.

¹⁰⁹ *Baxter v Montana* SC *ibid* para 50.

In avoiding the recognition of a constitutionally protected right to die (the approach taken by the Montana District Court) and proceeding on the basis of the availability of raising a consent defence on the part of the assistor, the Montana Supreme Court implicitly acknowledged a distinction between a “right to die” and a “right to choose”, terms that are frequently used interchangeably in assisted death reform discourse.

To date, no court of final jurisdiction in the United States has yet recognized a right to PAS or euthanasia under federal or state constitutional protections.

iii. Position Statements, Reports and Recent Legislative Initiatives

While the American Medical Association (AMA) has clearly set out its opposition to physician participation in assisted suicide and euthanasia,¹¹⁰ the Montana Medical Association (MMA) has not issued a clear position on PAS. However, in its current position statement, the MMA has stated that while it does not condone the deliberate act of precipitating the death of a patient, this should not be taken to imply “that a physician using his or her best judgment should not allow a patient to die with dignity”.¹¹¹ In further acknowledging that the patient has a legitimate right to autonomy at end of life, the MMA also stated that it “does not accept the proposition that death with dignity may be achieved only through physician assisted suicide” demonstrating that dignity-related duty from the medical perspective extends beyond the facilitation of autonomous agency to include duties that address subjective and experiential indignity.¹¹²

Following the 2008 *Baxter v. Montana* decision, a draft assisted suicide bill, LC1818, the *Montana Death with Dignity Act* [short title],¹¹³ was proposed in the Montana Legislature. LC1818 set out substantive and procedural guidelines for a PAS scheme similar, though not entirely identical, to the Oregon and Washington PAS Statutes. The draft bill died in process in April 2009.

¹¹⁰ Instead of engaging in euthanasia or assisted suicide, “physicians must aggressively respond to the needs of patients at the end of life”. American Medical Association, ‘Code of Medical Ethics Opinion 2.211- Physician-Assisted Suicide’ (updated June 1996) ss 2.21 and 2.211 <<http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2211.page>> accessed 31 May 2011 (AMA Code of Ethics).

¹¹¹ Montana Medical Association, *Position Statement Manual* (February 2011) 3.

¹¹² *ibid.*

¹¹³ Bill LC1818, A bill for an act entitled: “An act allowing a terminally ill patient to request medication to end the patient's life; establishing procedures; providing the right to rescind the request; providing definitions; providing immunity; and providing rulemaking authority.”

In January 2011, two further bills were introduced in the Montana Senate: SB167, *Montana Death with Dignity Act* [short title]¹¹⁴, similar to LC1818 and aimed at regulating PAS in the same manner as the Oregon and Washington PAS Statutes and SB116, *Prohibit physician-assisted suicide* [short title], aimed at banning PAS altogether.¹¹⁵

Neither SB167 nor SB116 proceeded to second reading. SB167 died in Standing Committee on April 28, 2011, with its current status indicated as “probably dead”.¹¹⁶ A motion on February 2, 2011 to bring SB116 to second reading was also defeated in a vote of 35 to 15; its status is also indicated as “probably dead”.¹¹⁷

iv. Alignment and Limits

When viewed alongside the Dutch approach it can be seen that the Montana and Netherlands’ approaches to AD share some similarities – both are physician-oriented and both are constructed as some form of defensible activity. The main distinguishing feature between the two approaches however is that the Dutch scheme builds on the physician conflict of professional duties to shape the primary (or positive) justification for entry into AD whereas the Montana articulation commences construction on the more malleable principle of patient consent to articulate the physician conduct that might properly arise therefrom.

Thus, the justification for “entry” into AD under the Montana approach hinges on a formulation of patient consent that has been infused with a quasi-right status due to the existence of fluid public policy grounded in the recognition of the dying patient’s right to self-determination. In this way, the Montana approach is similar to the Belgium and Luxembourg AD policies. It is important to point out that even though the Montana court stopped short from connecting any dots between AD and constitutionally protected rights such as privacy or dignity, the Montana court nonetheless appears to be advancing AD primarily on the basis of autonomy and self-determination, albeit through the legal tool of consent to an otherwise illegal activity. This perspective is particularly evident in the observation made by the Montana Supreme Court that PAS, in which the patient commits the final act, requires less involvement by the physician

¹¹⁴ Bill SB167, A bill for an act entitled: “An Act Allowing A Terminally Ill Patient To Request Medication To End The Patient’s Life; Establishing Procedures; Providing The Right To Rescind The Request; Providing Definitions; Providing Immunity For Persons Participating In Good Faith Compliance With The Procedures; Providing Rulemaking Authority; And Providing An Immediate Effective Date”.

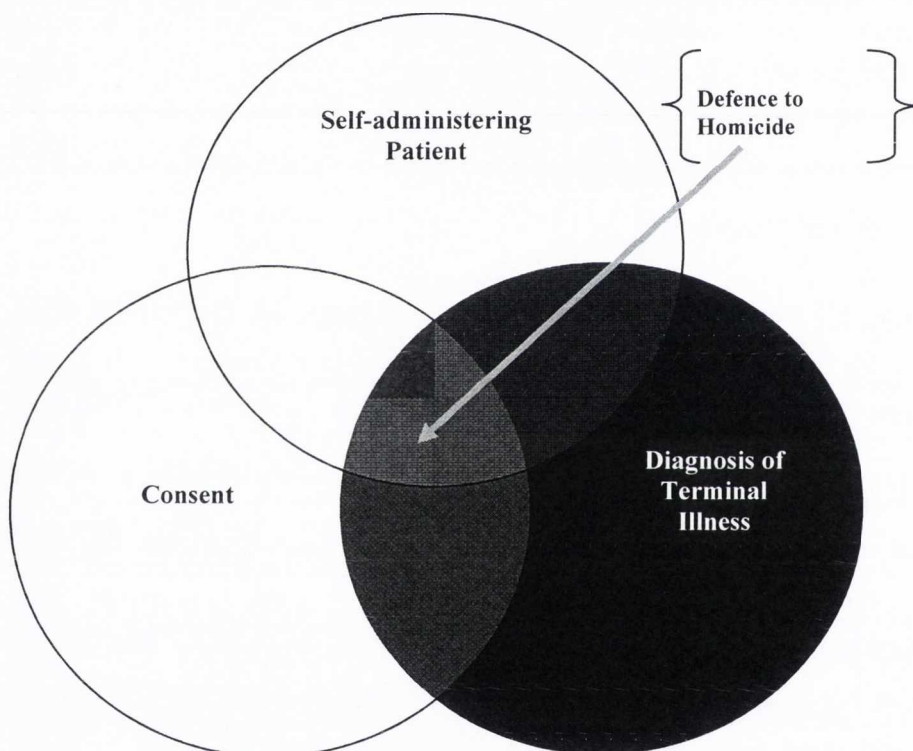
¹¹⁵ Bill SB116, A bill for an act entitled: “An Act Prohibiting Aid In Dying; Amending Sections 45-2-211 And 50-9-205, MCA; And Providing An Immediate Effective”.

¹¹⁶ Montana Legislature, *2011 Session: Detailed Bill Information* (2011) <<http://leg.mt.gov/css/default.asp>> accessed 31 May 2012.

¹¹⁷ *ibid.*

than does the withdrawing or withholding of life-sustaining treatment. Thus, what is being constructed by the court is a form of physician immunity involving a conceptual shift in focus and responsibility away from the physician towards the self-determining, self-administering patient. This construction also exhibits an apparent preference towards establishing an inverse relationship between the expression of autonomy and the modes of death made available – the *Baxter v. Montana* consent defense only extends to the practice of PAS, not euthanasia. This outcome is consistent with the scope of the AD legislation in Oregon and Washington, as is the suffering requirement that the patient must be dying i.e. suffering from a terminal condition.

Figure 10. AD advanced on the basis of consent as physician defence



Thus the AD model from developed by the Montana court can be seen to involve elements identified under the Netherlands and Luxembourg models as well as the American AD schemes, notwithstanding that it has only recognized the availability of a physician defense and has not technically legalized AD practice. On the one hand, access to assisted death is constructed on a physician defense that becomes available through the principle of consent and the patient’s autonomous “right to choose”. On the other hand, the patient’s right to choose is constrained to the provision of PAS and situations of terminal illness, which in turn creates a bright-line for physician participation.

What is not well articulated however is how AD conforms as a medical activity, in particular, the connection(s) between assistance with dying and physician duties to the patient. Thus, physician participation also appears to be triggered and defined in a manner similar to that of the Switzerland AD model, that is, it is through the physician that a prescription for a lethal dose of medication can be obtained. Therefore, the obligations of the physician appear to relate primarily to the confirmation of patient competency and diagnosis. Furthermore, while the defense appears to be only available to the physician or other participating health care practitioners, a concurring opinion in *Baxter v Montana* noted that the “logic of the Court’s opinion is not necessarily limited to physicians.”¹¹⁸ In other words, with respect to aid in dying, the consent defence to homicide should be available whether inside or outside the physician-patient nexus. Arguably, the same logic of consent could also potentially prompt expansion from PAS to euthanasia, unless a stronger public policy distinction could be made.

IV.C.2. England

i. Legislative Prohibition

As earlier stated, PAS and euthanasia are prohibited in England and Wales. Euthanasia constitutes the crime of murder under the common law of England¹¹⁹ while the offence of assisting or encouraging a suicide is made illegal pursuant to Section 2(1) of the *Suicide Act 1961*¹²⁰ as amended by the *Coroners and Justice Act 2009*¹²¹ which makes encouraging or assisting a suicide a crime punishable by up to 14 years imprisonment.¹²² The decision over whether to prosecute for assisting or encouraging suicide under the *Suicide Act 1961* is, pursuant to Section 2(4), at the discretion of the Director of Public Prosecutions (DPP).¹²³

The three most significant cases to challenge the English assisted suicide prohibitions are *Pretty* (2002),¹²⁴ *Purdy* (2009)¹²⁵ and most recently, *Nicklinson* (2012).¹²⁶

¹¹⁸ *Baxter v Montana* SC (n 2) para 56 (per Warner J).

¹¹⁹ *R v Cox* (n 24), *R v Brown* (n 24), *R v Moor* (n 24).

¹²⁰ *Suicide Act 1961* (n 25).

¹²¹ *Coroners and Justice Act 2009* (n 26).

¹²² *Suicide Act 1961* (n 25) s 2(1).

¹²³ *Suicide Act 1961* *ibid* s 2(4): “no proceedings shall be instituted for an offence under this Section except by or with the consent of the Director of Public Prosecutions”.

¹²⁴ *Pretty* (n 3).

¹²⁵ *Purdy* (n 4).

¹²⁶ *Nicklinson Motion* (n 5).

ii. Case Law challenges: *Pretty, Purdy and Nicklinson*

Pretty v. DPP (2002)

In *Pretty v. DPP*, the applicant, Diane Pretty was suffering from motor-neuron disease, a progressive neuro-degenerative disease of motor cells within the central nervous system which caused her to be paralyzed from the neck down. Mrs. Pretty sought an undertaking from the DPP that the DPP would not prosecute her husband should he choose to assist her to commit suicide in accordance with her wishes.¹²⁷ When the DPP refused to give the undertaking, Mrs. Pretty sought judicial review of the DPP's decision. The Queen's Bench Divisional Court upheld the DPP's decision and refused relief.

On appeal to the House of Lords, Mrs. Pretty claimed, "that she has a right to her husband's assistance in committing suicide and that Section 2 of the 1961 Act, if it prohibits his helping and prevents the Director undertaking not to prosecute if he does, is incompatible with the European Convention on Human Rights."¹²⁸ Specifically, Mrs. Pretty argued that her rights were violated under Article 2 (*right to life*), Article 3 (*prohibition of torture*), Article 8 (*right to respect for private and family life*), Article 9 (*freedom of thought conscience and religion*) and Article 14 (*prohibition of discrimination*) of the European Convention for the Protection of Human Rights and Fundamental Freedoms.¹²⁹

When the House of Lords refused relief, Mrs. Pretty appealed her application to the European Court of Human Rights at Strasbourg. The European Court of Human Rights (the Strasbourg Court) refused her application to find the *Suicide Act 1961* incompatible with the European Convention.¹³⁰ The court's decision was, for the most part consistent with the House of Lords decision with the exception of the interpretation of Article 8(1) as will be discussed.

Pursuant to Article 2 of the European Convention, *the right to life*, Mrs. Pretty argued that Article 2 protected not only the right to life but also the right to choose whether or not to go on living, thus protecting the individual's right to self-determination in relation to issues of life and death. This protection would include a positive obligation

¹²⁷ *Pretty* (n 3) para 10.

¹²⁸ *R (Pretty) v DPP (Secretary of State for the Home Department Intervening)* [2001] UKHL 61 [2002] 1 AC 800 (*Pretty* HL)

¹²⁹ *ibid* para 1.

¹³⁰ *Pretty* (n 3).

to protect both the right to live and, as the corollary of the right to live, the right to die, in order to avoid inevitable suffering and indignity.¹³¹

The Strasbourg Court did not agree that the right to life in Article 2 could be interpreted as involving a negative aspect¹³² relying on a 1999 Recommendation of the Parliamentary Assembly of the Council of Europe which stated:¹³³

... that the Committee of Ministers encourage the member States of the Council of Europe to respect and protect the dignity of terminally ill or dying persons in all respects: ... c. by upholding the prohibition against intentionally taking the life of terminally ill or dying persons, while:

- i. recognising that the right to life, especially with regard to a terminally ill or dying person, is guaranteed by the member States, in accordance with Article 2 of the European Convention on Human Rights which states that 'no one shall be deprived of his life intentionally';
- ii. recognising that a terminally ill or dying person's wish to die never constitutes any legal claim to die at the hand of another person;
- iii. recognising that a terminally ill or dying person's wish to die cannot of itself constitute a legal justification to carry out actions intended to bring about death.

Accordingly the Strasbourg Court held that “no right to die, whether at the hands of a third person or with the assistance of a public authority” could be derived from Article 2 of the European Convention.¹³⁴ In so finding the court also stated, “Article 2 cannot, without a distortion of language, be interpreted as conferring the diametrically opposite right, namely a right to die; nor can it create a right to self-determination in the sense of conferring on an individual the entitlement to choose death rather than life.”¹³⁵

With respect to Article 3 (*prohibition of torture*), the Strasbourg Court stated that although it imposes a positive obligation on the state to protect people from suffering¹³⁶ and also imposes requirements on state authorities to protect the health of persons deprived of liberty,¹³⁷ an obligation for the state to sanction actions intended to terminate life could not be derived from Article 3.¹³⁸ According to the court, Article 3 is to be construed in harmony with Article 2, which is “first and foremost a prohibition on the use of lethal force or other conduct which might lead to the death of

¹³¹ *ibid* 4, 26.

¹³² *ibid* 27, para 39.

¹³³ Parliamentary Assembly of the Council of Europe, *Protection of the human rights and dignity of the terminally ill and the dying* (Recommendation 1418. June 1999) para 9.

¹³⁴ *Pretty* (n 3) para 40.

¹³⁵ *ibid* para 39.

¹³⁶ *ibid* paras 44, 52.

¹³⁷ *ibid* para 51.

¹³⁸ *ibid* para 55.

a human being and does not confer any right on an individual to require a State to permit or facilitate his or her death.”¹³⁹

Article 8(1) confers a right to respect for private and family life. Article 8(2) allows for the restriction of that right, if in accordance with the law and is necessary in a democratic society in order to protect public interests.¹⁴⁰ Mrs. Pretty argued that Article 8 explicitly guaranteed the right to self-determination, which included the right to *choose* when and how to die.¹⁴¹

Different from the House of Lords position, the Strasbourg Court found that Mrs. Pretty’s Article 8(1) rights were engaged. The court acknowledged that Article 8(1) could extend to a right to choose one’s manner of dying pursuant to the notion of personal autonomy and that prohibiting the exercise of choice to avoid an undignified and distressing end to life might constitute an interference with the right to respect for private life. However, the Strasbourg Court held that interference with that right was justified per Article 8(2) in order to protect the rights of others, particularly the weak and vulnerable, “especially those who are not in a condition to take informed decisions against acts intended to end life or to assist in ending life.”¹⁴²

With respect to Article 9 (*freedom of thought, conscience and religion*), the Strasbourg Court held that no violation had occurred, finding that Mrs. Pretty’s claim under Article 9 was a restatement of the complaint raised under Article 8 of the Convention.¹⁴³

Pursuant to Article 14, Mrs. Pretty made the argument that although the “blanket ban on assisted suicide applied equally to all individuals, the effect of its application to her when she was so disabled that she could not end her life without assistance was discriminatory.”¹⁴⁴

The Strasbourg Court also dismissed this claim. According to the court,

There is, in the Court’s view, objective and reasonable justification for not distinguishing in law between those who are and those who are not physically capable of committing suicide. Under Article 8 of the Convention, the Court has found that there are sound reasons for not

¹³⁹ *ibid* para 54.

¹⁴⁰ European Convention (n 30) art 8(2): “There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.”

¹⁴¹ *Pretty* (n 3) para 58.

¹⁴² *ibid* paras 61-78.

¹⁴³ *ibid* paras 80-3.

¹⁴⁴ *ibid* para 85-6.

introducing into the law exceptions to cater for those who are deemed not to be vulnerable Similar cogent reasons exist under Article 14 for not seeking to distinguish between those who are able and those who are unable to commit suicide unaided. The borderline between the two categories will often be a very fine one and to seek to build into the law an exemption for those judged to be incapable of committing suicide would seriously undermine the protection of life which the 1961 Act was intended to safeguard and greatly increase the risk of abuse.

Consequently, there has been no violation of Article 14 of the Convention in the present case.¹⁴⁵

Following the *Pretty v. DPP* case, a number of legislative initiatives to legalize PAS and euthanasia for individuals with terminal illness were introduced in the House of Lords. These initiatives were touched on in IV.B.2.i above in the context of overall legislative trends and are discussed in more detail in IV.C.2.iii. below.

Purdy v. DPP (2009) and the DPP Policy on Encouraging or Assisting Suicide

In the more recent case of *Purdy v. DPP*, Ms. Purdy, who suffers from a progressive form of multiple sclerosis, wanted to know whether her husband would face criminal charges in Britain if her husband assisted her in leaving England for the purpose of committing suicide in a jurisdiction where suicide is lawful. The DPP refused to provide any specific guidance as to the factors he would take into consideration when deciding whether or not to prosecute an individual for assisting another in committing assisted suicide under Section 2(1) of the Suicide Act 1961.

After unsuccessfully seeking judicial review¹⁴⁶ and an unsuccessful appeal,¹⁴⁷ Ms. Purdy appealed to the House of Lords and argued that her Article 8(1) privacy right under the European Convention was engaged and that the exercise of prosecutorial discretion pursuant to Section 2(4) of the Suicide Act 1961 was unclear and in contravention of Article 8(2).¹⁴⁸ The House of Lords this time agreed that Article 8 was engaged and allowed the appeal. The House of Lords held that it was incumbent on the DPP “to clarify what his position is as to the factors that he regards as relevant for and against prosecution” in cases of encouraging and assisting suicide.¹⁴⁹

¹⁴⁵ *ibid* paras 88 and 89.

¹⁴⁶ *R (on the application of Purdy) v Director of Public Prosecutions* [2008] EWHC 2565.

¹⁴⁷ *R (on the application of Purdy) v Director of Public Prosecutions* [2009] EWCA Civ 92 (*Purdy* EWCA).

¹⁴⁸ *Purdy* (n 4) paras 30-1, 42.

¹⁴⁹ *ibid* para 55.

Following the *Purdy* decision, the DPP issued an interim policy in September 2009 and a final policy in February 2010.¹⁵⁰ The DPP Policy identifies the criteria that the DPP will consider when deciding whether or not to prosecute cases of assisted suicide. The policy applies “when the act that constitutes the encouragement or assistance is committed in England and Wales; any suicide or attempted suicide as a result of that encouragement or assistance may take place anywhere in the world, including in England and Wales.”¹⁵¹

Under the DPP policy, the 16 public interest criteria tending in favour of prosecution are [author’s emphasis]:¹⁵²

1. The victim was under 18 years of age;
2. The victim did not have the capacity (as defined by the Mental Capacity Act 2005) to reach an informed decision to commit suicide;
3. The victim had not reached a voluntary, clear, settled, and informed decision to commit suicide;
4. The victim had not clearly and unequivocally communicated his or her decision to commit suicide to the suspect;
5. The victim did not seek the encouragement or assistance of the suspect personally or on his or her own initiative;
6. *The suspect was not wholly motivated by compassion*; for example, the suspect was motivated by the prospect that he or she or a person closely connected to him or her stood to gain in some way from the death of the victim;
7. The suspect pressured the victim to commit suicide;
8. The suspect did not take reasonable steps to ensure that any other person had not pressured the victim to commit suicide;
9. The suspect had a history of violence or abuse against the victim;
10. *The victim was physically able to undertake the act that constituted the assistance him or herself*;
11. The suspect was unknown to the victim and encouraged or assisted the victim to commit suicide by providing specific information via, for example, a website or publication;
12. *The suspect gave encouragement or assistance to more than one victim who were not known to each other*;
13. The suspect was paid by the victim or those close to the victim for his or her encouragement or assistance;
14. *The suspect was acting in his or her capacity as a medical doctor, nurse, other healthcare professional, a professional carer [whether for payment or not], or as a person in authority, such as a prison officer, and the victim was in his or her care*;
15. The suspect was aware that the victim intended to commit suicide in a public place where it was reasonable to think that members of the public may be present;
16. *The suspect was acting in his or her capacity as a person involved in the management or as an employee (whether for payment or not) of an organisation or group, a purpose of which is to provide a physical environment (whether for payment or not) in which to allow another to commit suicide.*

¹⁵⁰ DPP Policy (n 37).

¹⁵¹ *ibid* para 8.

¹⁵² *ibid* para 43.

The six (6) public interest factors tending against prosecution are:¹⁵³

1. The victim had reached a voluntary, clear, settled, and informed decision to commit suicide;
2. *The suspect was wholly motivated by compassion;*
3. The actions of the suspect, although sufficient to come within the definition of the offence, were of only minor encouragement or assistance;
4. The suspect had sought to dissuade the victim from taking the course of action which resulted in his or her suicide;
5. The actions of the suspect may be characterised as *reluctant encouragement* or assistance in the face of a determined wish on the part of the victim to commit suicide;
6. The suspect reported the victim's suicide to the police and fully assisted them in their enquiries into the circumstances of the suicide or the attempt and his or her part in providing encouragement or assistance.

In describing the policy, Keir Starmer, the DPP, stated:

The policy is now more focused on the motivation of the suspect rather than the characteristics of the victim. The policy does not change the law on assisted suicide. It does not open the door for euthanasia. It does not override the will of Parliament. What it does is to provide a clear framework for prosecutors to decide which cases should proceed to court and which should not. ...

Assessing whether a case should go to court is not simply a question of adding up the public interest factors for and against prosecution and seeing which has the greater number. It is not a tick box exercise. Each case has to be considered on its own facts and merits.

...

As a result of the consultation exercise there have been changes to the policy. But that does not mean prosecutions are more or less likely. The policy has not been relaxed or tightened but there has been a change of focus.¹⁵⁴

The public consultation exercise undertaken in the course of development of the DPP Policy was described by Starmer as “taking account of thousands of responses received as part of what is believed to be the most extensive snapshot of public opinion on assisted suicide since the *Suicide Act 1961* was introduced”.¹⁵⁵

When issued, the DPP Policy became both the subject of commendation and criticism. On the one hand it was praised for demonstrating compassion and sensibility, on the other it was criticized from two main perspectives: i) for potentially representing the “thin edge of the wedge” towards legalization of assisted death; and ii) for establishing an assisted suicide model entirely different from those implemented in other jurisdictions – an amateur model outside of the medical profession, potentially rife

¹⁵³ *ibid* para 45.

¹⁵⁴ The Crown Prosecution Service, ‘*Assisted Suicide: Policy for prosecuting cases of assisted suicide and further information*’ (2010) <http://www.cps.gov.uk/publications/prosecution/assisted_suicide.html> accessed 31 May 2012.

¹⁵⁵ *ibid*; The public consultation is compiled and released as *Public Consultation Exercise on the Interim Policy for Prosecutors in respect of Cases of Assisted Suicide Summary of Responses* (n 37).

with negative and dangerous outcomes.¹⁵⁶ Notwithstanding these criticisms and particularly the latter criticism, recently there has been some discussion in the House of Commons as to the overall merits of the DPP policy and the consideration of enshrining the DPP Policy into law.¹⁵⁷ This and other legislative initiatives are discussed further below in Chapter IV.C.2.iii.

Since the publication of the DPP Policy, there have been no prosecutions for the offence of assisted suicide, although over 40 cases of assisted suicide have been reported.¹⁵⁸

Nicklinson v. Ministry of Justice (MoJ) 2012

In *Nicklinson*, the Ministry of Justice (MOJ) unsuccessfully applied to strike the claim of Tony Nicklinson, a claimant who was seeking a lawful route to end his suffering by ending his life at a time of his choosing with physician assistance.¹⁵⁹ Mr. Nicklinson suffers from “locked-in syndrome, having become paralysed below the neck and unable to speak as the result of a stroke that occurred in 2005.”¹⁶⁰

Mr. Nicklinson had brought an application before the High Court of Justice seeking three declarations which can be summarized as follows:¹⁶¹

1. that it would not be unlawful on the grounds of necessity, for a physician to terminate or assist him in terminating his life;
2. that the current law of murder and/or assisted suicide is incompatible with his right to respect for private life per Article 8 European Convention;
3. that existing domestic law and practice do not adequately regulate euthanasia in breach of Article 2 (the right to life) of the European Convention.

Charles J found that while the claimant did not have sufficient interest to seek the third declaration,¹⁶² the Claimant did have an arguable case with respect to the first two

¹⁵⁶ Commission on Assisted Dying, *Transcript of Evidence from Penney Lewis, Professor of Law, Kings College London* (25 May 2011) 6 <<http://www.commissiononassisteddying.co.uk/wp-content/uploads/2011/10/Evidence-from-Professor-Penney-Lewis.pdf>> accessed 31 May 2012; See also critique that the DPP Policy takes “a whole identifiable category of case out of the ambit of the criminal justice process” in The Commission on Assisted Dying Report (Demos, January 2012) 285-6 (UK Commission 2012 Report).

¹⁵⁷ Hansard HC 27 March 2012, vol 542, cols 1363-1440; Staff, ‘MPs back assisted dying guidelines’ *BBC News* (London, 27 March 2012) <<http://www.bbc.co.uk/news/uk-politics-17516998>> accessed 31 May 2012.

