



# **Assisted Suicide & Euthanasia | *White Paper*** **WorldYouthAlliance**

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## I. Introduction

Increased life expectancy and ageing populations have made end-of-life care a pressing need, particularly in developed countries, where these trends are strongest. Medical advancements now cure once untreatable diseases, and can prolong life much longer than before for those with illnesses that remain incurable. Yet these advances cannot prevent ageing itself, or the limitations it causes, such as decreased mobility, loss of sight and hearing, dementia, or pain. The best way to support patients approaching the end of their lives is now a matter of intense debate.

The “right to die” movement claims that the answer is to allow medical professionals to hasten death, directly through euthanasia, or indirectly, through physician assisted suicide (PAS). It asserts that there is a right to choose the manner of one’s death, even as part of the right to life, and as a human right. This, proponents insist, is necessary for “death with dignity.” Although many countries still ban the practices, there has been a significant increase in the number of jurisdictions allowing the practices in recent years.

This white paper will critically examine the “right to die” and what is required to respect the dignity of each person in end-of-life care in light of law, policy, and practice, with a special concern for the protection of the vulnerable. First, it will discuss assisted suicide and euthanasia within international human rights law, and then provide an overview of existing national and subnational laws permitting the practice. Next it will discuss the primary arguments for assisted suicide, namely autonomy and suffering, and how those arguments fall short, before moving on to concerns about disability prejudice, the risk of coercion, and the effects of the practice on the medical profession. Finally, the paper will discuss how best to care for those approaching the end of their lives in a way that respects their dignity: improved physician-patient relationships in the end-of-life care context, palliative care, and psychosocial support.

### *Definitions*

For the purposes of this paper, euthanasia is the “intentional killing by act or omission of a dependent human being for his or her alleged benefit.”<sup>1</sup> Physician assisted suicide (PAS) means “physician participation in advising or providing, but not directly administering, the means or information enabling a person to intentionally end his or her life (e.g., ingesting a lethal dose of medication prescribed for that purpose).”<sup>2</sup> PAS differs from euthanasia in that the patient is the one administering the drug to him or herself, while in euthanasia a different person (usually