¹⁵⁸ UK Commission 2012 Report (n 156).

¹⁵⁹ *Nicklinson Motion* (n 5) para 3.

¹⁶⁰ *ibid.*

¹⁶¹ *ibid* para 5.

¹⁶² *ibid* paras 46-53.

declarations and granted the Claimant permission to proceed with his claim and seek relief by way of judicial review.¹⁶³

With respect to the necessity defence, Mr. Nicklinson asserted that the common law defence of necessity can be available to a charge of murder (in the case of euthanasia) or a charge of assisted suicide (under the Suicide Act 1962) provided that the court confirms in advance that the defence of necessity will arise on the facts of the particular case and provided that certain factors exist including that:¹⁶⁴

- the person is suffering from a medical condition that causes unbearable suffering;
- there is no alternative by which to relieve the suffering;
- the decision to end life is voluntary, clear, settled and informed;
- the medical doctor is satisfied that the duty to respect autonomy and ease suffering is outweighed by the duty to preserve life.

The gist of the Nicklinson's argument is that the common law develops over time and, in addition to the need to address the apparent lack of logic in the common law around assisted death (i.e. lawful death by: suicide for physically able; the withdrawal of treatment; and palliative sedation) there had not yet been a case where a court had decided on the availability of the necessity defence pursuant to the combination of the following factors:¹⁶⁵

- (i) that only death could avoid or end the inevitable evil of unbearable suffering and that the continuation of unbearable suffering was contrary to common law rights of self determination and dignity and Article 8 rights;
- (ii) that the doctor who performs the act that kills has a duty to: 1) respect the patient's right of autonomy; and 2) ease suffering.

In refuting Nicklinson's claim on the basis that the Claimant had no real prospect of success, the MOJ also argued that contrary to the Claimant's position, the law on murder and assisted suicide is clear and settled and neither the doctrine of necessity or the consent to death provide a defence. Furthermore, the MOJ argued that the law did not infringe on the Article 8 privacy right and in any event, any change in the law is a matter for Parliament.¹⁶⁶

In allowing Mr. Nicklinson to proceed on the necessity claim, Charles J held that the law was not as fixed and clear as asserted by the MOJ¹⁶⁷ and that the common law "is

¹⁶³ *ibid* paras 37 and 45.

¹⁶⁴ *ibid* para 6.

¹⁶⁵ *ibid* para 11.

¹⁶⁶ *ibid* paras 12-5.

¹⁶⁷ *ibid* para 25.

by its very nature capable of application to a new situation, or of development to take account of changing circumstances and new arguments.”¹⁶⁸ Furthermore, the court held that an arguable base was established on a number of grounds including that previous cases did not provide any binding authority in terms of the combination of factors at issue and the engagement of physician duties in the determination of the availability of the necessity defence to a charge of murder or assisted suicide.¹⁶⁹

The court also held that the court should not refuse to entertain the claim on the basis that only Parliament could bring about the change sought and that although Parliament has foregone opportunities to legislate, that was not determinative. According to Charles J, while it might be preferable, for issues of broad social and moral policy to be determined by Parliament, “the fact that they are hotly contested can be a factor in favour of the court intervening, particularly, if, as here, the suggested solution involves the participation of the courts on a case by case basis,” as has been done in previous cases.¹⁷⁰

With respect to Article 8, the Court noted the overlap between common law rights of autonomy and dignity, the relevant convention rights and the role of convention rights in the availability of the necessity defence¹⁷¹ and alluded to the potential invitation to the court to engage in striking a balance between the competing interests in the necessity defence. The court however did not find it appropriate to attempt to strike a different balance between the necessity defence line of argument and the Article 8 argument.¹⁷² Rather, the court viewed the claimant’s arguments as seeking alternative relief, and in so doing, provided the example that it might be more appropriate for the court to grant relief on the basis of a human rights infringement and engage Parliament in changing the law rather than by proceeding on a case by case basis pursuant to a common law approach.¹⁷³

In response to the MOJ’s argument that the Article 8 issue had been previously decided in the *Pretty* and *Purdy* cases, Charles J, noted *inter alia* that the cases related to the discretion and policy of the DPP and that neither case considered Article 8 in the actual context of voluntary active euthanasia or assistance by doctors to those, who by virtue of disability, are unable to commit suicide other than by refusal of food or water.¹⁷⁴ Charles J also noted that there had been a number of developments since

¹⁶⁸ *ibid.*

¹⁶⁹ *ibid* para 26.

¹⁷⁰ *ibid* para 32.

¹⁷¹ *ibid* para 41.

¹⁷² *ibid.*

¹⁷³ *ibid* para 42.

¹⁷⁴ *ibid* para 44.

Pretty, including the January 2012 report from the Commission on Assisted Dying which reached the conclusion that the current legal status on assisted suicide was indeed inadequate and incoherent.¹⁷⁵ Accordingly, the claim for the second declaration was allowed to proceed.¹⁷⁶

iii. Position Statements, Reports and Recent Legislative Initiatives

Following the *Pretty* decision, in 2003 private member Lord Joel Joffe introduced *The Patient (Assisted Dying) Bill (HL Bill 37)*¹⁷⁷ to the House of Lords.¹⁷⁸ The bill enabled “assisted dying”, that is, PAS or euthanasia¹⁷⁹ for a competent adult suffering unbearably as a result of a terminal illness which was defined as an incurable and physical illness “likely to result in death within 6 months”.¹⁸⁰ HL Bill 37 went to second reading but did not proceed further.¹⁸¹

On March 10, 2004, Lord Joffe introduced a second bill, *The Assisted Dying for the Terminally Ill Bill (HL Bill 17)*.¹⁸² HL Bill 17, like HL Bill 37, was “based on the principle of personal autonomy and patient choice, the right of each individual to decide for themselves how best he or she should lead their lives”.¹⁸³

While HL Bill 17 was still aimed at the legalization of PAS and euthanasia¹⁸⁴ and contained similar and familiar eligibility requirements and safeguards (such as competency, voluntariness, consultation with a second physician, discussion of alternatives such as palliative care, waiting periods, ability to revoke request, psychiatric referral, documentation, physician conscientious objection and so forth), the definition of terminal illness was slightly different, defined as: a progressive irreversible illness “likely to result in the patient’s death within a few months at most”.¹⁸⁵

¹⁷⁵ *ibid.*

¹⁷⁶ *ibid* para 45.

¹⁷⁷ HL Bill 37 (n 32).

¹⁷⁸ For discussion of earlier unsuccessful attempts in the United Kingdom to pass legislation to legalize euthanasia or PAS see Parliament of Australia, *Euthanasia - The Australian Law in an International Context* (Research Paper 4 1996-07, 1996) 33-37 <<http://www.aph.gov.au/library/pubs/rp/1996-97/97rp4.htm>> accessed 31 May 2012.

¹⁷⁹ *ibid* Section 1(2). Assisted dying, means the attending physician, at the patient’s request, either providing the patient with the means to end his life or ending the patient’s life.

¹⁸⁰ *ibid.*

¹⁸¹ Hansard HL Deb 6 June 2003, vol 648, cols 1585-1690.

¹⁸² HL Bill 17 (n 33).

¹⁸³ Select Committee on the Assisted Dying for the Terminally Ill Bill, *Assisted Dying for the Terminally Ill Bill [HL]* (HL Paper 86-I, 2005) para 22 (UK Select Committee 2005 Report on HL Bill 17).

¹⁸⁴ HL Bill 17 (n 33) s 1(2). Assisted dying” means the attending physician, at the patient’s request, either providing the patient with the means to end the patient’s life or, if the patient is physically unable to do so, ending the patient’s life.

¹⁸⁵ *ibid.*

In terms of suffering, under Bill 17 the attending physician would have to come to the conclusion that the requesting patient was “suffering unbearably as a result of that terminal illness”. “Unbearable suffering” was defined as “suffering whether by reason of pain or otherwise which the patient finds so severe as to be unacceptable”.¹⁸⁶ Thus requisite suffering must come from the patient’s perspective and can encompass existential suffering including feelings of loss of dignity or self-worth in addition to physical suffering.¹⁸⁷

HL Bill 17 was given Second Reading and referred to a Select Committee which then proceeded to consider oral testimony and written evidence on the bill. The Select Committee produced an extensive report published in April 2005 (the “2005 Select Committee Report”) which provided an accounting of the evidence received and gathered by the Select Committee and recommendations on how the Select Committee believed the matter should be handled.¹⁸⁸

Recommendations included that a new bill be introduced by a Member of the House and following Second Reading, be referred for detailed examination in light of the 2005 Select Committee Report which called for serious consideration of a number of key issues including issues related to:

... that the demand for assisted suicide or voluntary euthanasia is particularly strong among determined individuals whose suffering derives more from the fact of their terminal illness than from its symptoms and who are unlikely to be deflected from their wish to end their lives by more or better palliative care. In any new bill which may be brought forward seeking to legalise assistance with suicide or voluntary euthanasia consideration should be given to focusing primarily on this group of people. ...

... that there is a strong link between the scope of legislation in this area and its take-up by terminally ill people. In particular, where legislation is limited to assistance with suicide, the take-up rate is dramatically less than in places where voluntary euthanasia is also legalised. If therefore a new bill should be brought forward, it should distinguish clearly between assisted suicide and voluntary euthanasia and thereby give the House the opportunity to address these two courses of action separately. ...

If any future bill is to claim credibly that palliative care is regarded as complementary rather than alternative to assisted suicide or voluntary euthanasia, consideration will need to be given to finding a means by which applicants can experience the effects of good palliative care rather than simply be informed of the existence of such treatment.¹⁸⁹

¹⁸⁶ HL Bill 17 (n 33) s 1.

¹⁸⁷ UK Select Committee 2005 Report on HL Bill 17 (n 183) para 26.

¹⁸⁸ *ibid.*

¹⁸⁹ *ibid* 6-8.

The 2005 Select Committee Report further noted *inter alia* its concern about the difficulty in coming to an accurate prognosis for terminal illness, and recommended that if any future bill should include terminal illness as a qualifying condition, then it should be defined in such a way as to reflect this difficulty.¹⁹⁰ Furthermore the report suggested that consideration should also be given to include a test for “unrelievable” or “intractable” as opposed to “unbearable” suffering in order to impart more of an objective medical assessment and better ensure that all available steps were taken to relieve distress before an application for PAS or euthanasia was granted.¹⁹¹ Although a specific recommendation was not articulated, the report discussed at length, evidence given pursuant to slippery slope concerns and the foreseeable difficulty in restricting assistance to cases of terminal illness because of incremental extensions in the law including through the use of equality arguments.¹⁹² Indeed, Lord Joffe himself imparted to the committee his own view which did not necessarily match the report’s view of point *B* on the slippery slope,

when we considered the opposition to the previous bill, we felt that there was such strength of feeling in the debate about extending it to younger people who had a long lifetime ahead of them that we thought it wise... to limit it to terminally ill patients who were already suffering terribly and had a very short time to live. But I can assure you that I would prefer that the law did apply to patients who were younger and who were not terminally ill but who were suffering unbearably, and if there is a move to insert that into the Bill I would certainly support it.¹⁹³

The report also discussed the different views on sanctity of life, autonomy and the rights of the individual versus the individuals’ duty to others in society¹⁹⁴ noting opinions that describe how the physician’s obligation to respect the wishes of the patient can clash with other ethical imperatives such as the wider patient community and thus challenge autonomy’s purported paramouncy. One opinion described in the report suggested that respecting patient autonomy might be better understood as respecting the patient’s right to self-govern rather than purely self-determination.¹⁹⁵

In November 2005, following the Select Committee Report, Lord Joffe introduced his revised *Assisted Dying for the Terminally Ill Bill (HL Bill 36)*.¹⁹⁶ HL Bill 36 addressed some of the key issues in the Select Committee Report. For example, HL Bill 36 narrowed the scope of the bill to exclude euthanasia but included an expanded form of

¹⁹⁰ *ibid* para 269.

¹⁹¹ *ibid* para 256.

¹⁹² *ibid* paras 42, 91-103.

¹⁹³ *ibid* para 92.

¹⁹⁴ *ibid* paras 39-73.

¹⁹⁵ *ibid* para 52.

¹⁹⁶ HL Bill 36 (n 35).

PAS permitting the physician not only to prescribe the medication, but also in the case of a patient “unable to orally ingest the medication”, to provide “such means of self-administration as will enable the patient to end his own life.”¹⁹⁷ The definition of terminal illness under HL Bill 36 was again slightly revised to a progressive illness that “cannot be reversed by treatment” and likely to result in “death within six months”.¹⁹⁸

On May 12, 2006, the House voted to adjourn on HL Bill 36 for six months, in substance a decision for the bill not to proceed. “This was the first private member’s bill to be defeated at Second Reading since 1998.”¹⁹⁹

In 2009, during the appeal of *Purdy v. DPP* to the judiciary of the House of Lords, the issue of whether persons who accompanied a patient to another jurisdiction to obtain a suicide was put to both the House of Commons and the House of Lords. The proposal did not end up being discussed in the House of Commons due to a timetabling matter; however, a similar proposal was introduced into the House of Lords in 2009.²⁰⁰

The 2009 proposal sought to amend the *Coroners and Justice Bill 2008-09* (which at the time was under consideration) by adding a clause to provide that an offense of encouraging or assisting suicide would not include assistance done “solely or principally” for the purpose of enabling or assisting an individual suffering from a terminal illness to travel to a country or territory in which assisted dying is lawful. The clause included certain safeguards including certification from two independent medical practitioners that, prior to the act for the purpose of enabling or assisting the person travel to the other jurisdiction, the person seeking suicide had a terminal illness as well as capacity to make a declaration concerning informed consent.²⁰¹ After a lengthy debate where a number of concerns were raised, including that the amendment would make a “decisive shift” as opposed to clarifying the law, the amendment was not advanced.²⁰²

In September 2010, following the February release of the DPP Policy earlier that year, an independent Commission on Assisted Dying was established to assess the current

¹⁹⁷ *ibid* s 1(a).

¹⁹⁸ *ibid* s 13(1).

¹⁹⁹ House of Lords, *Annual Report 2006/07* (HL Paper 162) 11 <<http://www.publications.parliament.uk/pa/ld200607/ldb/162/162.pdf>> accessed 31 May 2012.

²⁰⁰ Hansard HL Deb, 7 July 2009, vol 712, cols 595-637.

²⁰¹ *ibid*.

²⁰² Hansard HL Deb, 7 July 2009, vol 712, cols 631-634; See also ‘Coroners and Justice Act 2009: Explanatory Notes’ 55-6, paras 356-9 <<http://www.legislation.gov.uk/ukpga/2009/25/notes>> accessed 31 May 2012.

state of the law on assisted death. Specifically, the Commission on Assisted Dying was tasked with ascertaining whether the current legal and policy approach to assisted dying in England and Wales was “fit for the purpose” and providing a possible framework for assisted death that might be “most acceptable to health and social care professionals and the general public”.²⁰³ Members of the commission included prominent barristers and politicians, physicians, a former police commissioner and an Anglican priest. The establishment of the commission was brokered by Dignity in Dying and funded by private individuals.²⁰⁴

In January 2012, after collecting written and oral evidence, the Commission on Assisted Dying published its report (the 2012 UK Commission on Assisted Dying Report) to conclude that the current legal status of assisted suicide is “inadequate, incoherent and should not continue.”²⁰⁵ Reasons provided included the absence of prosecutions under the DPP Policy, concern that assisting suicide is an “amateur activity” without proper safeguards as well as the ongoing lack of certainty as to the types of behaviour that will attract prosecution.²⁰⁶

Founding its case for change principally on choice at end of life,²⁰⁷ the report proposed a legal framework that would allow PAS for individuals suffering from terminal illness defined as “an advanced, progressive, incurable condition that is likely to lead to the patient’s death within the next 12 months.”²⁰⁸ The report recommended that the individual with the terminal illness must take the final “action” that will end their own life. The report also pointed out that there would be a need to continue to use the DPP policy to address cases where the individual was not suffering from a terminal illness.²⁰⁹

In addition to the diagnosis of terminal illness, some of the key eligibility requirements under the proposal include that the individual:²¹⁰

- be 18 years or older;
- request assisted death on his or her own behalf;
- has the capacity to make a voluntary and informed choice, not impaired by depression; and

²⁰³ UK Commission 2012 Report (n 156) 37.

²⁰⁴ Commission on Assisted Dying, ‘About the Commission’ (*Demos*, 17 August 2010) <<http://www.commissiononassisteddying.co.uk/about-the-commission-for-assisted-dying>> accessed 31 May 2012.

²⁰⁵ UK Commission 2012 Report (n 156) 19.

²⁰⁶ *ibid* 23.

²⁰⁷ *ibid* 19.

²⁰⁸ *ibid* 27.

²⁰⁹ *ibid* 21.

²¹⁰ *ibid* 21-3.

- is fully informed of all the options available for treatment, care and support.

Recommended procedural safeguards included to ensure that the eligibility criteria were met included standard safeguards such as the settled intention to die and assessment by at least two doctors independent of each other but also the requirement that the individual be supported by a doctor throughout the process including that the prescribing doctor remain with the patient up to and including their death.²¹¹

Reporting requirements recommended by the report included that the death certificate record the death as “assisted death” and the establishment of a national monitoring commission to review and investigate cases.²¹² The report also noted the need for supervising and supporting doctors involved in assisted dying and the need for continuing government investment in improving end of life care.²¹³

The reception of the 2012 UK Commission on Assisted Dying Report has been mixed. While many have commended the report for being comprehensive and robust others have criticized it for being biased, lacking in transparency and flawed.²¹⁴

Notably, the British Medical Association (the “BMA”) refused to give evidence to the Commission, maintaining its opposition to assisted death. After the release of the DPP Policy in February 2010, the BMA stated its opposition to all forms of assisted dying, a position it has maintained since 2006.²¹⁵

The BMA has long advised doctors - for moral as well as legal reasons - to avoid actions that might be interpreted as assisting, facilitating or encouraging a suicide attempt. This means not giving patients advice on what constitutes a fatal dose or on anti-emetics in relation to a planned overdose, not suggesting the option of suicide abroad nor writing medical reports specifically to facilitate assisted dying abroad, nor on any other aspects of planning a suicide.

²¹¹ *ibid* 28-31.

²¹² *ibid* 21.

²¹³ *ibid* 22.

²¹⁴ See discussion in Michael Cook, ‘Controversial UK commission backs assisted suicide’ (*Bioedge*, 17 January 2012) <http://www.bioedge.org/index.php/bioethics/bioethics_article/9893> accessed 31 May 2012.

²¹⁵ In 2005, the policy-making body of the BMA, the annual representative meeting in recognizing the existence of diverse opinions on assisted dying within society and the profession took a neutral position on assisting dying while Parliament looked at the issue of possible legalization. In 2006, after determining the position of the majority of BMA members voting at the annual representative meeting, the BMA returned to its position of opposing all forms of assisted dying. British Medical Association Ethics Department, *End of Life Decisions: View of the BMA* (British Medical Association, August 2009) 4-6 (BMA Views).

The BMA remains opposed to doctors taking a role in any form of assisted dying.” [emphasis original]²¹⁶

The BMA’s current policy includes that the BMA:²¹⁷

- believes that the ongoing improvement in palliative care allows patients to die with dignity;
- insists that physician-assisted suicide should not be made legal in the UK;
- insists that voluntary euthanasia should not be made legal in the UK;
- insists that non-voluntary euthanasia should not be made legal in the UK; and
- insists that if euthanasia were legalised, there should be a clear demarcation between those doctors who would be involved in it and those who would not.

In January 2012, Richard Ottaway requested the Backbench Business Committee to call for a debate in the House to express a view on the DPP Policy guidelines on a substantive motion and to invite the government to consult on “whether the changes in the law, or the discretion of the guidance, should be put on statutory basis.”²¹⁸

Debate took place on 27 March 2012. The Debate was explained as follows per Ottaway:

Let me begin by explaining what the debate is not about. The motion welcomes the DPP’s “Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide”. This is not a debate on the recently published report of the Commission on Assisted Dying. The House is not being asked to express a view on voluntary euthanasia, which requires a change in the law of murder, and it is not being asked to support assisted dying for the terminally ill, which requires a change in the law on assisted suicide. Whatever our views, the debate is not about the application of Mr. Tony Nicklinson to the High Court for assistance in ending his life, and whatever the outcome of the debate, assisted suicide will remain a criminal offence. This is a debate about the application of the existing law of England, Wales and Northern Ireland. There is not an exact equivalent in Scotland, which has an offence of culpable homicide and no guidelines.²¹⁹

One of the principle reasons for requesting the government to consult on whether the DPP Policy guidelines should be put on a statutory basis was to pre-empt future amendment to the prosecutorial guidelines without first obtaining Parliamentary approval, that is, the view was that by enshrining the policy in statute, it would take a further statute to amend, thus triggering debate and ultimately a Parliamentary vote.

²¹⁶ British Medical Association, *BMA Comment on Director of Public Prosecutions’ Final Guidance on Assisted Dying* (March 2010).

²¹⁷ BMA Views (n 215) 5.

²¹⁸ Hansard HC 27 March 2012, vol 542, cols 1363-1440.

²¹⁹ *ibid* col 1363.

After debating a number of perspectives including whether the prosecution guidelines were sufficiently transparent, concern that statutory footing would legalize assisted suicide, the impact of legalized assisted death on those with disabilities, slippery slope concerns, the proper role for physicians and an amendment regarding palliative care, the House appeared to agree that the DPP guidelines achieved the right balance between respect for life and the principle of compassion. The House however did not see any need to put the guidelines on a statutory footing and instead resolved to support the DPP guidelines and encourage development of palliative care and hospice provision.²²⁰

iv. Alignment and Limits

Beginning with the *Pretty* decision, (notwithstanding that the case did not seek to attack the AD prohibitions *per se* but rather sought to attack the DPP's refusal to provide an undertaking not to prosecute her assistor), the line between the right to life (and its corollary, the protection of life) and the right to privacy was clearly demarcated by the Strasbourg Court in terms of possible avenues towards AD legalization. The Strasbourg Court (as well as the House of Lords) clearly expressed that the right to life could not be interpreted as including a right to die or an entitlement to choose death. The Strasbourg Court was however willing to consider that the right to privacy might extend to a right to self-determination regarding choosing one's manner of dying,²²¹ a position later accepted by the House of Lords in the *Purdy* case.²²² This interpretation points to a construction whereby it is the right to privacy that potentially carries with it, some relief of a duty to protect life as opposed to finding a right to life that also carries with it exceptions on the basis of the will of the individual. It might be argued that this is a distinction without a difference but then again such a distinction may have added utility when attempting to reconcile human rights obligations of the state with obligations that arise out of other relationships such as physician-patient, whereby a duty to protect life may be enhanced and thus a bright line may be desirable.

Additionally, as noted by the House of Lords in *Pretty*, accepting the right to life as extending to the right to die or to enlist another in bringing about one's own death could not be logically limited to assisted suicide but would have to extend to euthanasia. According to the Court,

If article 2 does confer a right to self-determination in relation to life and death, and if a person were so gravely disabled as to be unable to perform any

²²⁰ *ibid* col 1440.

²²¹ *Pretty* (n 3) paras 61-78

²²² *Purdy* (n 4) paras 30-1, 42.

act whatever to cause his or her own death, it would necessarily follow in logic that such a person would have a right to be killed at the hands of a third party without giving any help to the third party and the state would be in breach of the convention if it were to interfere with the exercise of that right. No such right can possibly be derived from an article having the object already defined.²²³

The hard line drawn by the Strasbourg Court in *Pretty* distinguishing between the right to life and the right to private life however is contrary to the position advanced in the political debates leading up to the Luxembourg Law of 2009. In that debate, the two rights were bridged to come to an interpretation that the obligation to protect life (the corollary of the right to life) is indeed to be interpreted in terms of self-determination, meaning that the right to life must reflect the will of the person (Figure 5).²²⁴ Note that the “slippery slope” to euthanasia that such an interpretation could trigger as voiced by the House of Lords in *Pretty* was not a concern, as Luxembourg extended the right to both PAS and euthanasia. As will be seen in the discussion of the Canadian *Carter* case that follows below which also finds rights to both PAS and euthanasia, a hybrid interpretation of the right to life is stumbled upon by Smith J, which although not directly interpreting it as including the right to die, nonetheless does so indirectly.

When considering these two divergent approaches to the interpretation of the right to life, one arising out of strict legal interpretation, the other out of political advocacy, the Netherlands experience provides additional insights. In the Netherlands, the obligation to protect life was to be interpreted, not by the will of the person, but pursuant to the counter-obligation to relieve suffering – both obligations stemming from the physician’s professional duties to the patient (Figure 2). The Dutch experience thus draws nuanced attention to differences in the scope and fulfillment of state and medical obligations regarding the protection of life, and therefore prompts a line of questioning aimed at ascertaining the differences and similarities between state and medical views.

The Dutch medical conflict of duties approach was also faced with incorporating what was not necessarily needed for justifying AD practice, but nonetheless required – the consent of the patient. In the Netherlands evolution of AD, one can observe how patient consent requirement is superimposed on the medical justification for AD (Figure 2) and then later the transformation to patient will and self-determination as the primary justification to proceed with AD (Figure 3). At this point there emerges conceptual alignment with the Luxembourg political perspective – the right to life

²²³ *Pretty* HL (n 128) para 5 per Lord Bingham of Cornhill.

²²⁴ See discussion at Chapter III.B.3.a at fn 213 and accompanying text.

interpreted according to the will of the person as well as the Belgium perspective – the physician duty to protect life in accordance with the will of the individual.²²⁵

This transformation of the Dutch justification of AD illustrates the de-coupling, however slight,²²⁶ of AD practice from a purely medical classification. Thus the Dutch experience viewed in combination with the interpretations of the right to life and right to privacy in the *Pretty* case again points to the need for a thorough consideration of: how the protection of life is being defined medically in the context of AD discussions; whether emerging medical definitions of AD are consistent or inconsistent with interpretations in the broader human rights context; and the role played by political conversations on the right to self-determination in the interpretation and transformation of the medical appreciation of the fulfillment of the professional duty to protect life.

In the case of *Purdy* (again notwithstanding that this case did not challenge the prohibition of AD but rather the lack of clarity regarding the exercise of discretion with respect to the prosecution of assisted suicide) and the DPP Policy that followed, the DPP establishes a foundation for an AD model entirely different from all legislative models discussed herein, that is, a foundation outside of an organized medical framework. Under the DPP Policy, notwithstanding that the individual seeking death must have reached a voluntary, clear, settled and informed decision to commit suicide, it is the compassion of the assistor in response to the individual's suffering, not the autonomy or self-determination of the individual seeking death that can be viewed as the principal threshold for ascertaining whether or not to proceed with a prosecution. None of the legislated AD schemes employ *compassion* as a safeguard.

Additionally, the DPP Policy does not include the status of the individual with respect to, for example, that the individual have a terminal illness or severe incurable physical condition, as a relevant factor. On the other hand it should be noted that the DPP policy does identify that where a person is physically able to undertake the act him- or herself that this will be considered a factor in favour of prosecution. This criterium appears to point prosecutorial leniency more towards narrow circumstances of material physical disability and thus would not necessarily include all circumstances

²²⁵ See discussion at Chapter III.B.2.c. and III.B.3.c.

²²⁶ But see comments by the KNMG that it is to remain connected to the medical domain. KNMG, 'KNMG Calls for Research on Older People with a Wish to Die' (KNMG, 2012) <<http://knmg.artsennet.nl/Nieuws/Nieuwsarchief/Nieuwsbericht-1/KNMG-roept-op-tot-onderzoek-naar-ouderen-met-stervenswens.htm>> accessed 31 May 2012 (KNMG, Wish to Die).

of terminal illness nor would necessarily be restricted to only a terminal illness diagnosis.

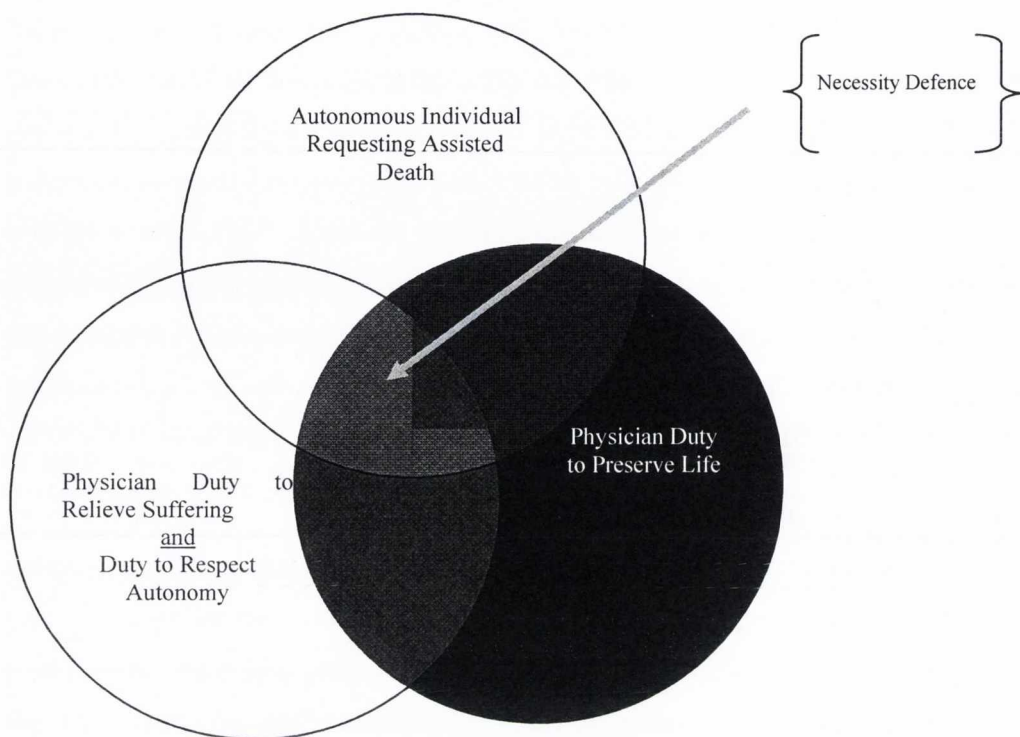
Other than acknowledgment that the prohibition of AD can engage privacy rights, the *Pretty* and *Purdy* cases along with the DPP guidelines do not demonstrate any significant alignment with the AD models canvassed in Chapter III. Nor do they appear to signal any signs of future collapse or convergence of schemes. Indeed, a careful distinction has been made with respect to the right to life and the right to privacy, and for the most part, the DPP policy has articulated the prosecutorial status quo, which, notwithstanding criticism, is unique in its non-medicalized approach and in its inclusion of compassion as the principal “safeguard”.

The case of *Nicklinson* on the other hand signals the entry of a synthesized or collapsed AD argument, one that combines:

- the Netherlands necessity defence that arises out of a conflict between the duty to protect life and the duty to relieve suffering (Figure 2);
- the Belgium perspective that the physician’s positive duty to protect life must be interpreted in accordance with the will of the individual (Figure 4); and
- the Luxembourg perspective that the right to life must be interpreted through the rights to respect for private life and self-determination (Figure 5).

Specifically, under the necessity argument, *Nicklinson* argues that the physician duty to preserve life can be outweighed not only by the duty to relieve suffering (Netherlands approach) but also by the duty to respect autonomy (Belgium / Luxembourg approach). The duty to respect autonomy, as argued, arises out of the common law rights of self-determination and dignity as well as the European Convention Article 8 privacy right.

Figure 11: AD advanced through conflicting physician duties: duties to relieve suffering and respect autonomy versus duty to preserve life.



Consistent with the other jurisdictions, suffering must be unbearable and there must be no alternative by which it can be relieved. However, by articulating the conflict as a conflict between duty to preserve life and the combined duty to relieve suffering and respect autonomy, (as opposed to a combined duty to protect life in accordance with the will of the individual) there emerges out of the *Nicklinson* line of argumentation, increased transparency with respect to the acknowledgement of the subjective nature of suffering and an opening up of the suffering criteria to be construed principally from the individual's perspective, unconstrained by medical perspectives such as terminal diagnosis. That said, because the justification to enter AD is reliant on the physician duty to relieve suffering, AD practice can only be justified within a medical context. However, just like the situation in the Netherlands, the necessity defence underpinning for AD stands to justify a physician decision to proceed with either euthanasia or PAS practice.

By constructing the argument along the lines of a conflict of professional duties, this potential AD model does not appear to undermine, at least not directly, the integrity of how the right to life is defined and protected by the state, a critical concern in the *Purdy* case. Furthermore, by positioning respect for autonomy as a trigger for physician conflict, the *Nicklinson* formulation also appears to respond to one slippery slope concern arising out of the U.S. *Baxter v. Montana* case, that autonomy *qua*

consent could become available as a defence for assisted death outside the physician-patient nexus.

Presumably, if the *Nicklinson* case were to succeed in advancing an AD model developed on a necessity formulation, the question would remain whether the model would be able to preserve its unique perspective on autonomy and limit assisted death to situations of medical necessity or whether autonomy *qua* self-determination would eventually come to be viewed as the paramount justification for AD, as has been observed through the transformation of necessity into AD legislation in the Benelux experience.

It should be noted that Mr. Nicklinson also argued that the laws on murder and/or assisted suicide were incompatible with his Article 8 right to private life under the European Convention. Because, according to the court, the *Pretty* and *Purdy* cases did not directly address the issue of the interpretation of Article 8 privacy right with respect to assisted death, the *Nicklinson* case was allowed to proceed with this argument. As already mentioned, the court noted the analytical challenge in attempting to reconcile the overlap between the Article 8 privacy argument and the necessity argument and thus allowed both arguments to proceed in the alternative.²²⁷ In allowing both lines of argument to proceed, the court raised the issue of whether a civil court, rather than permitting a common law case by case approach on the basis of necessity, would conclude it more appropriate to proceed on the basis of the human rights infringement in order to trigger a parliamentary process in changing or developing the law on AD.²²⁸

Whether to approach AD reform via the judiciary or legislature is a key conversation found throughout the AD debates, and frequently results in what some have described as a stalemate scenario. Indeed, the courts are appropriately reluctant to entertain AD reform on the basis of it being a disputed area of social policy (as opposed to an issue of law) particularly when the legislature has considered but rejected the opportunity to legislate or make changes to the status quo. Additionally, the use of judicial creativity in resolving the AD debate is criticized on the basis that interpreting rights pursuant to a court process could not yield a regulatory proposal with the rigour and detail required to ensure a result with all the “necessary in-built protections”.²²⁹ Interestingly, the combined argument advanced in *Nicklinson*, incorporates into the

²²⁷ *Nicklinson Motion* (n 5) paras 41-3.

²²⁸ *ibid* para 42.

²²⁹ *Pretty* HL (n 128) para 57.

necessity defence, a number of substantive safeguards including that the decision is voluntary, clear, settled and informed.

On the other hand, the U.K. parliamentary debate on AD bills introduced during the years 2003-2006 demonstrates the great difficulty in attempting to articulate the scope of legalized assisted death, particularly with respect to the issue of whether AD should or can be limited to terminal illness, whether to exclude or include euthanasia in addition to PAS, and how to properly measure the suffering criteria. The AD model proposed by the 2012 UK Commission on Assisted Dying would only allow PAS for individuals suffering from a terminal condition, that is, a condition that is incurable and likely to lead to the patient's death within 12 months. The commission's proposed PAS model would not necessarily be able respond to the severe conditions similar to that suffered by Mr. Nicklinson making it foreseeable that such a model, if advanced, would eventually encounter a challenge on the basis of equality, whether through informal or formal legal processes.²³⁰

Nonetheless, the court's contemplation in *Nicklinson* regarding allowing a human rights approach in order to trigger what historically has been a stalled parliamentary process, is indeed the approach that has been taken by the British Columbia Supreme Court in the 2012 Canadian case of *Carter*.

IV.B.3. Canada

i. Legislative Prohibitions

Euthanasia and assisted suicide are prohibited in Canada. Euthanasia constitutes the crime of murder and is prohibited pursuant to Sections 229 and 222 of the Criminal Code.²³¹ Consent to death does not provide a defence and motive is considered irrelevant.²³² Euthanasia can be prosecuted pursuant to a charge of first degree murder (planned and deliberate)²³³ or second degree murder²³⁴, the former carrying a

²³⁰ See discussion on legislative developments in Switzerland at Chapter III.B.4.a.iii.

²³¹ Criminal Code (R.S.C., 1985, c. C-46); Section 229: Culpable homicide is murder (a) where the person who causes the death of a human being (i) means to cause his death; Sections 222(4) and (5) describe culpable homicide as murder, manslaughter or infanticide and defines culpable homicide as "A person commits culpable homicide when he causes the death of a human being, (a) by means of an unlawful act" (Criminal Code); See non-voluntary euthanasia case of Robert Latimer who killed his 12 year old daughter Tracy Latimer by carbon monoxide asphyxiation. Tracy Latimer had a severe form of cerebral palsy and was unable to walk, talk or feed herself and suffered from considerable pain. Mr. Latimer was found guilty of second-degree murder. *R. v Latimer*, [1997] 1 S.C.R. 217.

²³² Canada Criminal Code *ibid* s 14.

²³³ *ibid* s 231(2).

²³⁴ *ibid* s 231(7).

mandatory minimum life sentence without eligibility for parole for twenty-five years, the latter also carrying a mandatory minimum life sentence but with availability of parole after ten years.²³⁵ Assisted suicide is prohibited pursuant to s.241 of the Criminal Code which states:

241. Every one who
(a) counsels a person to commit suicide, or
(b) aids or abets a person to commit suicide,
whether suicide ensues or not, is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years.

The offence of attempted suicide was repealed in 1972.²³⁶

ii. Case law challenges: *Rodriguez* and *Carter*

Historically, the most significant Canadian case to challenge (unsuccessfully) assisted suicide prohibitions on constitutional grounds was the *Rodriguez* case,²³⁷ a case heard by the Supreme Court of Canada in 1993.²³⁸ In April 2011, the *Carter* case brought a claim before the British Columbia Supreme Court (BCSC) again challenging the constitutional validity and applicability of the varied Criminal code provisions that would prohibit PAS and euthanasia.²³⁹ In its June 2012 decision, the BCSC held that the prohibitions were invalid on the basis of infringement of the right to equality (as concerned PAS) and the rights to life, liberty and security rights (as concerned PAS and euthanasia) under Sections 15 and 7 the Canadian Charter of Rights and Freedoms (the “Charter”)²⁴⁰ respectively. The BCSC suspended the operation of the declaration of constitutional invalidity for one year in order to provide Canadian Parliament with the opportunity to decide “whether or how to respond”.²⁴¹

Rodriguez v British Columbia (Attorney General) (1993) SCC

In *Rodriguez*, the Plaintiff Sue Rodriguez was a 42 year old woman suffering from the progressive degenerative disease amyotrophic lateral sclerosis (ALS). Her condition was deteriorating rapidly and she had a life expectancy between 2 and 14 months.²⁴² Ms. Rodriguez applied to the court seeking an order that s.241(b) of the Criminal

²³⁵ *ibid.*

²³⁶ *Criminal Law Amendment Act, 1972*, S.C. 1972, c. 13, Section 16.

²³⁷ *Rodriguez* (n 7).

²³⁸ Following *Rodriguez*, a 2002 case, *Wakeford v Canada (AG)* also attempted a constitutional challenge of the assisted suicide prohibition but was held by the Ontario Court of Appeal to have been fully settled by the SCC in *Rodriguez*. See *Wakeford v Canada (Attorney General)* (2001), 81 C.R.R. (2d) 342, 2001 CanLII 28318 (Ont. Sup. Ct.), *aff'd* (2001), 156 O.A.C. 385, leave to appeal to S.C.C. refused, [2002] S.C.C.A. No. 72.

²³⁹ *Carter* (n 6).

²⁴⁰ *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982* being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11 (Canadian Charter).

²⁴¹ *Carter* (n 6) para 1411.

²⁴² *Rodriguez* (n 7) 18.

Code (aiding or abetting assisted suicide) was invalid on the basis that, to the extent that the prohibition prohibited a terminally ill person from committing physician-assisted suicide, it violated her rights under Section 7 (the right to life, liberty and security),²⁴³ Section 12 (the right to not be subjected to cruel and unusual treatment)²⁴⁴ and Section 15 (the right to equality)²⁴⁵ of the Charter. In a 5-4 decision, the Supreme Court of Canada (SCC) refused her claim.

With respect to Section 7, Ms. Rodriguez argued that by prohibiting anyone from assisting her to end her life when her illness had rendered her incapable of terminating her life without such assistance, deprived her of her Section 7 right to liberty and security of the person and specifically asserted that Section 7 protected:

- the right to live her remaining life with the inherent dignity of a human person;
- the right to control what happens to her body while she is living; and
- the right to be free from governmental interference in making fundamental personal decisions concerning the terminal stages of her life.²⁴⁶

Pursuant to the liberty and security protection of Section 7, Ms. Rodriguez asserted that by not excluding persons who were terminally ill and mentally competent but who could not commit suicide on their own, the assisted suicide prohibition was over-inclusive.²⁴⁷

Ms. Rodriguez also asserted that given that suicide itself is not unlawful and that the common law “allows a physician to withhold or withdraw life-saving or life-maintaining treatment on the patient's instructions and to administer palliative care which has the effect of hastening death” the prohibition was arbitrary and unfair.²⁴⁸

The Section 7 analysis by the Court involved a two-stage analysis whereby the SCC first examined values related to the individual followed by an examination of the limitations on individual values pursuant to the “principles of fundamental justice”. Writing for the majority of the Supreme Court, Sopinka J rejected the contention related to choosing the matter and timing of one’s own death (the liberty line of

²⁴³ Canadian Charter (n 240) s 7: Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

²⁴⁴ *ibid* s 12: Everyone has the right not to be subjected to any cruel and unusual treatment or punishment.

²⁴⁵ *ibid* s 15: Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability

²⁴⁶ *Rodriguez* (n 7) para 2.

²⁴⁷ *ibid* para 140.

²⁴⁸ *ibid*.

reasoning) and instead viewed the issue as related to life and the choosing of death over life. For Sopinka J, the autonomy aspect of the claim related not so much as to liberty but rather to security of the person in the context of having control over one's bodily integrity. Sopinka J found that even though decisions to end life are not included in the security protection which is aimed at safeguarding life, Ms. Rodriguez' security interests were violated:

In my view, then, the judgments of this Court in *Morgentaler* can be seen to encompass a notion of personal autonomy involving, at the very least, control over one's bodily integrity free from state interference and freedom from state-imposed psychological and emotional stress. In *Reference re ss. 193 and 195.1(1)(c) of the Criminal Code (Man.)*, *supra*, Lamer J. also expressed this view, stating at p. 1177 that "[s]ection 7 is also implicated when the state restricts individuals' security of the person by interfering with, or removing from them, control over their physical or mental integrity". There is no question, then, that personal autonomy, at least with respect to the right to make choices concerning one's own body, control over one's physical and psychological integrity, and basic human dignity are encompassed within security of the person, at least to the extent of freedom from criminal prohibitions which interfere with these.²⁴⁹

Sopinka J held however that the prohibition was in accordance with the principles of fundamental justice, an assessment of which involved the balancing between the interests of the individual's infringed right – autonomy, and the interests of society – the preservation and protection of the vulnerable (a position that would be later echoed by the Strasbourg Court in the *Pretty* case as described above).²⁵⁰ The prohibition was neither arbitrary or overly broad. The review of the legislative and social policy, the history of the provision and the status of the law in various countries led the court to hold that no consensus existed in support of assisted suicide, and to the extent that consensus did exist, "it is that human life must be respected ...". Sopinka J noted that the principle of "sanctity of life" is the starting point from which limited and narrow exceptions can be carved out when notions of personal autonomy and dignity interests must prevail. This was not such a case.²⁵¹

It should be pointed out that Sopinka J also noted that because autonomy and dignity are concepts protected by Section 7, and a breach of Section 7 is only permitted if it is in accordance with fundamental justice, autonomy and dignity could not also constitute principles of fundamental justice, because no breach could ever be justified. Per Sopinka J :

To state that "respect for human dignity and autonomy" is a principle of fundamental justice, then, is essentially to state that the deprivation of the appellant's security of the person is contrary to principles of fundamental

²⁴⁹ *ibid* paras 136-7.

²⁵⁰ See (n 142) and associated text.

²⁵¹ *ibid* para 160.

justice because it deprives her of security of the person. This interpretation would equate security of the person with a principle of fundamental justice and render the latter redundant.²⁵²

In terms of Section 12, Ms. Rodriguez' argument was that the prohibition on assisted suicide had the effect of imposing cruel and unusual treatment because it subjected her to prolonged suffering until her natural death or required that she end her life earlier while she could still do so without help. The court rejected the Section 12 argument on the basis that the criminal prohibition by itself could not be considered "treatment". Section 12 required some form of state control over the individual and that did not exist in this case.²⁵³

With respect to the challenge under Section 15, Ms. Rodriguez argued that s.241(b) discriminated against persons who were unable to terminate their own life without assistance because they are effectively deprived of the right to commit suicide, an option available to other members of the public.²⁵⁴

Preferring not to make any fundamental findings concerning the scope of the Section 15 equality protection, the majority assumed infringement and proceeded to find that any infringement of the equality right would be justified under Section 1 of the Charter,²⁵⁵ that is, the prohibition of assisted suicide had a clearly pressing and substantial legislative objective grounded in the respect for and the desire to protect human life, a fundamental Charter value. The prohibition was also found to be proportional:

Section 241(b) protects all individuals against the control of others over their lives. To introduce an exception to this blanket protection for certain groups would create an inequality. As I have sought to demonstrate in my discussion of s. 7, this protection is grounded on a substantial consensus among western countries, medical organizations and our own Law Reform Commission that in order to effectively protect life and those who are vulnerable in society, a prohibition without exception on the giving of assistance to commit suicide is the best approach. Attempts to fine tune this approach by creating exceptions have been unsatisfactory and have tended to support the theory of the "slippery slope". The formulation of safeguards to prevent excesses has been unsatisfactory and has failed to allay fears that a relaxation of the clear standard set by the law will undermine the protection of life and will lead to abuses of the exception.

There is no halfway measure that could be relied upon with assurance to fully achieve the legislation's purpose; first, because the purpose extends to the protection of the life of the terminally ill. Part of this purpose, as I have explained above, is to discourage the terminally ill from choosing death over

²⁵² *ibid* para 145.

²⁵³ *ibid* para 12.

²⁵⁴ *ibid* para 48.

²⁵⁵ Canadian Charter (n 240) s 1: The *Canadian Charter of Rights and Freedoms* guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.

life. Secondly, even if the latter consideration can be stripped from the legislative purpose, we have no assurance that the exception can be made to limit the taking of life to those who are terminally ill and genuinely desire death.²⁵⁶

The “slippery slope” concerns regarding consequences of legalizing assisted suicide, were thus addressed by the SCC in the Section 7 right to security analysis as well as the Section 15 equality analysis.

The dissent by Chief Justice Lamer focused solely on the Section 15 equality argument to find that the prohibition did create an inequality in that the prohibition prevented persons with physical disabilities from choosing an option available to persons who were able-bodied and that the mere risk of the slippery slope did not justify the prohibition.²⁵⁷ The dissent by McLachlin J on the other hand chose to consider the able-bodied versus disabled-body comparative within the Section 7 security right and described that the risk of the slippery slope was not sufficient to justify the infringement on the right to make decisions concerning one’s own body; any risks could be mitigated by a regulatory regime.²⁵⁸ Contrary to the balancing approach to “fundamental justice” conducted by the majority, McLachlin J found that the Section 7 rights were frustrated because the prohibition was arbitrary (because of the “legality” of suicide for abled-bodied persons) and noted that balancing was more properly conducted under Section 1.²⁵⁹

After the *Rodriguez* decision in 1993, the Attorney General in the Province of British Columbia issued a Crown Counsel Policy Guideline on Euthanasia and Assisted Suicide (the BC Crown Counsel Policy).²⁶⁰ Under the policy, a prosecution is only to proceed when there is a “substantial likelihood of conviction and where prosecution is required in the public interest”.²⁶¹

Similar to the UK DPP Policy, the BC Crown Counsel Policy provides guidance with respect to persons who participated in causing a person’s death but were motivated by *compassion* for that person.²⁶² Unlike the UK policy however, the BC Crown Counsel policy focuses more on the activities of medical practitioners at end of life and appears

²⁵⁶ *Rodriguez* (n 7) paras 186-8.

²⁵⁷ *ibid* paras 48-57, 76-8 (per Lamer J dissent).

²⁵⁸ *ibid* para 198 (per McLachlin J dissent).

²⁵⁹ *ibid* paras 205-8 (per McLachlin J dissent).

²⁶⁰ Ministry of Attorney General, *Active Euthanasia and Assisted Suicide* (File no 56880-01, Eut 1, 1993). The current version of the policy is almost identical to the 1993 policy. See Ministry of Attorney General, *Euthanasia and Assisted Suicide* (File no 56880-00, Eut 1, 2004) <<http://www.ag.gov.bc.ca/prosecution-service/policy-man/pdf/EUT1-EuthanasiaAndAssistedSuicide-15Mar2004.pdf>> accessed 31 May 2012 (BC Crown Counsel Policy).

²⁶¹ *ibid* 1.

²⁶² *ibid*.

to serve more as a clarification of generally accepted ethical medical practices such as withholding and withdrawing of treatment and increases in pain medication with the intention of relieving pain or suffering that may also have the effect of hastening death.

Accordingly, with respect to the “substantial likelihood of conviction”, the BC policy requires Crown Counsel to characterize the conduct and resulting legal consequences the four categories of “active euthanasia”, “assisted suicide”, “palliative care” (defined within the policy as administering medication to relieve pain and suffering that may hasten death) and “withholding or withdrawing treatment”.²⁶³ When characterizing conduct, the factors to be considered by Crown Counsel include:²⁶⁴

1. the intention of the person *vis a vis* the criminal intents necessary for murder and counselling or aiding suicide.
2. when the conduct involves a physician and patient, medical expert opinions as to generally recognized and accepted ethical medical practices.
3. whether the act of the physician or a person acting under the general supervision of a qualified medical practitioner constitutes “palliative care” as defined within the policy (pain medication to relieve suffering that may hasten death). Factors here include assessment of whether there is terminal illness, near death with no hope of recovery; severe and unrelenting suffering; whether accepted ethical practices were followed; and participation in a palliative care program.
4. Whether the act of the medical practitioner constitutes withholding or withdrawing treatment. Factors here include assessment of consent; instructions by another person authorized on behalf of the patient; evidence of what the patient would have requested; and whether accepted ethical practices were followed.

If there is a substantial likelihood of conviction, Crown Counsel must then assess whether the public interest requires a prosecution. The factors to be considered when determining whether the public interest requires a prosecution are:²⁶⁵

1. the importance of supporting proper professional and ethical standards within health care professions;
2. society’s interest in the protection of vulnerable persons;

²⁶³ *ibid* 1-2.

²⁶⁴ *ibid* 2-3.

²⁶⁵ *ibid* 4.

3. society's interest in protecting the sanctity of human life, recognizing this does not require life to be preserved at all costs.

To date, no other Canadian province has issued similar prosecutorial guidelines.

Carter v. Canada (Attorney General)

In April 2011, a claim was commenced against the Attorney General of Canada (AG Canada) seeking declarations that the Criminal Code provisions that prohibit euthanasia and assisted suicide are unconstitutional.²⁶⁶ The British Columbia Supreme Court (BCSC) agreed but the declaration was suspended for one year to allow Parliament to respond. The Plaintiff Taylor who suffers from ALS was however provided with a constitutional exemption in order to allow her to proceed with assisted death in the interim (discussed further below).²⁶⁷

The *Carter* claim was filed by the British Columbia Civil Liberties Association, Gloria Taylor a 64 year old woman suffering from ALS, a physician willing to participate in PAS or euthanasia, and the daughter and son-in-law of Kay Carter, an 88 year old woman who suffered from spinal stenosis, (a progressive condition involving the narrowing of the spine which leads to limb weakness, lack of coordination, loss of sensation, pain and paralysis).²⁶⁸ The daughter and son-in-law of Mrs. Carter arranged and travelled with her to Switzerland where she died with the assistance of Dignitas in 2010. The Plaintiffs in the case challenged the validity of the various Sections in the Criminal Code²⁶⁹ that would prohibit PAS and euthanasia and claimed a constitutionally protected right to PAS and euthanasia on the basis of Section 7 (life, liberty and security rights) and Section 15 (equality rights) of the Charter.²⁷⁰

The Plaintiffs also challenged the prohibitions on the basis of constitutional division of powers and interjurisdictional immunity.²⁷¹ In its pleadings, the Plaintiffs argued that because PAS and euthanasia are matters related to health services, the practice of medicine and the regulation of the patient-physician relationship, the federal criminal jurisdiction does not apply and/or there should be a limited grant of immunity to allow PAS and euthanasia to fall within the Province of British Columbia's jurisdiction as

²⁶⁶ *Carter* Amended Notice of Civil Claim (n 6) part 2, paras 1-8; See also *Carter* (n 6) para 1.

²⁶⁷ *Carter* Amended Notice of Civil Claim *ibid*; *Carter* (n 6) para 1411.

²⁶⁸ *Carter* Amended Notice of Civil Claim *ibid* part 1, para 14; See also *Carter* *ibid* paras 57-60.

²⁶⁹ *Carter* Amended Notice of Civil Claim *ibid* part 1, paras 65-70: ss 241 (counsel or aid or abet a person to commit suicide), s 22(3) ("procure"); s 14 (cannot consent to own death), s 21(1)(b) and (2) (party to offence), s 222 (homicide).

²⁷⁰ *ibid* part 1, paras 7-9.

²⁷¹ *ibid* part 2, para 1.

part of its provincial powers.²⁷² It should be pointed out that the gist of the Plaintiffs' argument on this jurisdictional issue is that the "patient-physician relationship" positions AD as a health issue and thus falls to provincial regulation as opposed to federal criminal jurisdiction. The Plaintiffs in addition to seeking protection for physician involvement in PAS and euthanasia, sought protection for "the act of any person acting under the general supervision of a medical practitioner",²⁷³ presumably in order to extend protection to those involved in an organized form PAS and euthanasia. As observed throughout the jurisdictions canvassed in Chapter III of this discussion, organized PAS and euthanasia models demonstrate not only the ongoing criminal regulation of AD but also that the physician-patient nexus exists on a proximity spectrum ranging from circumstances where a physician knows the patient very well (e.g. The Netherlands) to circumstances a physician may have significantly less involvement (e.g. Switzerland). Thus to advance an AD model solely as a health related matter would be a noteworthy departure from other AD models. The Plaintiffs did not pursue this argument at trial.

The Plaintiffs' Section 7 argument runs along the same lines as those made in *Rodriguez*:

1. that the *right to life* is infringed by the deprivation of the individual right to make and carry out the decision to end one's own life (note the collapsing of the right to choose with a right to die);
2. that the *right to liberty* is infringed by interfering with the individual right to a protected sphere of autonomy over decisions of fundamental personal importance including the choice to live or die and to control the when and how of one's death; and
3. the *right to security* is infringed by restricting the right and ability of the individual to make and act upon decisions concerning his or her own body and to control matters fundamental to physical, emotional and psychological integrity and by the resultant impairment to his or her human dignity.²⁷⁴

The Plaintiffs in *Carter* asserted that the deprivation of Section 7 rights was not in accordance with fundamental justice because the provisions were both "arbitrary", "overbroad" and "grossly disproportionate". Similar to the *Rodriguez* argument, the Plaintiffs argued that arbitrariness arises given the legality of the right and ability to withdrawal or discontinuance of life-sustaining treatment by "grievously and

²⁷² *ibid* part 2, para 17; *ibid* part 3, paras 2 and 3.

²⁷³ *Carter* (n 6) paras 44-76; See also *Carter* Amended Notice of Civil Claim *ibid* part 1, paras 7 and 8.

²⁷⁴ *Carter* Amended Notice of Civil Claim *ibid* part 2, paras 5 and 6.

irremediably ill” persons or substitute decision makers.²⁷⁵ With respect to the provisions being overbroad, the argument was that the provisions prohibit more conduct than is necessary to achieve state objectives, that is, AD could be limited to grievously and irremediably ill persons who genuinely desire death.²⁷⁶ The Plaintiffs also argued that gravity of the infringement of the *Charter* rights of grievously and irremediably ill persons who are denied access to AD are grossly disproportionate to the benefit and legislative purpose of the law.²⁷⁷

In addition to the foregoing, the Plaintiffs advanced an argument regarding infringement of the right to liberty of the assistor (physician or other). The Plaintiffs stated that the liberty right of the assistor is engaged on the basis of prosecution or threat of prosecution and that in order to give meaning to the Section 7 rights of the “grievously and irremediably ill person”, the rights of the assistor must also be protected.²⁷⁸ According to the BCSC, while these adjudicative facts (facts relating to the parties and the “who, what, when and where of the events”) distinguished the *Rodriguez* and *Carter* claims, they did not do so in any meaningful way in terms of *stare decisis*.²⁷⁹

The Section 15 equality argument made in *Carter* was also similar to the *Rodriguez* equality argument i.e. that the provisions do not have the same effect on persons with requisite physical ability, that is, “persons unable to act to die without assistance are deprived of the ability to choose and carry out their death in a lawful way whereas the impugned provisions do not have that same effect on persons of requisite physical ability”.²⁸⁰

Despite the similarities between the two cases, Smith J of the BCSC held that the principle of *stare decisis* did not operate to bar the Section 15 and Section 7 claims in *Carter*. According to the court, with respect to Section 15, *Rodriguez* did not actually address whether or how the Section 15 equality right was infringed by s.241(b)²⁸¹ (it only assumed infringement) and furthermore only summarily addressed the balancing of salutary and deleterious effects of the legislation pursuant to Section 1, the final branch (and a “particularly fact-intensive branch”) of the test for justification under the *Charter*.²⁸² Additionally, *Rodriguez* did not decide whether the “right to life” under

²⁷⁵ *ibid* part 2, para 18.

²⁷⁶ *ibid* part 2, para 19.

²⁷⁷ *ibid* part 2, para 20.

²⁷⁸ *ibid* part 3, paras 12-7.

²⁷⁹ *Carter* (n 6) paras 938-42.

²⁸⁰ *Carter* Amended Notice of Civil Claim *ibid* part 3, paras 23-7.

²⁸¹ *Carter* (n 6) paras 936, 988.

²⁸² *ibid* paras 936, 989, 997, 1006.

Section 7 was engaged by s.241(b) of the Criminal Code (assisted suicide prohibition).²⁸³ Finally, although *Rodriguez* explicitly considered “arbitrariness”, the case did not address whether the deprivation of security or liberty was contrary to the principles of “overbreadth” and “gross disproportionality”, two principles that had joined the “pantheon of principles of fundamental justice” in addition to “arbitrariness”.²⁸⁴

Smith J also noted that the most notable difference between the *Carter* and *Rodriguez* records, was the inclusion of: legislative and social fact evidence pertaining to “the experience with legal physician-assisted death in Oregon, Washington, Belgium, Luxembourg and the Netherlands and with assisted death in Switzerland; opinion evidence of medical ethicists and practitioners informed by the experience in jurisdictions with legalized assisted death; specific evidence pertaining to current palliative care and palliative or terminal sedation practices; and evidence regarding prosecution policies in British Columbia and the United Kingdom ...”.²⁸⁵ According to Smith J, significantly and materially different legislative facts in combination with a change in legal principles warranted a fresh inquiry under Section 1.²⁸⁶

On the issue of equality, the court described that substantive equality is not limited to cases where a *benefit* has been provided by the law (there is no right to suicide conferred by government), but rather encompasses claims “for the removal of *burdens* imposed by the law, where those burdens are based on characteristics (such as disability) specified in Section 15 or analogous to them.”²⁸⁷ Furthermore, although both disabled and able-bodied persons are equally denied access to PAS or euthanasia (the Crown’s argument), this argument ignores the “adverse impact/unintended effects discrimination analysis central to the equality approach”.²⁸⁸

Accordingly, the BCSC found that the Criminal Code absolute prohibition on assisted suicide had a more burdensome effect on persons with physical disabilities than on others and created a distinction on the basis of physical disability – an enumerated ground.²⁸⁹ The Court held that the distinction was discriminatory because, in looking at the actual impact and effect of the law (as opposed to conducting a formalistic analysis), the law “perpetuates and worsens a disadvantage experienced by persons

²⁸³ *ibid* paras 924, 936.

²⁸⁴ *ibid* paras 927, 936, 985, 1007.

²⁸⁵ *ibid* para 944, 998.

²⁸⁶ *ibid* para 998.

²⁸⁷ *ibid* para 1064.

²⁸⁸ *ibid* para 1073.

²⁸⁹ *ibid* para 1077.

with disabilities.”²⁹⁰ According to the court, the “dignity of choice”, in this case of an “ultimately personal and fundamental choice”, is not afforded to Canadians equally pursuant to the law as it currently stands and is an infringement of the right to equality.²⁹¹ This determination would be consistent with the view of dignity *qua* autonomy whereby all people are to be equal in dignity and in rights, in this case the right to choose.

The BCSC also found that the prohibition on assisted death was not a reasonable limit pursuant to Section 1 of the Charter. When commencing its analysis as to (1) whether the purpose for the limit was “pressing and substantial” and (2) whether the means by which the purpose is furthered was “proportionate”,²⁹² the BCSC clarified that it wasn’t the overall prohibition that required justification but rather the infringing nature of the prohibition on persons with disabilities.²⁹³

In identifying the purpose of the legislation, the BCSC rejected the Crown arguments that the assisted suicide prohibition served broad objectives related to the states’ interest in the preservation of life and reflected state policy that human life should not be depreciated by allowing one person to take another’s life.²⁹⁴ Rather, the court read down the prohibition to identify a much narrower objective, that is, to protect vulnerable persons from being induced to commit suicide in times of weakness. (This is consistent with the Strasbourg Court’s interpretation of the prohibition against assisted suicide in the *Pretty* case).²⁹⁵ The court then stated that the narrow objective served the broader state interest underlying it, that is, the protection of life and maintenance of the Charter value that human life should not be taken.²⁹⁶ In responding to the Crown argument that the blanket prohibition was necessary to eliminate all risk to vulnerable persons, the court agreed with the Plaintiffs’ argument that the narrow legislative objective could not be prevention of all wrongful deaths given the absence of regulation regarding other accepted end-of-life practices such as withdrawing or withholding of treatment and administering of palliative sedation.²⁹⁷ The court again

²⁹⁰ *ibid* para 1161.

²⁹¹ *ibid*.

²⁹² *ibid* para 1169: The analytical framework for Section 1 analysis: “Is the purpose for which the limit is imposed pressing and substantial? (2) Are the means by which the legislative purpose is furthered proportionate? (a) Is the limit rationally connected to the purpose? (b) Does the limit minimally impair the *Charter* right? (c) Is the law proportionate in its effect?”

²⁹³ *ibid* para 1171.

²⁹⁴ *ibid* paras 1185-90.

²⁹⁵ *Pretty* (n 3) para 74.

²⁹⁶ *ibid*; See also para 1362: “To reiterate, the purpose of the prohibition against assisted suicide is the protection of vulnerable persons from being induced to commit suicide at times of weakness, a purpose grounded in the respect for and the desire to protect human life.”

²⁹⁷ *ibid* para 1198; Note that this argument is the flip side of the third argument raised by the plaintiff in *Nicklison* that “existing domestic law and practice do not adequately regulate

noted that a legislative objective cannot be so precise as to “effectively immunize the law from scrutiny” at the minimal impairment stage.²⁹⁸

Bound by *Rodriguez*, Smith J found that the objective of preventing vulnerable people from committing suicide was pressing and substantial²⁹⁹ and that there was a rational connection between objectives and the prohibition on assisted death.³⁰⁰ However, notwithstanding that Parliament was owed some deference,³⁰¹ the BCSC held that there were alternative less harmful/drastring means of achieving the legislative goal³⁰² (which again could not be so precise as to avoid scrutiny).³⁰³ The evidence from other jurisdictions where AD had been legalized did not demonstrate a practical slippery slope³⁰⁴ and did not support a conclusion that legalization of AD, disproportionately impacts socially vulnerable groups such as the elderly or those with disabilities.³⁰⁵ According to the court:

A less drastic means of achieving the objective of preventing vulnerable persons from being induced to commit suicide at times of weakness would be to keep the general prohibition in place but allow for a stringently limited, carefully monitored system of exceptions. Permission for physician-assisted death for grievously ill and irremediably suffering people who are competent, fully informed, non-ambivalent, and free from coercion or duress, with stringent and well-enforced safeguards, could achieve that objective in a real and substantial way.³⁰⁶

Concluding on the equality analysis, the BCSC held that the benefits of the prohibition “were not worth the costs of the rights limitation they create”.³⁰⁷ Benefits or “salutary effects” identified by the court included: the anti-suicide message; the message of the value of every life including lives of those who are disabled or elderly; the simplicity and clarity of the law; and the “presumed” effect on maintaining a high social value on human life.³⁰⁸ The cost or “deleterious effects” of the limitations on rights on the other hand included: the negative message that the wishes of persons who are physically disabled, grievously ill and suffering intractably are not as important as other considerations; the denial of the comfort of an “exit strategy”; requiring persons to

euthanasia in breach of Article 2 of the European Convention.” *Nicklison* (n 162) para 5. See also (n 162) and associated text.

²⁹⁸ Carter (n 6) para 1201.

²⁹⁹ *ibid* para 1204.

³⁰⁰ *ibid* para 1209.

³⁰¹ *ibid* paras 1179, 1228.

³⁰² *ibid* para 1226, 1232.

³⁰³ *ibid* para 1231.

³⁰⁴ *ibid* para 365: “... the concern that even carefully crafted criteria will, over time, be reinterpreted or ignored, leading to euthanasia or assisted suicide of people never contemplated at the outset”.

³⁰⁵ *ibid* paras 1238-42.

³⁰⁶ *ibid* para 1243.

³⁰⁷ *ibid* para 1266.

³⁰⁸ *ibid* paras 1265, 1268, 1275.

take steps to end life earlier than would otherwise have to; and the categorical denial of autonomy to persons who are suffering while they face death “in any event”.³⁰⁹

The BCSC noted that it believed that the salutary effects of the legislation could be preserved by “leaving an almost-absolute prohibition in effect, and permitting only stringently limited exceptions”.³¹⁰

With respect to the Section 7 arguments, the BCSC consistent with *Rodriguez*, held that the legislation engaged the Plaintiff Ms. Taylor’s security of the person interest, that is, personal autonomy involving control over one’s bodily integrity. The court further found, based on subsequent courts’ interpretation of *Rodriguez*,³¹¹ that the legislation also engaged Ms. Taylor’s liberty interest in the same manner as the security interest. The court also held the liberty interest to be engaged on the basis of a right to non-interference by the state with fundamentally important and personal medical-decision-making.³¹² The liberty interest of the persons who assist or support a person to obtain assisted death was conceded by the Crown.³¹³ The BCSC noted that the essence of the Plaintiffs’ claim related primarily to these two interests – security of the person (i.e. quality of life) and liberty (i.e. non-interference).³¹⁴

With respect to right to life argument, the Plaintiffs pled that the right to life carries with it a right to make and carry out the decision to end one’s own life,³¹⁵ an argument similar to that which was argued and rejected in the U.K. *Pretty* case. The BCSC, consistent with the European courts, held that the right to life could only be engaged where there was a threat of death.³¹⁶ Smith J however also elaborated a novel right to life argument that appears to have emerged out of the narratives surrounding the equality argument³¹⁷ – i.e. the argument concerning the inability of a person with physical disability to commit suicide within the bounds of the law, while that option is available to those who are physically-abled. The argument that emerged from the court is that the right to life becomes engaged “because the provisions may cause her to end her own life earlier than she would otherwise want to, out of fear that the progression of her illness will prevent her from doing so later.”³¹⁸ According to the

³⁰⁹ *ibid* paras 1266, 1276-81.

³¹⁰ *ibid* para 1283.

³¹¹ *ibid* 1303.

³¹² *ibid* paras 1302-3.

³¹³ *ibid* para 1294.

³¹⁴ *ibid* paras 1321.

³¹⁵ *Carter* Amended Notice of Civil Claim (n 6) part 3, para 5; *Carter* (n 6) para 1307.

³¹⁶ *Carter* *ibid* para 1320.

³¹⁷ But see *ibid* para 1309.

³¹⁸ *ibid* para 1309.

BCSC, the right to life was implicated “in the sense of a right not to die.”³¹⁹ The legislation therefore had the effect of “forcing an earlier decision and possibly an earlier death on persons in Ms. Taylor’s situation.”³²⁰ As described earlier, while this interpretation appears consistent with the Strasbourg Court view in *Pretty* that the right to life cannot carry with it the right to die,³²¹ it is not as clear that Smith J’s interpretation has not created a right to self-determination “in the sense of conferring on an individual the entitlement to choose death rather than life.”³²²

On the issue of whether the Section 7 infringement was in accordance with fundamental justice, the court looked at principles of arbitrariness, overbreadth and gross disproportionality. With respect to arbitrariness, the court deferred to *Rodriguez* which held that the blanket prohibition could not be said to be arbitrary or unfair or that it was not reflective of fundamental values at play in society.³²³ In *Rodriguez*, this was the stage where the Supreme Court of Canada balanced interests between the individual and the state and in so doing considered the ample evidence from other jurisdictions where the illegality of assisted suicide had been preserved. The BCSC refrained from re-entering the discussion of ongoing legislative prohibition articulating instead that having reviewed the evidentiary record,³²⁴ it did not find there to be a bright line ethical distinction, in an individual case, between physician assisted dying (PAS or euthanasia) and other currently accepted end-of-life practices.³²⁵

With respect to overbreadth, the BCSC line of questioning largely paralleled its Section 1 analysis concerning the narrow objective of the legislation and largely centred around the evidence from permissive AD jurisdictions: “Is an absolute prohibition the least restrictive means of preventing the inducement to suicide of vulnerable persons? Is an absolute prohibition necessary in order for the state to achieve its objective?”³²⁶ According, to the BCSC, an absolute prohibition might be called for if: the evidence showed that physicians would fail to understand or apply informed consent for medical treatment; if the evidence from permissive jurisdictions demonstrated the reality of a practical slippery slope; or if physician-assisted death was clearly inconsistent with medical ethics.³²⁷ The BCSC found otherwise:

³¹⁹ *ibid* para 1322.

³²⁰ *ibid* para 1322, 1325.

³²¹ *Pretty* (n 3) para 40.

³²² *ibid* para 39.

³²³ *Carter* (n 6) paras 1335-7.

³²⁴ *ibid* part VII.

³²⁵ *ibid* para 1336.

³²⁶ *ibid* para 1363; See also *ibid* para 1362: “To reiterate, the purpose of the prohibition against assisted suicide is the protection of vulnerable persons from being induced to commit suicide at times of weakness, a purpose grounded in the respect for and the desire to protect human life.”

³²⁷ *ibid* paras 1365-9.

I have found that the evidence supports the conclusion that a system with properly designed and administered safeguards could, with a very high degree of certainty, prevent vulnerable persons from being induced to commit suicide while permitting exceptions for competent, fully-informed persons acting voluntarily to receive physician-assisted death.

...
as set out in my review of the evidence with respect to safeguards, in the opinion of a number of respected ethicists and practitioners, physician-assisted death in an individual case is not ethically distinguishable from currently legal and ethically accepted end-of-life practices.

I also take into account the unknown extent to which physician-assisted death and assisted death by non-physicians already occurs in Canada. I have found that the evidence supports the conclusion that such deaths do occur, though likely in a very small number of instances. Moving to a system of physician-assisted death under strict regulation would probably greatly reduce or even eliminate such deaths and enhance the likelihood that only competent, fully-informed, voluntary and non-ambivalent patients would receive such assistance.

I conclude, therefore, that the impugned provisions are overbroad and that the plaintiffs have established their claim under Section 7.³²⁸

On gross disproportionality, the court further stated:

...that the effect of the absolute prohibition on the life, liberty and security of the person interests of the plaintiffs is very severe, and is grossly disproportionate to its effect on preventing inducement of vulnerable people to commit suicide, promoting palliative care, protecting physician-patient relationships, protecting vulnerable people, and upholding the state interest in the preservation of human life.³²⁹

Accordingly, the BCSC declared the prohibitions on assisted death in the Criminal Code to be invalid on the basis of unjustified infringement of the rights to equality, life, security and liberty. In so doing, reminiscent of the comments by Charles J in *Nicklinson*,³³⁰ the court noted that it is the role of Parliament to determine how to rectify the legislation and suspended its declaration of constitutional invalidity for one year in order to allow Parliament time to determine how to rectify the impugned legislation.³³¹ The BCSC however further noted that it was incumbent upon it to specify the circumstances out of which the unconstitutionality arose,³³² and thus provided the BCSC with the opportunity to articulate an AD model based on the factual and legal matrix of the *Carter* claim. It should be noted that the Court did not accept the Plaintiffs' contention that the term "physician-assisted" should include the

³²⁸ *ibid* paras 1367-9.

³²⁹ *ibid* para 1378.

³³⁰ See (n 173) and associated text; *Nicklinson Motion* (n 5) para 42.

³³¹ *Carter* (n 6) para 1399.

³³² *ibid* para 1386.

provision of assistance by persons other than physicians³³³ or that the term “grievously and irremediably ill persons”³³⁴ should incorporate the reference to psychosocial suffering.³³⁵

Accordingly, the general AD model that can be extracted from *Carter*³³⁶ would include PAS or euthanasia (as the terms are understood in the context of this paper) for adults who are competent, fully-informed and non-ambivalent³³⁷ and who are free from coercion and undue influence and are not clinically depressed when making the request. The request cannot be through a substitute decision-maker.³³⁸

With respect to the requisite condition, the individual must be in a “state of advanced weakening capacities” with “no chance of improvement” arising from a serious illness, disease or disability (including disability arising from injury) without remedy and are enduring physical or psychological suffering intolerable to that person which cannot be alleviated by medical treatment. The availability of treatment is determined by what treatment options are acceptable to the individual.

Procedurally, access to PAS or euthanasia is to take place within the context of the physician-patient relationship and thus requires medical assessment of the substantive criteria including: diagnosis of the illness; the state of weakening capacities; and, on the basis of what is acceptable to the patient, the lack of remedy for the illness and the inability to alleviate intolerable suffering.

It is important however to observe that Smith J imposed the additional substantive requirement of “Materially physically disabled or soon to become so” to the framework of the AD scheme that would stem from the Section 15 equality infringement and further limited an equality-grounded AD scheme to PAS.³³⁹ These additional constraints are derived logically from the nature of the equality argument whereby the infringement rests on the “arbitrary” distinction between able-bodied persons who are able to commit suicide within the bounds of the law to disabled-bodied persons who are not. This approach runs contrary to the interpretation of equality protection articulated by the Strasbourg Court in *Pretty*.³⁴⁰

³³³ *ibid* para 1389; See also *Carter* Amended Notice of Civil Claim (n 6) part 1, paras 7 and 8.

³³⁴ *Carter* Amended Notice of Civil Claim (n 6) part 1, paras 7 and 8.

³³⁵ *Carter* (n 6) paras 1389-90.

³³⁶ *ibid* paras 1388-93.

³³⁷ Non-ambivalence is described in the plaintiffs claim as a “continuing and genuine desire for death”. *Carter* Amended Notice of Civil Claim (n 6) part 1, paras 59.

³³⁸ *ibid* part 1, para 72-73.

³³⁹ *Carter* (n 6) para 1393.

³⁴⁰ See discussion at (n 145) and associated text.

In October 2011, six months after the *Carter* claim was filed in the province of British Columbia, a claim challenging the constitutional validity of the criminal prohibition on assisted suicide was filed in the province of Quebec (the *LeBlanc* case).³⁴¹ Ginette LeBlanc suffers from ALS and is seeking to be able to end her life at a time of her own choosing when her illness and suffering become intolerable.³⁴² While the *LeBlanc* claim points to the same Charter protections as *Carter*, Section 7 (life, liberty and security) and Section 15 (equality) to challenge the Criminal Code provision against assisted suicide, *LeBlanc* does not expressly challenge the provisions that would prohibit the practice of euthanasia.³⁴³ The case is expected to be heard in fall 2012.

iii. Position Statements, Reports and Recent Legislative Initiatives

Since 1991, nine (9) AD bills have been introduced into the House of Commons by private members.³⁴⁴ Of these, six were extensively debated. The most recent bill introduced in May 2009, Bill C-384, *An act to amend the Criminal Code (right to die*

³⁴¹ Notice of Claim, *Ginette LeBlanc v AG Canada and AG Quebec* (No. 400-17-002642-110, Province de Quebec, District de Trois-Rivieres) [author's translation].

³⁴² *ibid* paras 7, 10, 13 and 14.

³⁴³ See however *ibid* para 11 which appears to include the practice of euthanasia, "En raison de ses limites physiques, la demanderesse ne pourra pas sans l'aide d'un professionnel de la santé et/ou celle d'une personne agissant sous la supervision d'un tel professionnel, obtenir et/ou s'administrer la médication et/ou le traitement nécessaire(s) pour mettre fin à ses jours." [authors emphasis].

³⁴⁴ Bill C-203, An Act to amend the Criminal Code (terminally ill persons), 3d Sess., 34th Parl., 1991, (Introduced by Mr. Robert Wenman and pertained to withholding or withdrawing life sustaining treatment on request or best interests and pain relief in amounts that might cause secondary effect of death. Debated at second reading and sent to committee, no further action taken; Bill C-261, An Act to legalize the administration of euthanasia under certain conditions to persons who request it and who are suffering from an irremediable condition and respecting the withholding and cessation of treatment and to amend the Criminal Code, 3d Sess., 34th Parl., 1991. Introduced by Mr. Chris Axworthy and pertained to withholding and withdrawing life sustaining treatment on request or in best interests, pain relief with possible secondary effect of death as well as euthanasia. Debated at second reading and dropped from the Order Paper; Bill C-351, An Act to amend the Criminal Code (terminally ill persons), 2d Sess., 34th Parl., 1991, (Mr. Robert Wenman) not debated and never went to vote; Bill C-385, An act to amend the Criminal Code (aiding suicide), 3d Sess., 34th Parl., 1992. Introduced by Mr. Svend Robinson and pertained to PAS for terminally ill persons. Not debated and never went to vote; Bill C-215, An Act to amend the Criminal Code (aiding suicide), 1st Sess., 35th Parl., 1994, (1st reading 16 February 1994. Introduced by Mr. Svend Robinson and pertained to PAS for terminally ill persons. Debated and dropped from the Order Paper; Bill C-407, An Act to amend the Criminal Code (right to die with dignity), 1st Sess., 38th Parl., 2005. Introduced by Ms. Francine Lalonde and pertained to amending the criminal code to permit PAS and euthanasia for persons with terminal illness or severe physical mental or physical pain with not prospect of relief. Person assisting must be a medical practitioner or person assisted by medical practitioner. Debated but not voted on due to a federal election; Bill C-562, An Act to amend the Criminal Code (right to die with dignity), 2d Sess., 39th Parl., 2008, Introduced by Ms. Francine Lalonde and almost identical to C-407 except assistance limited to medical practitioners. The bill was not debated and never went to vote; Bill C-384, An act to amend the Criminal Code (right to die with dignity), 2d Sess., 40th Parl., 2009. Introduced by Ms. Francine Lalonde and almost identical to C-407 (Bill C-384). The bill was debated and defeated at second reading 228-59 (Bill C-384).

with dignity) (Bill C-384).³⁴⁵ With the exception of the term “lucid”, the amendments sought by Bill C-384 are very similar to the relief sought by the Plaintiffs in *Carter*.

For example, Bill C-384 sought to amend the criminal code provisions related to consent to death (s.14), homicide (s.222) and assisted suicide (s.241) in order to permit PAS and euthanasia for persons who are 18 years of age or older. Additional eligibility criteria included that the individual must be suffering from a terminal illness or severe mental or physical pain without prospect of relief after having tried or refused treatment, and that the individual appear to be lucid when providing the request.³⁴⁶

Procedural safeguards under Bill C-384 included: two written requests 19 days apart identifying that consent is free and informed; a second written confirmation of diagnosis as well as confirmation that the individual is informed of consequences and alternatives available.

The House of Commons 2009 debate over Bill C-384 canvassed many issues including: Parliament’s duty to protect human life including the life of vulnerable members of society, such as the elderly and those with disabilities; impacts on the trust relationships between physicians and their patients; experiences from jurisdictions that have legalized AD; the importance of palliative care and the lack of equal access to palliative care in Canada; the adequacy of safeguards; the impact on society; and the message being sent regarding the value of human life.³⁴⁷

The Canadian Senate has also considered the issue of AD. In 1995, following the *Rodriguez* case and 30 days of hearings, a Special Senate Committee established for the purpose of considering PAS and euthanasia issued its report, *Of Life and Death* (the 1995 Senate Report).³⁴⁸ The committee recommended *inter alia* that:

- palliative care programs be a top priority in restructuring of health care systems,³⁴⁹
- criminal code be amended to improve clarification with respect to practices of withholding or withdrawing life-sustaining treatment and the establishment of national guidelines;³⁵⁰ and
- the adoption of advance directive legislation across Canada.³⁵¹

³⁴⁵ Bill C-384 *ibid*.

³⁴⁶ *ibid*.

³⁴⁷ See discussion in *Carter* (n 6) para 111.

³⁴⁸ 1995 Canadian Senate Report (n 13).

³⁴⁹ *ibid* 24.

³⁵⁰ *ibid* 46.

³⁵¹ *ibid* 50.

With respect to assisted suicide, the majority of the committee recommended no changes to the Criminal Code.³⁵² With respect to euthanasia (“voluntary euthanasia”), the majority of the committee also recommended that it remain as a criminal offence but described potential amendments “to allow for a less severe penalty... where there is an essential element of compassion or mercy”.³⁵³ The committee also recommended that further research be undertaken as to the extent, reasons and profile of requests for both assisted suicide and euthanasia.³⁵⁴

The reasons given by the committee for its recommendation that no changes should be made to the existing criminal prohibitions on assisted suicide and euthanasia included the importance of maintaining the fundamental social value of respect for life, “[i]n a pluralistic society, respect for life is a societal value that transcends individual, religious or diverse cultural values”.³⁵⁵ The committee also articulated the concern that legalization could lead to abuses, particularly with respect to vulnerable members of society who are particularly dependent on those around them and on the health care system:

If assisted suicide were legalized and accepted by the community, how could the expectations of the people surrounding the patient not influence his or her decision, particularly if the patient feels she or he is a burden on the family.³⁵⁶

The committee pointed to one of the “slippery slope” concerns that changes in the law concerning competent persons could potentially lead to changes in the law for incompetent persons.³⁵⁷ The committee further articulated that there was a fundamental difference between assisted suicide and euthanasia. With respect to the latter according to the committee, no adequate safeguards could ever be established to ensure that consent was given freely and voluntarily.³⁵⁸ Additionally, raising a different slippery slope concern (this time describing euthanasia as point *B*), the committee described that decriminalizing assisted suicide only would still potentially open the door to euthanasia on the basis that to only allow the former might create inequality contrary to Section 15, particularly for those who are physically incapable of committing assisted suicide.³⁵⁹

³⁵² *ibid* 74.

³⁵³ *ibid* 88-9.

³⁵⁴ *ibid*.

³⁵⁵ *ibid* 71.

³⁵⁶ *ibid*.

³⁵⁷ *ibid*.

³⁵⁸ *ibid* 86.

³⁵⁹ *ibid* 71.

On autonomy, the committee (again implicitly describing another slippery slope concern) noted *inter alia*:

Individual rights must be limited to the extent that they cause harm to other persons. While disallowing assisted suicide may seem unfair or harsh in an individual circumstance, this is outweighed by the negative impact that decriminalization would have on the popular conscience. How can society say that assisted suicide is a valid course of action without sending the message that suicide is appropriate? Since we are aware of an unacceptably high rate of suicide among young people, especially in the aboriginal community, how can we justify any action that suggests assisted suicide is a legitimate response to suffering? Accepting decriminalization would trivialize death and lead to a view of death as a solution to problems.

In addition, these members are of the opinion that dying with dignity is not simply a matter of controlling the time or means of death but involves the right to receive, up to the end, the care needed to relieve one's suffering and to be surrounded by human attention and compassion. It is the right to feel one still has value as a person. Dignity exists when one faces the final stages of life with a feeling of self-worth and with the care, solicitude and compassion to which all human beings are entitled.³⁶⁰

Since 1995, three further reports have been issued by Senate committees with respect to end-of-life care. A report entitled, *Quality of End-of-Life Care: The Right of Every Canadian* was issued in 2000 (the 2000 Senate Report).³⁶¹ The 2000 Senate Report called for change and progress in the advance of end-of-life care programs in Canada in order to ensure that each person in Canada is "entitled to die in relative comfort, as free as possible from physical, emotional, psychological, and spiritual distress."³⁶² A 2005 follow-up report, *Still Not There: Quality End-of-Life Care: A Progress Report* (2005 Senate Report),³⁶³ called for the ongoing education and training of health care professionals in end-of-life care and again called for continued research in end-of-life matters. The most recent Senate report, *Raising the Bar: A Roadmap for the Future of Palliative Care in Canada*³⁶⁴ was tabled in 2010 and noted that at least 90% of Canadians at end-of-life can benefit from palliative care. Notwithstanding certain improvements to end-of-life care in Canada, the 2010 Report calls for further development in palliative care to ensure access to quality palliative care for all Canadians.³⁶⁵

³⁶⁰ *ibid*.

³⁶¹ The Senate Subcommittee to update "Of Life and Death" of the Standing Senate Committee on Social Affairs, Science and Technology, *Quality of End-of-Life Care: The Right of Every Canadian* (Parliament of Canada, Final Report, June 2000) <<http://www.parl.gc.ca/Content/SEN/Committee/362/upda/rep/repfinjun00-e.htm>> accessed 31 May 2012.

³⁶² *ibid* Conclusions.

³⁶³ Sharon Carstairs, *Still Not There: Quality End-of-Life Care: A Progress Report* (June 2005) <http://www.chpca.net/media/7883/Still_Not_There_June_2005.pdf> accessed 31 May 2012.

³⁶⁴ The Senate of Canada, *Raising the Bar: A Roadmap for the Future of Palliative Care in Canada* 2010 Senate Report (June 2010) <http://www.chpca.net/media/7859/Raising_the_Bar_June_2010.pdf> accessed 31 May 2012.

³⁶⁵ *ibid* 18.

In November 2011, a report on end-of-life decision-making was released by an expert panel appointed by the Royal Society of Canada, (the 2011 RSC Report)³⁶⁶ and in March 2012, a Select Committee established in 2009 by the Assemblée National Québec to study end-of-life issues, palliative care and euthanasia released its report “Dying with Dignity” (the “2012 Quebec Report”).³⁶⁷ Both reports recommended legalization of AD and both were considered in the *Carter* case. However, because the reports were released after evidentiary deadlines and were also challenged by the defendants on a number of grounds (including the concern that three of the authors of the RSC Report were consultants for the Plaintiffs in *Carter*), the BCSC admitted the reports only for the recommendations made but not as evidence of the truth of their contents.³⁶⁸ It should be pointed out that the BCSC in *Carter* considered numerous additional reports including the Canadian Senate committee reports described above and concluded that the “substantial majority of committees that have studied the question, in Canada and elsewhere, oppose physician-assisted death but a minority support it.”³⁶⁹

The identified purpose of the RSC Report was to “revisit the public policy questions surrounding assisted death in light of new evidence and arguments” since the 1995 Senate Report.³⁷⁰ The RSC panel was tasked with *inter alia*: summarizing relevant medical science evidence; presenting evidence from various jurisdictions; reviewing the pros and cons of physician-assisted death decriminalization and proposing policy recommendations for public consideration.³⁷¹ The RSC panel report addressed in turn: the status of end-of-life care in Canada; end-of-life law in Canada; the ethics of end-of-life care; the experiences of jurisdictions that have permissive AD regimes; and proposals for reform.

A significant portion of the RSC Report addressed palliative care in Canada. On that issue, the panel concluded that “Canada performs poorly in ensuring access to high

³⁶⁶ The Royal Society of Canada, the Academies of Arts, Humanities and Sciences of Canada (RSC) is a senior national, bilingual body of Canadian scholars, humanists, scientists, and artists “whose objective is to promote learning and research in the arts, the humanities and the sciences.” The RSC commissioned panel was comprised of six Canadian and international experts on bioethics, clinical medicine, health law and policy, and philosophy. Royal Society of Canada Expert Panel, *End-of-Life Decision Making* (RSC, November 2011) 1. (RSC 2011 Report).

³⁶⁷ Commission Spéciale, *Mourir dans la dignité* (Assemblée Nationale Québec, March 2012) <<http://www.assnat.qc.ca/fr/actualites-salle-presse/nouvelle/actualite-25939.html>> accessed 31 May 2012 (Quebec 2012 Report).

³⁶⁸ *Carter* (n 6) paras 119-36

³⁶⁹ *ibid* para 7.

³⁷⁰ RSC 2011 Report (n 366) 5.

³⁷¹ *ibid* 5-6.

quality palliative care. Governments should increase efforts to achieve goals for standards of palliative care established in multiple reports and commissions.”³⁷²

With respect to end-of-life care in Canada, the RSC panel identified that “a significant majority of the Canadian population appears to support a more permissive legislative framework for voluntary euthanasia and assisted suicide”.³⁷³ The RSC panel identified such support notwithstanding that it had also noted that the attitudes and perspectives of the very old toward assisted death haven’t been ascertained and furthermore that the literature hasn’t fully considered Canadian cultural perspectives including those of First Nations.³⁷⁴

On the issue of end-of-life law in Canada, the RSC panel concluded *inter alia* that the legal status of assisted suicide and voluntary euthanasia is “hotly contested”.³⁷⁵ With respect to the ethics of end-of-life care, the panel reviewed Canadian political and legal culture in order to identify Canadian core values with respect to competent agents and assisted death. Core Canadian values identified by the panel included respect for individual autonomy and self-determination as well as the protection of vulnerable citizens and the promotion of human dignity.³⁷⁶

With respect to autonomy, in order to strike a balance between over-simplified procedural conceptions of autonomy and over-paternalistic substantive conceptions of autonomy, the RSC panel identified that it was guided by and adopted the doctrine of *informed choice*, “a central pillar of contemporary health ethics and of Canadian health law”.³⁷⁷ Thus, “an autonomous person would, according to this conception, be a substantively cognitively competent and uncoerced individual who arrives at his or her decisions after having been offered relevant information about the decision at hand.”³⁷⁸ Furthermore, according to the panel, the commitment to autonomy, a “cornerstone” of Canadian constitutional order, “quite naturally yields a *prima facie* right to choose the time and conditions of one’s death, and thus, as a corollary, to *request* aid in dying from medical professionals.”³⁷⁹

The RSC panel concluded:

³⁷² See Royal Society of Canada Expert Panel, *Main Messages — End-of-life Decision Making* (RSC 2011) 1; RSC 2011 Report (n 366) Chapter 1.

³⁷³ RSC 2011 Report *ibid* 28

³⁷⁴ *ibid* 27.

³⁷⁵ *ibid* 36.

³⁷⁶ *ibid* 41-2.

³⁷⁷ *ibid* 43.

³⁷⁸ *ibid*.

³⁷⁹ *ibid* 45.

1. That there is a moral right, grounded in autonomy, for competent and informed individuals who have decided after careful consideration of the relevant facts, that their continuing life is not worth living, to non-interference with requests for assistance with suicide or voluntary euthanasia.

2. That none of the grounds for denying individuals the enjoyment of their moral rights applies in the case of assisted suicide and voluntary euthanasia. There are no third-party interests, self-regarding duties, or duties toward objective goods that warrant denying people the right to assisted suicide and voluntary euthanasia. Prophesied undesirable social consequences are not sufficient to negate the right to choose assisted suicide and voluntary euthanasia. Rather, they should be taken into account in constructing the regulatory environment within which this right can be exercised.

3. That health care professionals are not duty-bound to accede to the request of competent and informed individuals who have formulated the uncoerced wish to die, but they may do so. If their religious or moral conscience prevents them from doing so, they are duty bound to refer their patients to a health care professional who will.³⁸⁰

Having then reached a conclusion that “there are persuasive arguments in support of the development of a legally permissive regime with respect to assisted dying in Canada” the RSC panel looked at the experiences of jurisdictions that accommodate assisted suicide and/or euthanasia. The panel considered some of the standard AD safeguards that have been implemented to conclude that there was no evidence following decriminalization to show the emergence of a slippery slope, harm to the doctor/patient relationship or a “corrosive effect” on palliative care.³⁸¹ Conversely, the panel found that the evidence was that the law is capable of managing decriminalization and state policies can reassure citizens of their safety and well-being.³⁸²

In addition to offering recommendations with respect to withholding and withdrawing treatment, potentially life-shortening symptom relief, terminal sedation, palliative care and end-of-life planning, and training and education, the RSC panel recommended that the Criminal Code be modified so as to permit assisted suicide and euthanasia in carefully circumscribed and monitored circumstances.³⁸³ According to the RSC panel, a federal approach is to be preferred because it would among other things allow for provincial consistency and certainty as to rights and responsibilities as well as the creation of a national oversight body.

While decriminalization of AD through the “mechanism” of Criminal Code reform was its principal recommendation, the RSC panel identified the development of prosecutorial guidelines (which could “spell out the circumstances in which cases of

³⁸⁰ *ibid* 68.

³⁸¹ *ibid* 90-1.

³⁸² *ibid* 90-1.

³⁸³ *ibid* 90-6.

assisted suicide or voluntary euthanasia will not result in charges of assisted suicide or murder being laid”) and the use of prosecutorial discretion (to divert a case away from the traditional court system) as alternative legal mechanisms to AD reform.³⁸⁴

Once the legal mechanism is determined, according to the RSC panel recommendations, the “core elements” of a permissive AD regime should be one where both PAS and euthanasia are available as there is “no morally significant difference” between the two activities. Furthermore, these activities should be provided by health care professionals.³⁸⁵

In terms of substantive due care (i.e. the “features of the patient”), the panel identified the standard requirements of competency when making the request (currently or by advance directive) and that the decision be voluntary and well-informed.³⁸⁶ Consistent with the AD models of the permissive jurisdictions, the substantive requirements recommended by the RSC panel did not however include restriction to a diagnosis of terminal illness. According to the RSC panel, its decision to exclude terminal illness was due to the difficulty in defining the term from a regulatory perspective but also because there was no principled basis to exclude individuals who are suffering greatly and permanently but are not imminently dying.³⁸⁷ Additionally, aligning with the Dutch approach, the RSC panel did not include an age restriction to adults in its recommendations, describing that any age restriction would appropriately flow from the mature minor laws of the particular province.³⁸⁸

The procedural requirements recommended by the RSC panel included a preference for written requests but noted that verbal requests would be sufficient if properly documented. In terms of the time that is to elapse between the initial request and the granting of assistance, the RSC panel recommended that there must be enough time to ensure that the request is voluntary and informed and that the individual is competent and that there must also be a short pause before assistance (for example, twenty-four hours) to ensure all conditions and procedural requirements are met. Beyond that, the panel did not recommend any minimum delay requirements.³⁸⁹ The panel also noted that in terms of assistance by health care professionals, that permission might be granted to others provided they possessed the requisite knowledge and skills to ensure

³⁸⁴ *ibid* 96-9.

³⁸⁵ *ibid* 100-1.

³⁸⁶ *ibid* 100.

³⁸⁷ *ibid* 101.

³⁸⁸ *ibid*.

³⁸⁹ *ibid*.

conditions for access are met.³⁹⁰ Additionally and significantly, the panel noted that “the more restrictive the list of those who are permitted to provide assistance, the less that group should be permitted to refuse to provide assistance.”³⁹¹

Finally, again consistent with the AD models in permissive jurisdictions, the RSC panel recommended the establishment of a national oversight commission tasked with the monitoring and annual reporting of AD in Canada. The role of such a commission would be related to the maintenance of public trust in the system (via data collection and reporting) and the prevention of mistaken or intentional violation of the new law (via assessment of specific cases and follow-up).³⁹² Authority and responsibility to investigate and prosecute violations of the law would remain a criminal matter involving coroners, police and prosecution services.³⁹³

The March 2012 Quebec Report expressed views on both end-of-life care (refusal and termination of treatment, palliative care, palliative sedation) and euthanasia. Similar to the RSC Report, half of the report constitutes a demand for improved palliative care including: improvements related to access; development and healthcare professional training; swift implementation of stronger policies; and public information campaigns concerning end of life issues.³⁹⁴ The other half of the report specifically addresses the issue of “aide médicale à mourir”, that is, medical aid in dying.

Following a discussion on changing social values, medicine and law, the Quebec Select Committee recommended *inter alia* the amendment of relevant legislation to recognize medical aid in dying as part of the “continuum of care” available at the end of life in exceptional circumstances and provided certain criteria are met.³⁹⁵ Accordingly, the committee did not endorse assisted suicide outside the healthcare setting.

The Select committee described that a medical aid in dying option is compatible with the evolution of social values, medicine and law. On social values the committee described the distancing of social values from ideological or religious beliefs to reflect notions of individual freedom, respect for autonomy and the inviolability and integrity of the person. On the evolution of medicine the committee described the recognition of the right to refuse or stop treatment and the benefits of palliative care that focuses

³⁹⁰ *ibid.*

³⁹¹ *ibid.*

³⁹² *ibid.* 102.

³⁹³ *ibid.*

³⁹⁴ Quebec 2012 Report (n 367) Part I and Recommendations 1-12.

³⁹⁵ Assemblée Nationale Québec, Select Committee, *Dying with Dignity: Recommendations* (March 2012) (Quebec 2012 Recommendations); *ibid.* 78, 97.

on the relief of symptoms rather than preserving life at all costs. The committee noted how the Quebec Civil code also recognized these social and medical values. On law, the committee pointed to the absence of criminal prosecution and conviction of physicians in cases of aid in dying.³⁹⁶

With respect to the value of human life and dignity, the committee stated that the option of medical aid in dying is not to diminish the value of human life or the dignity of the person that arises from intrinsic human status. Rather the practice attaches greater importance to the freely expressed and informed will of the individual to end intolerable suffering and respects dignity by allowing the individual, as he or she can throughout his or her life, to judge for him- or her-self, an end consistent with his or her own aspirations and values.³⁹⁷

Accordingly, the three key principles used by the Quebec Select Committee to analyze other jurisdictional experiences and in turn to circumscribe its recommended AD model (particularly with respect to qualifying criteria and safeguards) were identified as:

1. to locate medical aid in dying within the continuum of end of life care;
2. to associate medical aid in dying to the relief of suffering; and
3. to ensure respect for autonomy of the person.³⁹⁸

The Quebec Select Committee preferred not to use the “charged” term “euthanasia”, notwithstanding the recognition of the use of the term in The Netherlands and Belgium, opting instead to use the term “aide médicale à mourir” or medical aid in dying. The term “aid” in dying was expressly used by the committee to demonstrate the value being very near a patient until the very end whereas the term “medical” was used to indicate the nature of the nearness required, that is, the intervention of a physician.³⁹⁹ Thus it is an attending physician who is to assess whether the eligibility criteria are present.

The eligibility criteria described by the Select committee include that:

- the individual be a Quebec resident (as defined by the relevant health insurance law) and an adult with legal capacity to consent to treatment;
- the request is based on a free and informed decision;
- the individual is in an advanced state of weakening capacities with no chance of improvement;
- suffering arises from a serious, incurable disease; and

³⁹⁶ Quebec 2012 Report (n 367) 78-9.

³⁹⁷ *ibid* 80.

³⁹⁸ *ibid* 82.

³⁹⁹ *ibid* 78.

- suffering is constant and unbearable (physical or psychological) and cannot be eased under conditions the individual deems tolerable.⁴⁰⁰

Procedural safeguards include: written and repeated request, consultation by the attending physician with a consulting physician (independent and competent on the disease in question) regarding whether eligibility criteria are met, and a formal declaration of medical aid in dying by the attending physician.⁴⁰¹

Similar to the Belgian approach, the Quebec Select Committee recommended the availability of euthanasia for unconscious patients pursuant to advance directives and further recommended future investigation into the possible use of advance directives to allow euthanasia for persons suffering from dementia.⁴⁰² With respect to euthanasia for unconscious patients, in addition to setting out preferences with respect to aid in dying, the advance directive allows the patient to identify one or more “trusted persons” who can ensure that the directive is known. The directive is to be signed and witnessed by two witnesses one of whom must be a commissioner of oaths. The attending physician must consult another physician independent of the patient and the attending physician, who is to confirm the irreversible nature of the unconsciousness.⁴⁰³ Again, similar to the Belgian model, the Select committee further recommended the establishment of a formal register for aid in dying advance directives which can be canvassed by physician’s to check for the existence of an advance directive in addition to the patient’s medical file.⁴⁰⁴

With respect to review, the committee, consistent with the RSC panel and the AD models for the permissive jurisdictions, recommended the establishment of a control and evaluation body that can verify whether acts were carried out in accordance with the law and to publish both an annual statistical report as well as a five year report regarding implementation of provisions.

In addition to generally acknowledging the right to conscientious objection, the Quebec Select Committee recommended the amendment of physician and nursing codes to allow participation in “medical aid in dying” in accordance with the legal criteria.⁴⁰⁵ Unlike many other medical associations, the Collège des médecins du Québec (the “Quebec Medical College”) has not taken a position against the practice of euthanasia or assisted suicide. Conversely, it has described that there is a “new

⁴⁰⁰ Quebec 2012 Recommendations (n 395) 5.

⁴⁰¹ *ibid* 6.

⁴⁰² *ibid* 8.

⁴⁰³ *ibid* 6 and 7.

⁴⁰⁴ *ibid* 7.

⁴⁰⁵ *ibid*.

sensitivity” “clearly evident among both doctors and the public that there are exceptional situations where euthanasia could be considered by patients and their loved ones and by doctors and other caregivers as a final step necessary to assure quality care to the very end.”⁴⁰⁶

According to the Quebec Medical College, euthanasia as part of the continuum of care available at end of life is not inconsistent with the Code of Ethics of Quebec Physicians, particularly Section 58 which states:

A physician must, when the death of a patient appears to him to be inevitable, act so that the death occurs with dignity. He must also ensure that the patient obtains the appropriate support and relief.

The Canadian Society of Palliative Care Physicians (the “CSPCP”) does not agree with “blending” of palliative care and assisted dying, stating that assisted suicide and euthanasia run counter to the fundamental tenets of the CSPCP and most practitioners of palliative medicine.⁴⁰⁷ Consistent with the Canadian Society of Palliative Care Physicians, the Canadian Medical Association (the “CMA”) is also opposed to assisted suicide and euthanasia.⁴⁰⁸ The BCSC in *Carter* recognized that many professional bodies, including the CMA do not support physician-assisted death, but also noted that notwithstanding that there was disagreement among medical practitioners, there were “respected practitioners who would support legal change” and that in defined cases, with safeguards, physician assisted death would be consistent with their ethical views.”⁴⁰⁹

A recent editorial in the Canadian Medical Association Journal has argued that the assisted death issue is not an issue that should be decided by the courts but rather that “therapeutic homicide” should be part of a democratic process.⁴¹⁰

⁴⁰⁶ Collège des médecins du Québec Physicians, *Appropriate Care and the Debate on Euthanasia: A Reflection* (16 October 2009) 9 <<http://www.cmq.org/en/medias/profil/commun/Nouvelles/2009/~media/208E2B537FB144FAAE33DEB458D3AA90.ashx?110904>> accessed 31 May 2012.

⁴⁰⁷ Canadian Society of Palliative Care Physicians, *CSPCP Position Statement: The Practice of Euthanasia and Assisted Suicide* <<http://www.cspcp.ca/english/Euthanasia%20pos%20state-FINAL4.pdf>> accessed 31 May 2012; Canadian Society of Palliative Care Physicians, “CSPCP adopts position statement in response to DWD report” <<http://www.cspcp.ca/english/WebStoryFINAL4.pdf>> accessed 31 May 2012 (CSPCP Position Statement).

⁴⁰⁸ Canadian Medical Association, *Euthanasia and Assisted Suicide* (CMA Policy, 2007). <<http://policybase.cma.ca/dbtw-wpd/Policypdf/PD07-01.pdf>> accessed 31 May 2012.

⁴⁰⁹ *Carter* (n 6) para 6.

⁴¹⁰ Ken Flegel and John Fletcher, ‘Choosing when and how to die: Are we ready to perform therapeutic homicide?’ (25 June 2012) Canadian Medical Association Journal <<http://www.cmaj.ca/content/early/2012/06/25/cmaj.120961.1.full.pdf>> accessed 30 June 2012.

iv. Alignment and Limits

The majority in *Rodriguez* accepted that the Criminal Code prohibition against assisted suicide engaged the security of the person (bodily integrity) protection. In other words, a “right to choose” AD could not extend from a right to freedom but could extend from a right to exercise control over one’s own body particularly with respect to physical and mental integrity. The majority held however that this protected expression of autonomy – the right to make decisions concerning one’s own body – could nonetheless be infringed if the balance between the individual and society favoured the interests of society. In this case, the majority found that the balance was in favour of societal interests related to the preservation and protection of its vulnerable members.

The 1993 *Rodriguez* case was influential in the later U.K. decisions of *Pretty* and *Purdy*, having been described by the House of Lords as containing one of the most detailed and erudite discussions on the issue of assisted suicide.⁴¹¹ Additionally, the Strasbourg Court in *Pretty* found that the Section 7 security right under the Canadian *Charter* and the Article 8 privacy right under the European Convention addressed comparable concerns with respect to the notion of autonomy in the sense of the right to make choices about one’s own body,⁴¹² an interpretation of the Article 8 privacy right with which the House of Lords in *Purdy* later concurred.⁴¹³ Because of the articulated comparisons between the Section 7 Charter right and the Article 8 European Convention right, the *Carter* case stands to (dependent on procedural timing) significantly impact the outcome of the *Nicklinson* case currently before the English courts and vice versa, in the case of an appeal.

The *Carter* case prescribes an AD model very similar to the Benelux models – PAS or euthanasia in the context of the physician-patient relationship for voluntary, competent individuals with a genuine desire for death who are irremediably ill and experiencing intolerable suffering (physical or psychological). There are however three discrete legal constructions underlying the *Carter* AD model. Whether or how the distinction between these three constructions will be considered in the event of legislative reform in favour of liberalization of AD in Canada is unknown. However, understanding the underlying justification of a given AD model identifies its internal constraints and in turn assists in identifying the factors critical to stabilizing boundaries or limits. Evidence of the operation of internal constraints can be observed in the “tired of life” discussion in the Netherlands whereby recourse to the necessity underpinning was

⁴¹¹ See discussion in *Purdy* EWCA (n 147) para 35.

⁴¹² *Pretty* (n 3) para 66.

⁴¹³ *Purdy* (n 4) para 34 et seq.

taken in order to maintain the link between suffering and the medical domain.⁴¹⁴ Additionally, an explicit examination of the foundation upon which AD is advanced in terms of constitutional protections is necessary in order to assess whether and to what extent the principle of autonomy is indeed at the heart of this socio-legal evolution.

The equality argument in *Carter* (which is also used to demonstrate arbitrariness under Section 7) that able-bodied persons are able to commit suicide within the bounds of the law while those with disabilities are not, is, for lack of a better phrase, analytically and substantively awkward. As pointed out in the counter-arguments by the defendants, there is indeed no actual right to assisted suicide and the prohibition applies to all, whether able-bodied or disable-bodied. Furthermore, asking a court to carve out an exception for those with disabilities with a legal tool designed to protect persons with disabilities (among other recognized groups) is questionable on the basis that to do so, would undermine the strength of the protection. As put by McLachlin J in the *Rodriguez* dissent, “this is not at base a case about discrimination under Section 15 of the *Canadian Charter of Rights and Freedoms*, and that to treat it as such may deflect the equality jurisprudence from the true focus of Section 15 – ‘to remedy or prevent discrimination against groups subject to stereotyping, historical disadvantage and political and social prejudice in Canadian society.’”⁴¹⁵

In *Carter*, the BCSC addresses these interpretive apprehensions by shifting from the idea of equal protection for a group to the idea of unequal imposition on the choices available to the individual, that is, the prohibition on assisted suicide perpetuates and worsens a disadvantage because it has a more burdensome effect on individuals with physical disabilities:⁴¹⁶ “The dignity of choice should be afforded to Canadians equally, but the law as it stands does not do so with respect to this ultimately personal and fundamental choice.”⁴¹⁷ Accordingly, the Section 15 equality construction provides the choice of assisted suicide (the impugned provision) for persons with “*material* physical disability or soon to become so” (i.e. those unable to physically commit suicide) [author’s emphasis].⁴¹⁸

⁴¹⁴ See discussion in Chapter III.B.1.d; See also KNMG, *Wish to Die* (n 226).

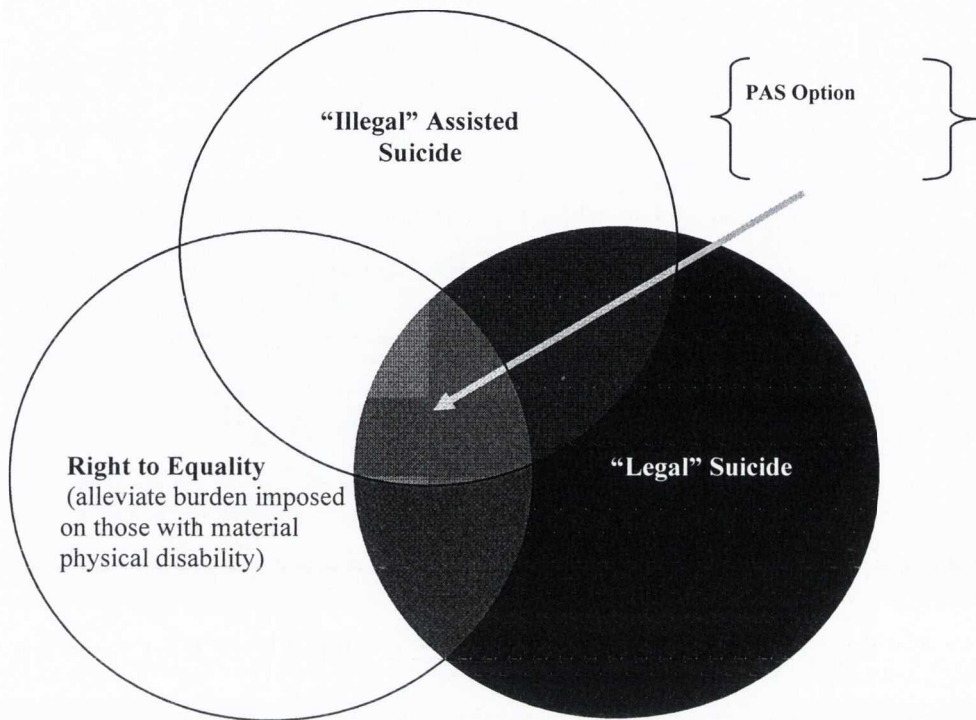
⁴¹⁵ *Rodriguez* (n 7) paras 616-17. See also similar point made by the ECHR in *Pretty* (n 3) para 89.

⁴¹⁶ *Carter* (n 6) para 1077, 1161.

⁴¹⁷ *ibid* para 1161.

⁴¹⁸ *ibid* para 1393.

Figure 12 PAS advanced as equality right for person with material physical disability



Consistent with the equality construction of AD, material physical disability, as recognized by the BCSC, can arise from traumatic injury and therefore will not restrict PAS to cases of terminal illness. However, Smith J imposed further conditions related to the nature of the illness for example, that assisted suicide must occur in the context of the physician-patient relationship, the person must have an illness causing enduring suffering (psychological or physical) and must be in an advanced state of weakening capacities.⁴¹⁹ There is seemingly nothing inherent to the inequality argument that points to these particular limitations,⁴²⁰ except insofar as illness and suffering can be the cause of the material physical disability.

Furthermore, while requisite illness and suffering is illness or suffering that cannot be remedied or alleviated by medical treatment, it is the person who determines whether these criteria are met, based on whether available treatment acceptable to that person. This in turn raises the corollary problem of how does the right to refuse treatment impact on a determination of whether the requisite “material physical disability” is

⁴¹⁹ The phrase “advance state of weakening capacities” was not specifically pled by the plaintiffs, but does appear in the requirements identified under the AD model proposed by the 2012 Quebec Committee. Quebec 2012 Report (n 367).

⁴²⁰ *Carter* (n 6) para 1031.

present or soon to be present, or, put another way, how does the right to refuse treatment impact the threshold of “material physical disability”.⁴²¹

To summarize then, some of the enhanced medical limitations typical of the legislated AD schemes and imposed by the Court in *Carter* pursuant to the equality infringement are not logically derived from the equality argument, and, the limit that is logically prescribed by the equality argument (material physical disability) is potentially destabilized by the imposition of other recognized protections such as the right to refuse treatment. As a result, an AD model grounded on equality protection that also attempts to incorporate medical boundaries is potentially vulnerable to critiques of arbitrariness and inconsistency.

On the other hand, an equality-based AD model, i.e. one grounded on the lifting of the discriminatory burden imposed by the prohibition of assisted suicide on particular individuals with disabilities, clearly relies on a factual matrix that considers the denial of a form of physical agency that would facilitate choice in the relief of suffering,⁴²² the contemplation of taking of one’s life before illness progresses to a point where one is no longer able to do so, and the added suffering associated with such contemplation.⁴²³ Medically-recognized decline or “death in any event”⁴²⁴ is thus *factually* infused into the *Carter* equality analysis and points to incorporation of a medical diagnosis, decision-making within the context of the physician-patient relationship, assessment of the state of advanced weakening capacities (or physical decline) with no chance of improvement and so forth. However it remains that the *medically-recognized decline* is not required to establish the equality infringement which rests squarely on discrimination related to material physical disability and the ending of life act. What also becomes apparent is the significant overlap between the construction of an AD model based on equality rights and the second discrete legal construction of AD under *Carter* – AD based on the infringement of the right to life.

Distinct from previous arguments for AD constructed on a right to life (i.e. the right to make and carry out the decision to end one’s own life),⁴²⁵ the right to life infringement as so held by the BCSC is that the impugned legislation shortens life on the basis that individuals may take their own life while they are physically capable of doing so, at a date earlier than they would find necessary if they could have been assisted.⁴²⁶ Under this construction, because the argument does not turn on the specific assisted suicide

⁴²¹ See *Pretty* (n 3) para 89.

⁴²² *Carter* (n 6) paras 1130, 1156, 1161.

⁴²³ *ibid* paras 1042-8, 1058.

⁴²⁴ *ibid* para 1281.

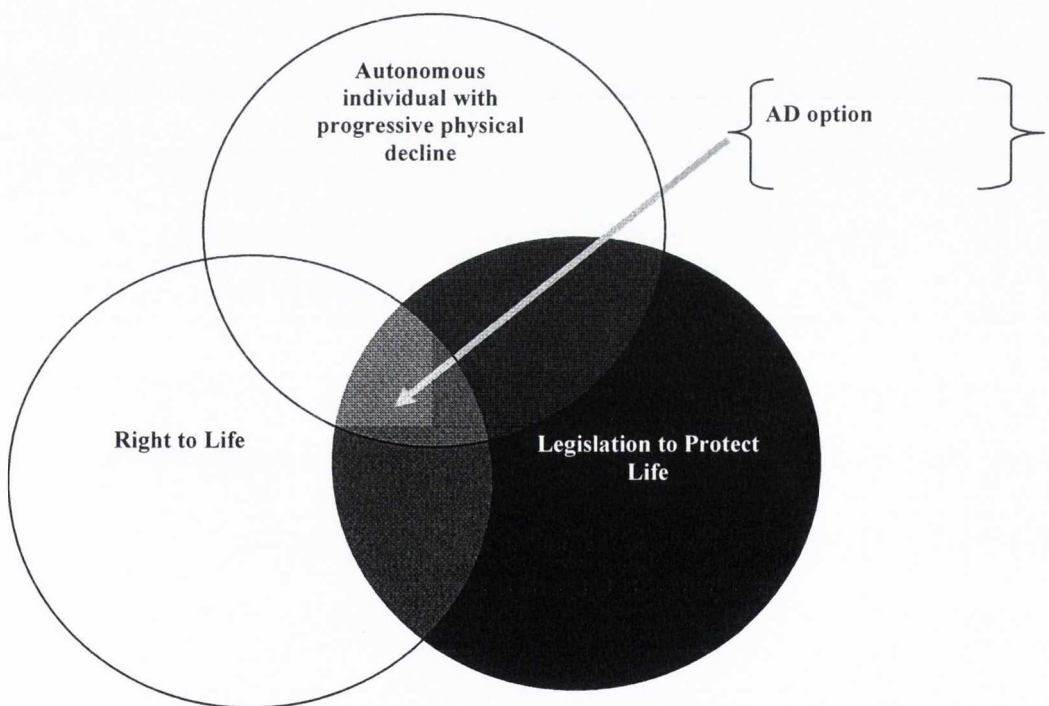
⁴²⁵ *ibid* para 1307.

⁴²⁶ *ibid* 17.

provision in the Criminal Code, the practices of assisted suicide and euthanasia are both implicated.

This particular construction appears consistent with the widely held judicial interpretation that the right to life does not carry with it, a right to die. Rather, the right to life is engaged only when there is a threat of death.⁴²⁷ In this case, the view of the BCSC is that the illegality of assisted death creates a threat of death for persons facing progressive physical decline i.e. “advanced weakening capacities with no chance of improvement”. According to Smith J, “the right to life is engaged by the effect of the legislation in forcing an earlier decision and possibly an earlier death on persons in Ms. Taylor’s situation.” Under this approach the court positions the right to life in conflict with legislative provisions aimed at the protection of life.

Figure 13 AD advanced as right to life for person facing progressive physical decline



The consideration that the right to life can be in conflict with legislation aimed at protecting life signals a perspective consistent with the view that the right to life is to be interpreted from the individual’s perspective, albeit constrained by the requirement of progressive physical decline (which stems from the underlying argument that the legislation has the effect of shortening the lives of person who fear they will be

⁴²⁷ *ibid* para 1320.

physically unable to commit suicide later).⁴²⁸ Thus, although this construction of the right to life cannot be said to be inconsistent with the view that the right to life cannot include a right to die, it nonetheless achieves that result by setting up the right to life and the protection of life as opposing forces, a conflict that only becomes conspicuous when the dilemma is viewed through an autonomy lens. The recognition of such a conflict is similar to how the conflict is perceived under the Luxembourg AD model (Figure 5) which also extends assistance to PAS and euthanasia.

With respect to Section 7 security and liberty rights, the BCSC described the security right as the right to be free from state interference in making choices concerning one's own body, control over physical and psychological integrity and basic human dignity.⁴²⁹ The court described the liberty right as the right to non-interference by the state with fundamentally important and personal medical decision-making.⁴³⁰ The court then described how both rights were deprived by the legislative interference with personal autonomy involving control over one's bodily integrity.⁴³¹ Thus in *Carter*, the right to security and liberty are collapsed and advanced jointly in the context of personal medical decision-making. The court then positions these combined rights against the purpose of the legislation which is described by the court not as a broad protection of life, but rather as a narrower protection of vulnerable persons from being induced to commit suicide in times of weakness.⁴³² Against that narrow conflict, the court asked whether the prohibition was arbitrary, overbroad or grossly disproportionate. Following the precedent set by *Rodriguez*, the BCSC did not find the prohibition arbitrary, but did find the absolute prohibition to be overbroad and grossly disproportionate on the basis that an absolute prohibition is unnecessary to achieve the state's narrow objective – the protection of the vulnerable.

⁴²⁸ *ibid* para 1322.

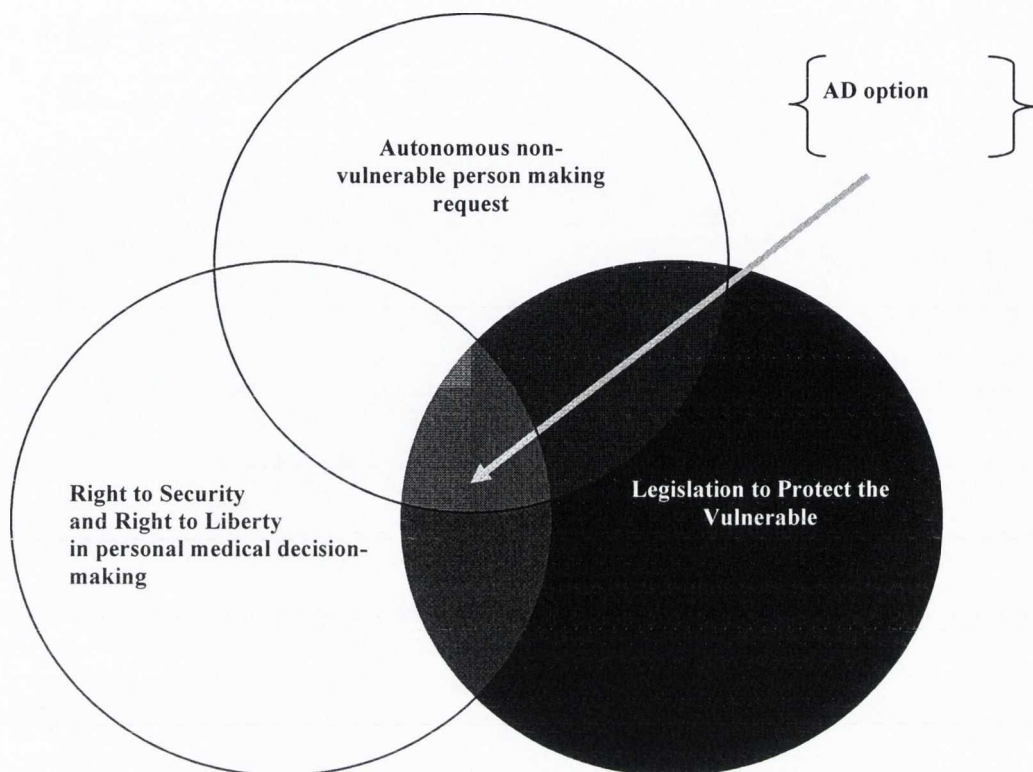
⁴²⁹ *ibid* para 1294.

⁴³⁰ *ibid* para 1302.

⁴³¹ *ibid* paras 1302-4.

⁴³² *ibid* paras 16, 1362.

Figure 14 AD advanced as the rights to security and liberty in conflict with State duty to protect to the vulnerable



Accordingly, with the legislative objective narrowed to the protection of the vulnerable, and the rights to security and liberty constrained to medical decision-making, supported by the doctrine of informed consent and the argument that there is no ethical distinction between physician-assisted death and other currently legal and ethically accepted end of life practices⁴³³ (both factors that enhance the medical contextualization of AD), the court held that a means other than an absolute prohibition could achieve the purpose: an almost-absolute prohibition with a limited carefully monitored system of exceptions allowing grievously and irremediably ill adult persons who are competent, fully informed, non-ambivalent and free from coercion or duress to access PAS or euthanasia.

The joint security/liberty-based AD construction is strongly linked to the doctrine of informed consent and the exercise of autonomy in the context of medical decision-making. Accordingly, only permitting assistance in the context of physician-patient relationship is logically inferred. Similarly, extending AD based on the lack of distinction between other legal and ethically accepted end of life practices such as

⁴³³ *ibid* paras 1362-70.

withholding and withdrawing of treatment, also logically entails constraints related to the diagnosis of a serious illness that is without remedy. On the other hand, AD as a logical extension of the right to forego life-sustaining treatment has at least in the American jurisdictions, implied limiting assistance to individuals diagnosed with a terminal illness and to the practice of PAS.⁴³⁴

Regardless, the AD model in *Carter* largely mirrors the Belgium and Luxembourg AD models, notwithstanding that it has emerged through a judicial interpretation of protected constitutional rights. *Carter* carves out an equality exception, notwithstanding concerns voiced by previous judiciary that to do so would undermine the protection the equality right is aimed at safeguarding. *Carter* provides an analytical pathway that permits an interpretation of right to life in accordance with the will of the individual that does not appear to directly challenge the integrity of that absolute right. It advances the right to make decisions of fundamental importance on the joint basis of security and liberty, while simultaneously constraining the freedom to choose to the medical decision-making context. Taken together, the AD model emerging from the *Carter* case is unquestionably advanced on an autonomy platform but constrained to a medical context.

It is also interesting to note that the *Carter* AD model significantly aligns with the recommendations by the RCS Panel and the 2012 Quebec Committee. This should not be surprising as both reports rely heavily on the AD models from the permissive AD jurisdictions and both reports were before the court in *Carter*. It should however be further noted that the *Carter* model more strongly resembles the AD model envisioned by the 2012 Quebec Committee rather than that of the RCS Panel,⁴³⁵ given the Quebec committee's stronger attachment to "medical aid in dying."⁴³⁶ Indeed some of the constraint terminology used by the 2012 Quebec Committee appears in the *Carter* case, most notably the requirement that the patient be in "an advanced state of weakening capacities with no chance of improvement."⁴³⁷

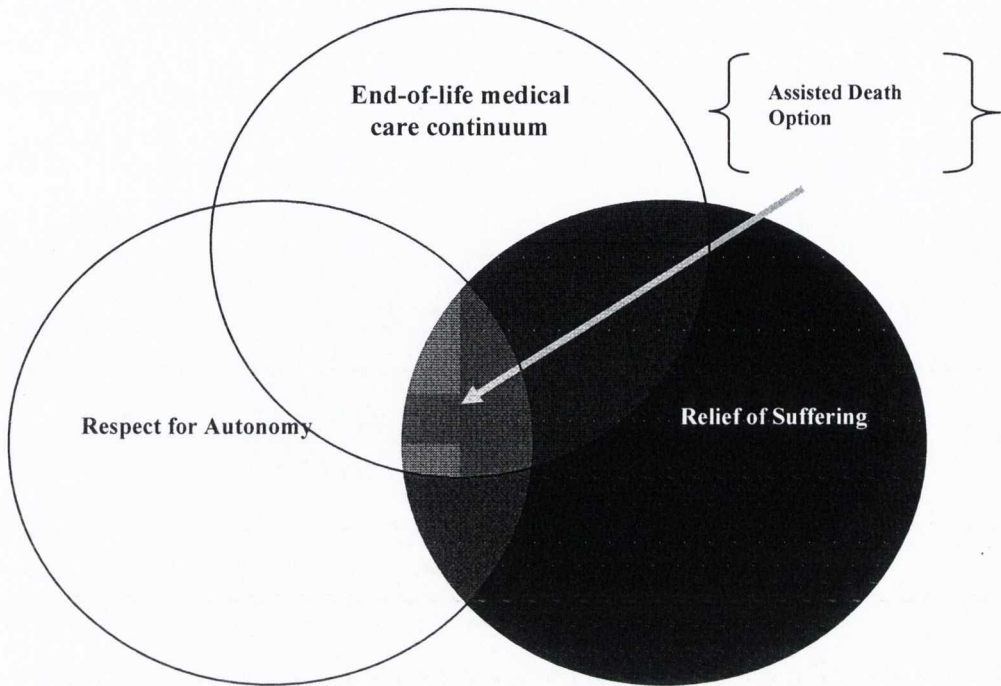
⁴³⁴ See discussion in Chapter III.B.5. and Chapter III.B. 6.

⁴³⁵ The RSC panel challenges the medical construction of AD to inquire whether it is necessary to limit AD to assistance by health care professionals, further noting that the more restrictive the list of assistors, the less that group of assistors should be permitted to refuse assistance. RSC 2011 Report (n 366) 101.

⁴³⁶ Quebec 2012 Report (n 367) 82.

⁴³⁷ Quebec 2012 Recommendations (n 395) 5.

Figure 15 AD advanced on “medical aid in dying” (Quebec 2012 Report)



That said, the *Carter* AD model is not as strict as the AD model envisioned by the Quebec Committee which locates respect for autonomy in connection to relief of suffering and the end-of-life (Figure 15). If end-of-life is to be taken as meaning “dying”, then *Carter* does not introduce this constraint. Similarly, because suffering is from the perspective of the individual and is likely to be subsumed by the more easily managed objective criteria of serious illness, disease or disability, suffering pursuant to the *Carter* model does not seem to be substantively operative. *Carter* does borrow from the Quebec committee, the phrase “advanced state of weakening capacities with no chance of improvement”, a phrase that implies a declining state of physical health. On that note, the *Carter* AD model is positioned to allow AD for persons of advanced age with multi-morbidities causing intolerable suffering, much in the same manner as the Netherlands.

To summarize, the *Carter* case establishes through a re-assertion of the constitutional arguments made in *Rodriguez*, a broad autonomy-based AD scheme, one that includes PAS and euthanasia for grievous and irremediable illness (from the patient’s perspective) pursuant to a voluntary, competent, free and informed genuine request; and the request can be by advance directive. The use of autonomy to justify euthanasia in addition to PAS and the extension to patients who are irremediably, but not necessarily terminally ill however, runs counter to the approach taken by the American states of Oregon and Washington which only allow PAS for terminal illness. Even the *Baxter v. Montana* case which anchors the practice of AD to consent

of the individual only contemplates the practice of PAS for patients with terminal illness.

IV.D. Summary: Alignment, Limits, Collapse, Convergence

As previously discussed, the most obvious internal constraints that emerge from the permissive jurisdictions are the necessity defence underpinning and AD as an extension of the “right to die”.⁴³⁸ While necessity extends to both PAS and euthanasia practice, it has the practical effect of constraining AD as an expression of autonomy to the realm of medicine, professional medical duty and its consequents.⁴³⁹ AD as a logical extension of the form of autonomy that concretizes the “right to die” (i.e. the right to refuse and the withholding or withdrawing life-sustaining treatment) on the other hand, is grounded in the doctrine of informed consent, which also constrains assistance to decision-making in the medical context but further points to the imposition of additional limits such as restricting the requisite medical condition to a diagnosis of terminal illness (i.e. dying) and only permitting PAS.⁴⁴⁰

The argument made in the UK case of *Nicklinson* proposes to advance AD *inter alia* on the basis of a necessity defence, but different than the Netherlands model, the *Nicklinson* model combines the duty to relieve suffering with the duty to respect autonomy. These joint duties are placed in conflict with the physician duty to preserve life. The infusion of the physician duty to respect autonomy points to the understanding that the duty to protect life is to be interpreted from the perspective of the individual. However because autonomy is tied to the physician duty to relieve suffering, rather than provoking expansion beyond the medical domain, autonomy in this context has the effect of shoring up the medical limits to AD practice. It should however be kept in mind that a necessity underpinning (in this case the threshold more overtly established from the patient’s perspective) justifies both PAS and euthanasia practice and runs contrary to strongly voiced parliamentary support for the alternative non-medicalized AD model elucidated by the DPP Policy.

The *Baxter v Montana* case while also building AD as a form of physician defence does not link the defence to physician conflict of duty or for that matter to constitutional protections, but rather identifies that AD practice may be justified on the basis of the consent of the individual seeking assistance in “dying”. The court in that case opines that PAS is an even lesser physician involvement than other end of life

⁴³⁸ See discussion at Chapter III.C.IV.

⁴³⁹ See discussion on the Netherlands Chapter III.B.1.

⁴⁴⁰ See discussion on Oregon and Washington Chapter III.B.5 and III.B.6 respectively.

practices such as the withholding or withdrawing of treatment.⁴⁴¹ This supports a view that the Montana court model cannot be framed as an extension of the U.S. “right-to-die” cases potentially challenging the restriction of AD to a medical context. The Montana consent defence model thus appears to hinge on a form of autonomy that is broader than (or not directly linked to) autonomy *qua* informed consent and thereby potentially creates the foundation to achieve wider access to AD.⁴⁴² On the other hand because the defence is so firmly connected to the autonomous actions of the individual,⁴⁴³ the mode of assistance is restricted to PAS. Additionally, because the availability of the consent defence turns on an interpretation of public policy and thus the particular factual circumstances, it is also arguable that PAS can only be made available to patients who are diagnosed as being terminally ill.

Again, consent of the individual becomes available as a defense in these circumstances through the use of the flexible legal tool of “public policy” analysis. This tool also emerges pursuant to the UK DPP Policy in the discretionary determination of whether it is in the public interest to pursue a prosecution of assisted suicide, with consent-type considerations (voluntary, clear, settled and informed decision to commit suicide) being only one of the factors under consideration. Intriguingly, the ability of the individual to undertake the act that constitutes assistance him- or herself is key to the Montana courts leniency on the assistor, whereas the opposite is true under the DPP policy, that ability meriting in favour of the assistor’s prosecution. Under the *Carter* equality AD model, the latter position would also be true, only individuals who were “materially physically disabled” could be legally assisted and in that instance only by a physician, a factor meriting prosecution under the DPP policy. Accordingly autonomy *qua* liberty is more perceptible in the *Baxter v. Montana* AD model, whereas autonomy *qua* agency is more perceptible under the DPP Policy and *Carter* equality AD models. This in turn raises the matter as to how non-medical and medical agents are respectively justified, appearing to turn on two different tests of integrity (or thresholds) that stem from two distinct relational spheres – the medical and the familial. In this way, the strength of autonomy *qua* agency is more perceptible under the *Carter* model particularly as there is nothing inherent in the equality argument that suggests medical agency instead of familial. Regardless, under all three approaches (Montana/consent, the UK DPP Policy and *Carter*/equality), only assisted suicide is permitted.

⁴⁴¹ See discussion on *Baxter v Montana*, Chapter IV.C.1.ii.

⁴⁴² See discussion at Chapter IV.C.1.iv.

⁴⁴³ *Baxter v Montana* SC (n 2) paras 21-32.

The *Carter* case does not incorporate the necessity defence but does to a certain extent, rely on arguments related to “right to die” in the context of the right to refuse treatment and informed consent. The distinction however is that *Carter* does not purport to expand AD on the basis of a direct legal extension of that right which would logically entail limiting AD to individuals who are “dying”, rather, it draws on accepted end-of-life practices to demonstrate that AD is not an ethically inconsistent medical practice as well as to solidify the interpretive overlap between the right to security and the right to liberty by linking the right to exercise control over bodily integrity to the right to make fundamental personal decisions. Under this construction, AD is about the right to choose and grounded in autonomy, however because of the collapse between security and liberty rights, the latter of which is asserted in the medical decision-making context, the AD model that emerges is arguably justified only within the patient-physician relationship, which in turn attracts a variety of the standard AD limits relating to medical diagnosis, physician obligations with respect to consent and so forth.

Notwithstanding potential internal constraints, it should be noted that the result in *Carter* meets three out of the five criteria identified from the review of the permissive jurisdictions that would support a broad construction of assisted death.⁴⁴⁴ First, the right to life is to be interpreted from the patient’s perspective. This was established when the right to life was placed in conflict with the state’s obligation to protect vulnerable persons. Second, the mode of assisted death is aligned with the Benelux countries i.e. PAS or euthanasia. This pertains only to the Section 7 infringement (security and liberty) and not the Section 15 infringement (equality). Third, the characterization of the slippery slope is in alignment with autonomy. That is, the slippery slope addressed by the BCSC was one that focused primarily on the free and informed request of the autonomous person. Pursuant to this perspective, *B* (or the bottom of the slope) is identified as non-voluntary or involuntary euthanasia. Thus the slide towards these undesirable consequences is easily avoided through the establishment of safeguards that the individual is capable, informed and acting voluntarily and genuinely when expressing the request to die. The court in *Carter* did not consider the possibility or risk of psycho-social processes leading to desensitization.⁴⁴⁵

The slippery slope analysis in *Rodriguez* took place in both the assessment of whether the prohibition was in accordance with the principles of fundamental justice (the test pursuant to section 7 of the Charter) and whether the prohibition had a pressing and

⁴⁴⁴ See discussion at Chapter III.C.4.

⁴⁴⁵ *Carter* (n 6) para 365.

substantial objective and was proportional to its purpose (the test pursuant to section 1 of the Charter) whereby it: surfaced in the balancing of interests between individual and state; demonstrated support for the broad state objectives in protecting life; and relied on jurisdictional evidence that showed the wide consensus for maintaining the criminal prohibition of AD. In *Carter*, the jurisdictional evidence related to PAS and euthanasia being criminal offences in most western countries was acknowledged by the BCSC but only emerged indirectly in the recognition of the precedent set by *Rodriguez* concerning arbitrariness and in the finding that deference was owed to Parliament because of the complexity of the social issue and requisite weighing of harms and benefits to society.⁴⁴⁶ Conversely, the evidence from permissive jurisdictions was extensively reviewed⁴⁴⁷ and used to both delineate the scope of the slippery slope under analysis as well as to elucidate the safeguards to prevent it from occurring.

Carter also meets one of the factors that merits against a broad construction, namely, the focus on the medical basis for assisted death. While this factor can be seen to be derived from the right to security/right to liberty construction of AD as discussed above, it is less obviously linked to the equality construction of AD. Furthermore, while the equality construction limits assistance to PAS, the life, security and liberty constructions extend to both PAS and euthanasia practice, as already discussed.

The necessity approach advocated in the *Nicklinson* argument also evidences these same three perspectives that would support a broad construction of AD: the right to life to be interpreted from the patient's perspective; the mode of assisted death aligned with the Benelux countries; and the characterization of the slippery slope in such a way as to focus on the safeguards to ensure that the decision is voluntary, clear, settled and informed.

Montana v. Baxter on the other hand demonstrates more of the factors that merit against a broad construction of assisted death: a focus on the inverse relationship between autonomy and the mode of death; support of PAS only; and a focus on the distinction between the regulation of death and the regulation of dying which in turn situates PAS in the context of terminal illness.

None of the court models can be seen to demonstrate or form an appreciation of suffering to the broad manner under the Switzerland approach.

⁴⁴⁶ *ibid* paras 1179-80.

⁴⁴⁷ *ibid* Part VIII and Part IX paras 359-889.

Having now considered in significant detail, the alignment and limits of the AD models at issue, the discussion now turns to Chapter V and an analysis of autonomy, its meanings and mechanisms, its relevance to the modes of assisted death available, and its connections to the slippery slope.

CHAPTER V. AUTONOMY: MEANINGS, MECHANISMS AND SLIPPERY SLOPES

The equations of dynamics completely express the laws of the historical method as applied to matter, but the application of these equations implies a perfect knowledge of all the data. But the smallest portion of matter which we can subject to experiment consists of millions of molecules, not one of which ever becomes individually sensible to us. We cannot, therefore, ascertain the actual motion of any one of these molecules, so that we are obliged to abandon the strict historical method, and to adopt the statistical method of dealing with large groups of molecules.

The data of the statistical method as applied to molecular science are the sums of large numbers of molecular quantities. In studying the relations between quantities of this kind, we meet with a new kind of regularity, the regularity of averages, which we can depend upon quite sufficiently for all practical purposes, but which can make no claim to that character of absolute precision which belongs to the laws of abstract dynamics.

Thus molecular science teaches us that our experiments can never give us anything more than statistical information, and that no law deduced from them can pretend to absolute precision. But when we pass from the contemplation of our experiments to that of the molecules themselves, we leave the world of chance and change, and enter a region where everything is certain and immutable.

James Clerk Maxwell¹

V.A. Construction of Autonomy and Relationship to Mode of Assisted Death

The general theme that emerges from the foregoing review is that “autonomy” is indeed at the heart of AD reform. The cases of *Nicklinson* and *Carter*, but perhaps moreso *Carter*, demonstrate increasing judicial willingness to entertain complex legal pathways in order to establish externally homogenous AD models² (i.e. PAS or euthanasia for irremediable suffering) that reflect the overarching message that the protection of life is to be interpreted in accordance with the patient’s will (Figures 3, 5, 6, 8, 11 and 14).³

¹ James Clerk Maxwell, ‘Molecules’ (1873) VIII(204) Nature 437-441.

² See comments by Smith J in *Carter* dismissing overall relevance of the Switzerland AD experience because “the practice there is quite different (assisted suicide, with no medical precondition and no requirement for a physician to be involved)”, revealing the importance of considering the extent to which the framework of the AD model arrived at through a judicial process is derivative of an interpretation of the domestic law and legal protections or is a reflection of what is perceived to be the popular approach that can then be supported with the legal tools available. *Carter v Canada (Attorney General)* 2012 BCSC 886 para 368. This is discussed further below.

³ See discussion on AD models of Belgium and Luxembourg, Chapters III.B.2 and III.B.3 respectively.

Furthermore, the most recent judicially prescribed AD model from Canada arising out of *Carter*⁴ and the more recent European legislative model (Luxembourg)⁵ find their structural origins in the resolution of a complex medical professional dilemma: how to protect an individual life while at the same time not causing harm to that individual's life. On the other hand, the AD models that have emerged from simpler unencumbered projections of autonomy or for that matter, from legal reform mechanisms that operate on simpler unencumbered expressions of autonomy (e.g. privacy, liberty and consent in the jurisdictions of Switzerland, Oregon, Washington and Montana)⁶ have generated what can be considered the more restrictive AD models, allowing only PAS not euthanasia, and furthermore, in the case of the American states, further restricting PAS to a diagnosis of terminal illness (Figures 8 and 9).

Part of what appears to be provoking this apparent inverse relationship between assisted death aims and means is whether the autonomy principle is intuited to be derivative of autonomy exercised in the context of medical decision-making (the biomedical model of autonomy) or whether the autonomy principle is intuited to be derivative of a set of broader rights associated with libertarianism, self-determination and inherent dignity *qua* autonomy. But rather than the narrower medical construction of autonomy leading to a narrower outcome, quite the opposite appears to be true. It is allegiance to a medical construction of autonomy that justifies the more expansive modes of assistance, that is, PAS and euthanasia (for example, as seen in the Netherlands, Belgium and the Quebec Select Committee models), because it invokes a spectrum of patient rights including the right to self-govern, informed consent and the right to be free from pain which in turn invoke a spectrum of corollary duties, including the duty of non-abandonment.⁷ Thus regardless of whether these physician duties come into conflict with other medical duties and ethics, such as the protection and preservation of life, the pre-existence of the patient-physician relationship mandates discussion and investigation towards collaborative resolution.

Accordingly, when the American libertarian models (i.e. the Oregon and Washington AD models)⁸ are considered and compared to the other AD models (i.e. the Benelux AD models),⁹ the result from the non-American perspective is the view that the American AD schemes are exceptionally narrow and also ethically inconsistent, that is, they only allow PAS for those with six months or less to live regardless of whether

⁴ Discussed in Chapter IV.C.3.iv.

⁵ Discussed in Chapter II.B.3.c.

⁶ Discussed in Chapters II.B and IV.C.1.

⁷ See evidence of Margaret Pabst Battin in *Carter* (n 2) paras 240-1.

⁸ Discussed in Chapters III.B.5 and III.B.6.

⁹ Discussed in Chapters II.B.1, II.B.2 and II.B.3.

an individual is enduring irremediable suffering.¹⁰ The extent to which “death with dignity” as a “liberty” or “freedom from” view of autonomy is culturally apprehended in the United States AD models is revealed not only in the comments by the judge in *Baxter v. Montana* regarding PAS as a lesser involvement¹¹ but also in firstly, the absence of a mandatory requirement that the prescribing physician stay with the patient when the medication is ingested under both Oregon and Washington AD laws¹² and secondly, the resistance to increasing procedural safeguards around the assessment for mental illness and depression.¹³ These latter safeguards which are fairly standard under a medical interpretation of autonomy are frequently seen as impositions under the broader libertarian interpretations.¹⁴ This tension is also very well reflected in the debate in Switzerland regarding assisted suicide for mental conditions.¹⁵

V.B. Construction of Autonomy and Relationship to Terminal Illness

While requiring the individual to take the last step is logically consistent with a broad construction of autonomy, the same cannot be said of the imposition of a terminal illness diagnosis. Indeed, under the Swiss model, the expansive view of autonomy and dignity *qua* autonomy correlate to suicide assistance for any condition.¹⁶ With respect to the American legislative models of Oregon and Washington and the judicial model from Montana, in order to be “eligible” for PAS, the individual must be suffering from a terminal illness, which restriction as described earlier, has been extensively criticized.¹⁷ Although the terminal illness requirement doesn’t appear to have a logical connection to expansive libertarian views of autonomy, it does appear to link to the political and historical foundation of the “death with dignity” movement in the United States which concerned establishing the right to refuse treatment of the dying competent individual.¹⁸ So although a broad construction of autonomy is in play in terms of the legal instruments used to provoke reform, because of the significant interface between medicine and the law from the outset of American end-of-life conversations, autonomy is only used as a conceptual vehicle in order to drive an

¹⁰ See discussion regarding criticisms of the Oregon law at Chapter III.B.5.c and reasons given by the Canadian RSC Panel for not restricting its recommendations to terminal illness at (n 386) above and associated text.

¹¹ *Baxter v Montana* 2009 MT 449; 354 Mont. 234; 224 P.3d 1211 (SC) (*Baxter v Montana* SC) para 32.

¹² See respectively Chapter III.B.5.b (n 524) and Chapter III.B.6.d (n 610) and associated text.

¹³ See Chapter III.B.5.d (n 564) and associated text.

¹⁴ *ibid.*

¹⁵ See discussion of the *Haas* case in Chapter III.B.4.c.

¹⁶ See discussion in Chapter III.B.4.

¹⁷ See (n 10) and associated text.

¹⁸ See discussion in Chapter III.B.5.c.

incremental social step in identifying what additional medico-legal options might be available to the dying patient.¹⁹

On the other hand, deeper consideration of the different legal processes by which PAS for individuals with terminal illness was achieved – that is, ballot initiative (Oregon and Washington) versus judicial recognition of consent as a physician defence to homicide (Montana) – challenges such an incrementalist view of PAS legalization, particularly as the Montana judicial forum expressly severed the politico-evolutionary connection between PAS activities and the withholding and withdrawing treatment, again on the basis that PAS is a lesser physician involvement than the practices of withholding or withdrawing treatment.²⁰ In this regard, the requirement of terminal illness does not appear to be a constraint intrinsic to the emergent Montana AD model and therefore the Montana judicial AD model appears inherently more vulnerable to expansion beyond its original form than its legislative counterparts.

V.C. Constructions of Autonomy and Connections to Slippery Slope Theory

Relating the foregoing to slippery slope theory, regardless of whether internal constraints will in the long run prove to be mechanisms of stabilization (as they appear to be so operating in current Dutch debates regarding “tired of life”²¹), it is also important to keep in mind as earlier described in Chapter II.D, that the perception of possible slide (and how to address it) largely relates to how the top of the slope (*A*) and the bottom of the slope (*B*) are being defined. So in addition to a consideration of which constructions of autonomy are generally in play historically, culturally and politically, express consideration must also be given to defining (and the processes involved in defining) what is *A*, the activity that is desired and socially beneficial, and what is *B*, the activity that is undesired and not socially beneficial. When these two points – top *A* and bottom *B* – are considered simultaneously, it becomes apparent that the descriptions of *A* and *B* are largely dependent on which construction of autonomy is in play. That is, because the construction of autonomy establishes the foundation of the AD scheme (which in turn delineates the internal constraints) it also serves to define *A*. Furthermore, the particular construction of autonomy will itself be

¹⁹ See also Margaret P Battin, ‘Euthanasia: The Way We Do It, The Way They Do It’ (1991) 6(5) *Journal of Pain and Symptom Management* 298. Battin describes an alternative hypothesis, that PAS is the practice that is most consistent with is the special characteristics and the culture of the United States. Cultural characteristics cited by Battin include for example, a “DIY” or “do-it-yourself” culture, a lack of close relationship between physicians and patients, a volatile legal climate, public naivety about totalitarian movements, and the need for patients to attend to the financial aspects of dying in ways that patients in other countries with public health care systems do not).

²⁰ *Baxter v Montana* SC (n 11) para 32.

²¹ See discussion in Chapter III.C.4.iv.

dependent on the processes and players involved ranging from physicians, to courts, to legislatures and the public.

Accordingly, as demonstrated by the Dutch scheme (at least under its original conception), the expression of autonomy is only one element that assists in the resolution of a medical professional conflict. Thus *A*, the top, is defined pursuant to the medical conflict and *B*, the bottom is potentially any activity that falls outside of the circumstances where that medical conflict does not exist – such as where suffering does not extend from a medical disorder and when the suffering is not unbearable, lasting, with no other reasonable solution; hence also the acceptability of the 2005 Groningen Protocol in the Netherlands. Under the protocol, Dutch paediatricians may not be prosecuted for euthanasia performed on a newborn if certain criteria are met, including certainty of diagnosis and prognosis, confirmation of hopeless and unbearable suffering and parental consent.²²

Likewise, the Swiss AD model stems from a non-medicalized view of autonomy (e.g. privacy, self-determination). Accordingly, *A* has been historically defined very broadly with competent and voluntary individuals being able to obtain assistance to die for any reason and *B* being any situation where the individual is not competent or voluntary. Later attempts by the Swiss government to then “superimpose” medicalized contours of autonomy on its PAS scheme as a way to address the emergence of *B*-related outcomes and stabilize the scope of *A* have been met with political and medical professional resistance, the former because of the perceived reduction of autonomous expression and the latter because assisting in dying was not understood to be part of professional medical activities.²³ State concern over the failure of internal constraints to operate satisfactorily directed attachment of the broad autonomy-based PAS scheme to the activities of the medical profession – a professional body known for its system of safeguards which can detect the existence of voluntariness and competency in the patient.²⁴

This overlay of the biomedical construction of autonomy, which in turn prompts additional duties under Swiss medical guidelines, is directing a progressive narrowing of the Swiss assisted suicide scheme to provide access to PAS only to individuals with conditions that have a medical basis and where the patient has been diagnosed with a terminal illness.²⁵ On the other hand, the non-biomedical approach to assisted suicide

²² E Verhagen and PJ Sauer, ‘The Groningen protocol—euthanasia in severely ill newborns’ (2005) 352 *New England Journal of Medicine* 959–62.

²³ See discussion at Chapter III.B.4.d.

²⁴ *ibid.*

²⁵ *ibid.*

can still take place within the bounds of the law in Switzerland. However, as Swiss physicians respond to requests for assistance in dying and reformulate their code of ethics to accommodate state concern, it is not inconceivable that through the operation of patient rights and the spectrum of corollary physician duties, that Swiss physicians and the state will come to consider euthanasia as also being appropriate in certain medical circumstances involving irremediable suffering, evidence of this having already being demonstrated in the acquittal of a Swiss physician who triggered a lethal drip on the patient's cue.²⁶

The UK DPP Policy is seen as standing apart from all other AD models canvassed in that it establishes a foundation for an AD model that expressly rejects AD pursuant to an organized medical framework. As described earlier,²⁷ notwithstanding that the individual seeking death must have reached a voluntary, clear, settled and informed decision to commit suicide, it is the compassion of the assistor in a one-off situation, not autonomy or self-determination of the individual seeking death that is the main threshold for ascertaining whether or not prosecution of the assistor should follow. Although this approach is contrary to many assisted death proponents' perspectives on how assisted death ought to be regulated, it cannot be said that the DPP Policy is inconsistent with a view of autonomy-based assisted death. This is evident in the identification of the person's ability to physically commit the act that constituted assistance him- or herself as a factor tending in favour of prosecution.²⁸ While this broad view of autonomy might point to the future development of a PAS-only scheme similar to one of the US models, the substitution of medical professional or other organized form of participation for familial participation stemming from compassion for the individual seemingly frustrates that vision. On the other hand, apart from the criticisms associated with the lack of professional sophistication to bring about death in a person and/or to address potential complications arising therefrom, a compassionate response to the request of an individual who is him- or herself physically unable to undertake certain acts to achieve relief of suffering through death, sets a fairly high threshold²⁹ not unlike the threshold established through the equality argument in the Canadian *Carter* case, which also rests on "material physical disability." This begs the question of whether the human driver(s) behind *Carter's* technical equality argument is not so much about the unequal imposition by the law on

²⁶ See Chapter III.B.4.d (n 454) and associated text.

²⁷ See Chapter IV.C.2.

²⁸ See DPP policy list of factors tending in favour of and against prosecution in Chapter IV.C.2.ii.

²⁹ For discussion on compassion and bioethics decision-making in France see Penny Lewis, *Assisted Dying and Legal Change* (Oxford University Press 2007) 113.

choices available to individual as it is about crafting a legal mechanism to be able to take advantage of the moral muscle in expressions or manifestations of empathy.

The Canadian case of *Carter* however uses a variety of constitutionally protected rights to generate a PAS/Euthanasia model consistent with the Benelux models and one which does not suffer from the same inconsistency and equality critiques of the American models. Apart from the particular facts of the case, there is nothing inherent to the formalistic equality and right to life arguments in *Carter* to imply a biomedical construction of autonomy is in play. The burden imposed or the loss of life that could occur is not justifiable because the individual is acting autonomously- voluntarily and without coercion. The only aspect of this construction of autonomy that connects to the medical framework is the particular skill-set of the medical professional to diagnose and confirm voluntariness; providing a net of safety similar to that being introduced in Switzerland. Conversely because of the way the British Columbia Supreme Court collapsed security and liberty rights, it does appear that the biomedical construction of autonomy is implicated as the right concerned involves the right to non-interference by the state with fundamentally important and personal medical decision-making.³⁰ This construction inherently carries with it a battery of intrinsic constraints related to the physician-patient relationship, diagnosis of irremediable medical conditions and so forth.

What potentially renders these intrinsic constraints vulnerable is the overall lack of clarity as to which formulation of autonomy is ultimately being pronounced by the British Columbia Supreme Court. It is precisely because of the collapse between liberty and security combined with the equality and right to life findings that the result in this regard is unclear. Clarity here is required given that the strength of any safeguards that are ultimately put in place are dependent on whether they are largely perceived as being inherent to or superimposed upon the AD scheme. The shortcomings of a judicial resolution of this ethical issue are palpable (not the least of which include how, in slippery slope terms, *A* and *B* come to be identified and the use of overly legalistic logic to achieve a particular result – discussed further below) but whether a parliamentary approach can engage at a judicial level of nuance and analytical intricacy is also a concern.

If it is the broader libertarian construction of autonomy at the core of the Canadian AD debate, *A* (the top of the slope and the desired activity) should be circumscribed much in the same manner as the United States and Switzerland. It will follow then that *B* (the bottom of the slope and the outcomes to be avoided) will be identified as anything

³⁰ *Carter* (n 6) para 1302.

outside the scope of voluntariness of the individual. What does not logically or intrinsically follow however is a limitation to terminal illness (a concern that is reflected in the *Carter* judgment) or the imposition of a medical basis for suffering (a position which can likewise be perceived in the *Carter* judgment through the contortions of the equality argument). Restricting a future Canadian AD model (based on *Carter*) to a medical model of AD will be challenging given that under this broader construction of autonomy such a constraint is likely to be viewed as foreign and super-imposed. On the other hand, as observed in the Swiss and American approaches, extending AD practice to include euthanasia is logically inconsistent with a broad construction of autonomy and will likely meet with significant resistance.

If the narrow biomedical construction of autonomy is however at the heart of the Canadian assisted death debate, it follows that *A* would incorporate both the practices of PAS and euthanasia but *B* will be identified as any activities that fall outside the scope of medical perspectives on irremediable suffering. This is what appears to be the outcome sought by the *Carter* judgment. As it stands however, *Carter* attempts to pre-empt concerns about future slippery slopes by breaking down the distinctions between the different potential legal constructions of autonomy through carefully articulated legal logic. The problem with this approach is that it is pre-empting the critical nuanced democratic debate that needs to occur between the state, its citizens and the medical profession in order to understand the essence of autonomy that is sought to be protected when dying or choosing the act of death.

Thus despite the criticisms towards the UK DPP policy regarding its apparent preference for a familial approach over a medical approach to AD, what the DPP Policy has done is flag the existence of an important cultural consideration as to the type of relationship that the UK perceives to more palpably reflect integrity with respect to decision-making in difficult medical situations. In so doing, it has also increased the likelihood of being able to constructively debate and identify the specific UK perspective on autonomy and relief of suffering at the end of life, and thereby *materially* decreased the overall probability of bringing about activity *B*, the bottom of the slippery slope, by having placed itself in a better position to clearly identify *A* – the activity desired at the top.

CHAPTER VI CONCLUSION

It means that the law is growing. As law embodies beliefs that have triumphed in the battle of ideas and then have translated themselves into action, while there still is doubt, while opposite convictions still keep a battle front against each other, the time for law has not come; the notion destined to prevail is not yet entitled to the field. It is a misfortune if a judge reads his conscious or unconscious sympathy with one side or the other prematurely into the law, and forgets that what seem to him to be first principles are believed by half his fellow men to be wrong.

I think that we have suffered from this misfortune, in State courts at least, and that this is another and very important truth to be extracted from the popular discontent. When twenty years ago a vague terror went over the earth and the word socialism began to be heard, I thought and still think that fear was translated into doctrines that had no proper place in the Constitution or the common law. Judges are apt to be naif, simple-minded men, and they need something of Mephistopheles. We too need education in the obvious to learn to transcend our own convictions and to leave room for much that we hold dear to be done away with short of revolution by the orderly change of law.

I have no belief in panaceas and almost none in sudden ruin. I believe with Montesquieu that if the chance of a battle I may add, the passage of a law has ruined a state, there was a general cause at work that made the state ready to perish by a single battle or a law. Hence I am not much interested one way or the other in the nostrums now so strenuously urged. ... For one in my place sees how often a local policy prevails with those who are not trained to national views and how often action is taken that embodies what the Commerce Clause was meant to end. But I am not aware that there is any serious desire to limit the Court's power in this regard. For most of the things that properly can be called evils in the present state of the law I think the main remedy, as for the evils of public opinion, is for us to grow more civilized.

If I am right it will be a slow business for our people to reach rational views, assuming that we are allowed to work peaceably to that end.

Oliver Wendell Holmes Jr.¹

This thesis has set out to examine the emergent assisted death laws in the jurisdictions of the Netherlands, Belgium, Luxembourg, Switzerland, Washington, Oregon, Montana, England and Canada. Through examining the political, legislative and judicial reform histories as well as the substantive framework of the assisted deaths laws that have emerged from these processes, this work has demonstrated that most, though not all, of the assisted death laws currently prescribe a fairly homogenous assisted death model, that is, assisted death (PAS or euthanasia) for irremediable suffering.

The examination also finds that despite the external homogeneity in these schemes, the internal policy goals of these laws, particularly with respect to how the principle of autonomy and the requirement of suffering are understood, expressed and advanced,

¹ OW Holmes, "The Path of the Law" in Oliver Wendell Holmes, *Collected Legal Papers* (first published 1920 Harcourt, Brace and Company, Peter Smith 1952) 294-6 <http://www.archive.org/stream/collectedlegalpa027872mbp/collectedlegalpa027872mbp_djvu.txt> accessed 31 May 2012.

are quite different. These internal distinctions operate as internal constraints within respective assisted death models and act as factors of stabilization that can maintain the parameters of the assisted death model as originally contemplated, thus avoiding what has been described by some as the “slippery slope”. To use an example cited earlier, the internal constraints that arise out the necessity defence in the Dutch AD scheme for example, squarely position assisted death as a medical practice which carries with it the varied limits and related physician duties that arise from the practice of medicine, including that the practice must related to medical diagnosis.

As assisted death reform discussions emerge in other jurisdictions however, there has been particular focus on autonomy as the principal mechanism to achieve the legalization of the practice. This work suggests that there is insufficient attention being paid to the particular construction of autonomy being advanced in assisted death reform and an over-emphasis on the legal vehicles (such as constitutional protections of liberty, security, privacy and equality) that are capable of achieving homogenized external results. Accordingly, constraints, particularly those related to the practice of medicine and/or medical diagnosis, that are inherently logical to and thus intrinsically part of earlier assisted death models have the semblance of being superimposed in later assisted death models thus rendering these limits particularly vulnerable to expansion through the same legalistic processes that were able to secure the latter models in the first place.

This discussion suggests that express and more nuanced democratic examinations of the construction of the principle of autonomy that is sought to be expressed and advanced in emerging assisted death reform is critical to ensuring that current and future laws do not unintentionally expand beyond that originally contemplated. In other words, autonomy-based assisted death is being constructed as a right to choose (stemming from rights to privacy and security), a right to die (stemming from the doctrine of informed consent), a right to free from unwanted interference (stemming from a right to liberty), death with dignity (stemming either from autonomy or normative and experiential perspectives on indignity), and a right to physical agency (stemming from a right to equality and compassion). As discussed in the preceding chapters, each one of these aims informs different limits to both the means of assisted death made available as well as the criteria that would qualify a person to become eligible for such assistance. However, in the deliberate process of articulating the particular rights and freedoms and consequently, legal pathways, that can achieve the desired result from an advocacy perspective, what appears to be occurring is the advancement of assisted death on the basis of a broad libertarian construction of

autonomy, the freedom or right to choose and the exercise self-determination in spheres of a private nature. The notion of sanctity of life and dignity as constraint fail to justify infringement of these individual freedoms particularly when dignity is perceived as stemming from autonomy and when, as it is within the current popular reform trend, slippery slope-type questions are drilled down to one particular line of analysis – one which presupposes that the bottom of the slope is anything related to non-autonomous decision-making. While it might be that this approach is the most morally justifiable in a “pluralistic and secular society”, it remains that such an approach pre-emptively ignores the catalyst of compassion and equally importantly, the rational desire of many members of the various states, including medical professional bodies (the members of which are largely tasked with the practice of assisted death), to understand better the mechanisms by which decisions today impact social outcomes and conditions tomorrow.

If it is however the case that the empirical version of the slope is the only “credible” version of the slope worth consideration in the resolution of this complex issue, apart from the careful monitoring of assisted death events and the statistics that follow, it also remains that the legal construction of assisted death reform relies principally on libertarian interpretations of autonomy, despite that in terms of constitutional protections, this perspective largely operates as a negative right. Notwithstanding the difficulty in transforming this freedom into some form of quasi-positive right (which incidentally is more readily achieved through legislative as opposed to judicial vehicles), a significant challenge with this approach is that it does not point to limiting assisted death to situations of irremediable medically-based suffering. This will be of concern to any law maker or law reformer who views *B* (that which is undesirable) as assisted death outside strict medical conditions.

Accordingly, if assisted death advanced on the broader notion of libertarian ideals is desired to be constrained to irremediable medically-based suffering, then at minimum this implies that the medicalized circumstances where assisted death is believed to be appropriate, must be positively linked to a threshold for state action, one established on the basis that it is *compelling* for the state to protect and regulate this perceived “right”. Different examples of the circumstances which have been considered *compelling* to various states on the matter of assisted death have been reflected, for example, in situations of irremediable physical suffering, or where medically-based suffering cannot be relieved without causing harm, or where assistance has been given as an act of compassion, and so forth. Under such compelling circumstances (as we have seen in the preceding discussion) and from a static point of view, it becomes

factually doubtful that assisted death for other situations such as paraplegia, financial considerations or tired of life could meet or surpass the threshold to extend state leniency for assistance with death. Still, because of the liberalism underpinning (and its intrinsic capacity for driving social evolution), in conjunction with the autonomy aspect of dignity and the subjectivity of the experience of indignity, the state would have to expressly consider and articulate precisely where the divide between compelling and not compelling is to be established. In determining that certain conditions or circumstances would not meet the threshold for state leniency in autonomy-based AD, it would arguably be incumbent upon the state to substantively acknowledge that threshold by providing the supports required to preserve and advance the autonomy and normative dignity of the other members of society who do not meet the current threshold (in addition to those that do). After all, as has already been observed in the preceding discussion, social vulnerability does not solely emerge from irremediable medical illness. In this way, the state can transparently and preemptively better address certain slippery slope concerns – which at this point might be considered to be addressing a particular social equilibrium matter rather than a slope – because such deliberate balancing activities can assist in revealing with more precision, what are now only intuitions of what undesirable consequences might come to evolve later. Accordingly, should there be a later shift in social or other conditions that provoke a consideration of the expansion of AD practice beyond its original limits, the responses (state or otherwise) to that shift will possess greater independence and transparency because of the defined starting point, and as such, can assist in the larger more sophisticated task of improving our ability to measure the probability of how our decisions today might affect the outcomes and conditions of tomorrow.

While very little of this discussion helps to predict whether or not the effect of assisted death legalization, (should reform continue in that direction) will ultimately decrease the value with which we currently ascribe to human life, it is important to think carefully and independently about the aims we are seeking and the means by which the aims are sought. While standardized regulatory systems can appear quite similar externally, differences in the organizations lead to differences in implementation and in turn different levels of performance. Thus the confidence obtained from having achieved a homogenous static result should not be misunderstood as having also achieved a fulsome democratic debate.

CHAPTER VII ADDENDUM

The spirit of liberty is the spirit which is not too sure that it is right; the spirit of liberty is the spirit which seeks to understand the minds of other men and women...

Judge Learned Hand¹

Following the completion of the foregoing discussion, the High Court of Justice, London, released the *Nicklinson* decision on 16 August, 2012.²

As discussed in Chapter IV.C.2., the Claimant, Tony Nicklinson sought recognition that voluntary euthanasia could be a defence to murder on the basis of necessity or alternatively, that the prohibition on assisted suicide was incompatible with Article 8 rights under the European Convention. A second Claimant, Martin, suffering from a condition similar to that of Mr. Nicklinson, sought *inter alia* declarations for further clarification regarding the potential prosecution under the DPP Policy of helpers such as health professionals or solicitors who might act as intermediaries in making arrangements for assisted suicide through the use of an organization such as *Dignitas* in Switzerland.³

In short, the gist of the High Court of Justice decision to deny the claims was premised on a refusal to develop any change to the current state of the law in this area on the basis of the rule of law. That is, according to the court, given the three potential constitutional pathways for law reform – judicial, executive and legislative – Parliament was the most appropriate law maker in the area of assisted suicide on the basis of *competence, constitutionality and consequences*.⁴

Regarding competence, the court recounted perceived limitations in terms of addressing the different priorities by different protagonists.⁵ Here the court, though not making mention of the term, also reflected aspects of a slippery slope analysis, namely that identifying decision *A* is dependent on the players and that the judicial approach itself could operate as a potential slippery slope mechanism:

A court hearing an individual case, concentrating rightly and inevitably on the dire circumstances of the claimant, is not in a position to decide such broader questions, but its decision would create a precedent which would affect many other cases.⁶

¹ Judge Learned Hand, *The Spirit of Liberty* (1944).

² *Nicklinson v Ministry of Justice & Ors* [2012] EWHC 2381 (*Nicklinson*).

³ *ibid* para 9.

⁴ *ibid* para 75.

⁵ *ibid* para 76.

⁶ *ibid* para 78.

On constitutionality, the court's position was that this was not a case of incremental justice, but rather one of major change and social policy, matters best suited for Parliament.⁷ As described by the court:

A decision by the court to alter the common law so as to create a defence to murder in the case of active voluntary euthanasia would be to introduce a major change in an area where there are strongly held conflicting views, where Parliament has rejected attempts to introduce such a change, and where the result would be to create uncertainty rather than certainty. To do so would be to usurp the role of Parliament.⁸

On consequences, the court described the difficulty for a court to establish the safeguards that would be necessary to prevent abuse and indirect social pressure on vulnerable persons to end their lives as well as the impossibility of the court being able to monitor such a regime.⁹

For those reasons, the court determined that it would be inappropriate for it to depart from the established position that voluntary euthanasia was murder.¹⁰ Furthermore, the court held that it was also not required to depart from this position pursuant to Article 8 of the European Convention. Specifically, after reviewing the *Pretty* and *Purdy* cases, the court held that the Strasbourg Court did not consider a blanket ban on assisted suicide to be disproportionate or indeed incompatible with Article 8 of the Convention and that given the wide margin of appreciation left to individual states, it was up to the state to determine which organ of the state should decide what legal regime to adopt, in this case, Parliament.¹¹

With respect to the necessity defence raised by Mr. Nicklinson, the court distinguished the facts of this case from the facts of other necessity cases again having noted the overall inappropriateness of using necessity or dispensing power as a means of introducing major and controversial policy change.¹²

With respect to Martin's claim, the court held that further clarification of the DPP Policy was not required. To provide clarification in the sense of identifying classes of cases that would be exempt from prosecution would be outside the scope of his discretionary executive powers.¹³ The DPP properly identified the facts and

⁷ *ibid* para 79.

⁸ *ibid* para 84.

⁹ *ibid* para 86.

¹⁰ *ibid* para 87.

¹¹ *ibid* paras 88-119.

¹² *ibid* paras 63-74.

¹³ *ibid* paras 123-144.

circumstances which he would take into account in deciding whether to consent to prosecution:

For the DPP to lay down a scheme by which it could be determined in advance as a matter of probability whether an individual would or would not be prosecuted would be to do that which he had no power to do, i.e. to adopt a policy of non-prosecution in identified classes of case, rather than setting out factors which would guide the exercise of his discretion.¹⁴

Thus, as concluded by the High Court of Justice:

Tony's and Martin's circumstances are deeply moving. Their desire to have control over the ending of their lives demands the most careful and sympathetic consideration, but there are also other important issues to consider. A decision to allow their claims would have consequences far beyond the present cases. To do as Tony wants, the court would be making a major change in the law. To do as Martin wants, the court would be compelling the DPP to go beyond his established legal role. These are not things which the court should do. It is not for the court to decide whether the law about assisted dying should be changed and, if so, what safeguards should be put in place. Under our system of government these are matters for Parliament to decide, representing society as a whole, after Parliamentary scrutiny, and not for the court on the facts of an individual case or cases. For those reasons I would refuse these applications for judicial review.¹⁵

Tony Nicklinson died from pneumonia on 22 August 2012, less than a week after the ruling.

While an application to enter the British Columbia Supreme Court decision of *Carter* into evidence was refused by the court in *Nicklinson*, it remains to be seen whether the *Nicklinson* decision will be allowed by the British Columbia Court of Appeal in *Carter*. Given however the likelihood that *Nicklinson* will be entered into evidence in the Quebec case of *LeBlanc*¹⁶ and the likelihood of further appeal to the Supreme Court of Canada and the joining of the British Columbia and Quebec cases, *Nicklinson* stands to inform the developing law in Canada.

In terms of the "slippery slope", the *Nicklinson* decision does not mention the term. However, as noted above, aspects of slippery slope concern and analysis are reflected throughout the decision. Examples here include, acknowledgment or reference to: unintended effects of precedent;¹⁷ that what is desired outcome (*A*) is dependent on the protagonists and players involved (a group much larger than the sitting judicial panel);¹⁸ potential risk to vulnerable members of society, particularly when their

¹⁴ *ibid* para 143.

¹⁵ *ibid* para 150.

¹⁶ *LeBlanc* (n 341).

¹⁷ *Nicklinson* (n 2) para 78.

¹⁸ *ibid* paras 76-8.

particular medical conditions are the conditions that may tilt the scale against investigation further;¹⁹ the inability of the judiciary to protect against and monitor that risk;²⁰ and finally that a blanket ban in order to reflect the importance of life and protect the vulnerable is not necessarily incompatible with right to privacy protections.²¹

Thus while the *Nicklinson* case may have come as a surprise to some, particularly given the outcome of the trial decision in the Canadian *Carter* case and furthermore, may be viewed by still others as simply a stalling technique, the case strongly re-asserts a central issue of the assisted death debate beyond the moral substantive question itself, namely, consideration for the appropriate process for legal reform. In so doing, it acknowledges that the legal pathway taken impacts and is relevant to how rights are to be shaped and constrained and also impacts social risk and conditions in the future. According to this court, the appropriate pathway and the subsequent social burden to be carried on this issue does not rightly rest on the shoulders of the judiciary but on society through orderly democratic responses. Perhaps in this way, technical legal pathways can be set aside to allow broad discussion as to whether it is solely protection of autonomy that is provoking this debate or whether the catalyst is compassion and empathy and our need to respond to the suffering of our fellow citizens. If compassion can be seen to be at the heart of or even just part of what is stirring this conflict, it is positioned as an important point in common for both sides of the debate.

¹⁹ *ibid* 36-42.

²⁰ *ibid* para 86.

²¹ *ibid* paras 118-121.

APPENDICES¹

CHART 1. Statutory Prohibitions on Assisted Suicide in the United States (Updated as of July 10, 2012)	
State	Current State Statutes
1. Alaska	Alaska has a law that specifically prohibits assisted suicide: Alaska Stat. §11.41.120 (a) (2).
2. Arizona	Arizona has a law that specifically prohibits assisted suicide: Ariz. Rev. Stat. §13-1103 (A) (3).
3. Arkansas	Arkansas has a law that specifically prohibits assisted suicide: Ark. Code §5-10-104 (a) (2), and a law that expressly prohibits physician-assisted suicide: Ark. Code §5-10-106.
4. California	California has a law that specifically prohibits assisted suicide: Cal. Penal Code §401.
5. Colorado	Colorado has a law that specifically prohibits assisted suicide: Colo. Rev. Stat. §18-3-104 (1) (b).
6. Connecticut	Connecticut has a law that specifically prohibits assisted suicide: Conn. Gen. Stat. §53a-56 (a).
7. Delaware	Delaware has a law that specifically prohibits assisted suicide: Del. Code, Title 11, §645.
8. Florida	Florida has a law that specifically prohibits assisted suicide: Fla. Stat. § 782.08.
9. Georgia	In 1994, Georgia enacted a law that specifically prohibits assisted suicide: Ga. Code §16-5-5 (b) and (c). The case <i>Final Exit Network, Inc. et al v. State of Georgia</i> 290 Ga.508 held the prohibition to be in violation of the free speech clauses of both the United States and Georgia Constitutions. The provision was amended with respect to public advertisements or offers to assist suicide and was passed into law May 2012 by House Bill 1114. The 2012 provision sets out a general prohibition on assisted suicide.
10. Hawaii	Hawaii has law that specially prohibits assisted suicide: Haw. Rev. Stat. §707-702 (1) (b).
11. Idaho	In 2011, a law prohibiting assisted suicide was signed by the Governor of Idaho (Session law Chapter 194) and the law is effective as of July 1, 2011: Idaho Code §18-4017.
12. Illinois	Illinois has a law that specifically prohibits assisted suicide: §720 III. Comp. Stat. 5/12-34.5.
13. Indiana	Indiana has a law that specifically prohibits assisted suicide: Ind. Code §35-42-1-2.5.
14. Iowa	Iowa has a law that specifically prohibits assisted suicide:

¹ These Appendices have been adapted from Mary J Shariff, 'Expert Report of Mary J. Shariff in Connection with Carter et al. v. Attorney General of Canada (Assisted Suicide Litigation)' (September 2011) Exhibits F, G and H.

	Iowa Code § 707A.2.
15. Kansas	Kansas has a law that specifically prohibits assisted suicide: Kan. Stat. § 21-3406.
16. Kentucky	Kentucky has a law that specifically prohibits assisted suicide: Ky Rev. Stat. § 216.302.
17. Louisiana	Louisiana has a law that specifically prohibits assisted suicide: La. Rev. Stat. §14.32.12. As of 1 August 2012, R.S. 40:1299.55 and 1299.58.10(A), provisions regarding consent to medical treatment including concerning life-sustaining procedures, will be amended and re-enacted to include the following reference, “nothing in this Part shall be construed to condone, authorize, or approve assistance to suicide, mercy killing, or euthanasia.”
18. Maine	Maine has a law that specifically prohibits assisted suicide: Me. Rev. Stat. Title 17-A, §204.
19. Maryland	Maryland has a law that specifically prohibits assisted suicide: Md. Code §3-102.
20. Michigan	In 1998, Michigan enacted a law that specifically prohibits assisted suicide: Mich. Comp. Laws §750.329a (1) and (3).
21. Minnesota	Minnesota has a law that specifically prohibits assisted suicide: Minn. Stat. §609.215.
22. Mississippi	Mississippi has a law that specifically prohibits assisted suicide: Miss. Code §97-3-49.
23. Missouri	Missouri has a law that specifically prohibits assisted suicide: Mo. Rev. Stat. §565.023.
24. Montana	Montana has a law that specifically prohibits assisted suicide insofar as it prohibits all homicide (defined as purposely or intentionally causing the death of another) but see <i>Baxter v. Montana</i> , 2009 MT 449 (Mont. 2009) which sets out physician defence to homicide in the context of assisted suicide based on the consent of the individual pursuant to Mont.Code Ann.§ 45-2-211(2).
25. Nebraska	Nebraska has a law that specifically prohibits assisted suicide: Neb. Rev. Stat. §28-307.
26. Nevada	Nevada does not have a specific offence for assisted suicide, however, in 1995 Nevada amended its health laws to expressly state that nothing in the health laws authorizes assisted suicide or euthanasia: Chapter 449, <i>Medical and Other Related Facilities</i> , NRS 449.670.
27. New Hampshire	New Hampshire has a law that specifically prohibits assisted suicide: N.H. Rev. Stat. §630:4.
28. New Jersey	New Jersey has a law that specifically prohibits assisted suicide: N.J. Stat. §2C:11-6.
29. New Mexico	New Mexico has a law that specifically prohibits assisted suicide: N.M. Stat. §30-2-4.
30. New York	New York has a law that specifically prohibits assisted suicide: N.Y. Penal Law. §120.30 and §125.15.

31. North Dakota	North Dakota has a law that specifically prohibits assisted suicide: N.D. Cent. Code §12.1-16-04.
32. Ohio	Ohio has no law that specifically prohibits assisted suicide nor does it recognize common law offences. However, in 2003, Ohio expressly legislated in its <i>Code on Health, Safety and Morals</i> (Title 37) that assisting suicide is against the public policy of Ohio, and Title 47, the <i>Code on Occupations and Professions</i> , permits professional discipline against health care professionals who participate in assisted suicide.
33. Oklahoma	Oklahoma has a law that specifically prohibits assisted suicide: Okla. Stat. title 21, §§813-818 and Okla. Stat. title 63, §§ 3141.1 to 3141.8.
34. Pennsylvania	Pennsylvania has a law that specifically prohibits assisted suicide: 18 Pa. Cons. Stat. §2505.
35. Rhode Island	In 1996, Rhode Island enacted a law that specifically prohibits assisted suicide: R.I. Gen. Laws § 11-60-4.
36. South Carolina	South Carolina has a law that specifically prohibits assisted suicide: S.C. Code §16-3-1090 (B), (E), (F) and (G1).
37. South Dakota	South Dakota has a law that specifically prohibits assisted suicide: S.D. Codified Laws §22-16-37.
38. Tennessee	Tennessee has a law that specifically prohibits assisted suicide: Tenn. Code Ann. §39-13-216 (a), (e), (f) and (g).
39. Texas	Texas has a law that specifically prohibits assisted suicide: Tex. Penal Code §22.08.
40. Virginia	Virginia does not have a law that specifically prohibits assisted suicide, however, in 1998 it enacted a mechanism for injunction power and civil damages as well as professional licence suspension/revocation for health care practitioners who engage in assisted suicide in Title 8.01 (<i>Civil Remedies and Procedure</i>), 1998, c. 624-622.1.
41. Wisconsin	Wisconsin has a law that specifically prohibits assisted suicide: Wis. Stat. §940.12.

Chart 2. Rejections of Proposals to Legalize Assisted Suicide in the United States: 1991-2012 (last updated 10 July 2012)		
State	Legislation Introduced But Not Passed	Defeated Ballot Initiatives
1. Alaska	HB 371 (1996)	
2. Arizona	SB 1007 (1996) HB 2167 (1999) HB 2454 (2003) HB 2564 (2004) HB 2311, HB 2313 (2005) HB 2572, HB 2357 (2007) HB 2387 (2008)	
3. California	AB 1080, AB 1310 (1995) AB 1592 (1999) AB 654 (2005) AB 651 (2006) AB 374 (2007)	1992: Proposition 161, "California Death with Dignity Act" (CA-DWDA), defeated by a vote of 54% to 46%
4. Colorado	HB 95-1308 (1995) HB 96-1185 (1996)	
5. Connecticut	SB 361 (1994) HB 6928, SB 334 (1995) HB 6083 (1997) SB 1138 (2009)	
6. Hawaii	HB 1669, SB 2095, SB 2372 (1997) SB 2095 (1998) HB 418, HB 347, (1999)	

	<p>SB 981, SB 692, SB 1037 (1999)</p> <p>HB 1155 (1999)</p> <p>HB 2491, SB2749, SB 709 (2001)</p> <p>HB 2487, SB 2745 (2002) 2487</p> <p>HB 862, SB 391 (2003-2004)</p> <p>HB 1454, SB 1308 (2005)</p> <p>HB 3013, SB 2900 (2006)</p> <p>HB 675, SB 800, SB 1995 (2007)</p> <p>HB 587, HB 806, SB 1159 (2009)</p>	
7. Illinois	HB 691, SB 948 (1997)	
8. Iowa	HF 2425 (2006)	
9. Louisiana	SB 128 (1999)	
10. Maine	<p>HP 552 (1995)</p> <p>LD 916, HP 663 (1997)</p> <p>IB 3 (LD2348), IB 10 (1999),</p>	2000: Question 1, the "Maine Death with Dignity Act", defeated by a vote of 51% to 49%
11. Maryland	HB 933, HB 474 (1995)	
12. Massachusetts	<p>H 3173 (1995)</p> <p>H 1543 (1997)</p> <p>H 1468 (2009)</p>	
13. Michigan	<p>HB 4501 (1992)</p> <p>HB 4134 (1994)</p> <p>SB 640 (1995)</p> <p>SB 653 (1997)</p> <p>HB 5474 (1998)</p>	1998: Measure B defeated by a vote of 71% to 29%

14. Mississippi	HB 1023 (1996)	
15. Montana	LC 1818 (2009) SB 167 (2011)	
16. Nebraska	LB 1259 (1996) LB 406 (1997) LB 70 (1999)	
17. New Hampshire	HB 339 (1996) HB 1433-FN (1998) SB 44 (1999) HB 304 (2009) HB 513 (2011)	
18. New Mexico	SB 446 (1995) HB 814 (2009)	
19. New York	S 1683, S 5024-A, A 6333 (1995) SB 4834 (1999) SB 677 (2001) A 9360 (2012)	
20. Pennsylvania	HB 1435 (2007) SB 404 (2009)	
21. Rhode Island	SB 2985 (1995) SB 2869 (1998) SB 2763 (2002) HB 7428, SB 2766 (2006) HB 6080 (2007)	
22. Vermont	H 335 (1995) H 109 (1997)	

	<p>H 493 (1999)</p> <p>H 318, S 112 (2003-2004)</p> <p>H 168 (2005-2006)</p> <p>H 44, S 63 (2007)</p> <p>H 455, S 144 (2009)</p> <p>Amendments to attach SB103 (2012) to H 157* (*H 157 without amendments passed)</p> <p>SB 103, H 274 (2011)</p>	
23. Washington	<p>SB 5596 (1995)</p> <p>SB 6576 (1998)</p> <p>SB 6843 (2006)</p>	1991: Ballot Initiative 119 defeated 54% to 46%
24. Wisconsin	<p>AB 174, SB 90 (1995)</p> <p>AB 32, SB 27 (1997)</p> <p>AB 297, SB 124 (1999)</p> <p>AB 417, SB 184 (2001)</p> <p>AB 348, SB 169 (2003)</p> <p>AB 507, SB 224 (2005)</p> <p>AB 298, SB 151 (2007)</p>	
25. Wyoming	<p>SF 0007 (2004)</p>	

Chart 3. Pending Legislation and Ballot Initiatives on Assisted Suicide: United States
 (Last updated as of July 10, 2012)

State	Legislative Initiative
Connecticut	2011: Proposed Bill No. 356, "An Act Concerning the Penalty for Assisted Suicide". Legislature is currently considering Bill 356 which introduces a mandatory minimum term of imprisonment for 2 years for the crime of assisting suicide.
Hawaii	2011: SB 803, "A Bill for an Act Relating to Death with Dignity", 2011: Proposed Companion Bills, HB 1383, "A Bill for an Act Relating to Death with Dignity", and HB 1165, "A Bill for An Act Relating to Compassion in Passing". Bills are currently before Committee.
Massachusetts	2011: Proposed Bill, H2233, "An Act relative to death with dignity". 2012: Proposed Bill, H3884, "An Act relative to death with dignity". 2012: Proposed Ballot Initiative (Petition Number 11-12). Ballot Initiative on physician-assisted suicide to be voted on in 2012.
Pennsylvania	2011: Proposed Bill, SB 431, "An Act amending Title 20 (Decedents, Estates and Fiduciaries) of the Pennsylvania Consolidated Statutes, providing for procedures regarding the request and dispensation of lethal medication to patients seeking to die in a dignified and humane manner, for duties of attending physicians, for duties of consulting physicians, for insurance or annuity policies; imposing duties on the Department of Health; providing for immunities and for attorney fees; and imposing penalties." Referred to committee 7 February 2011.

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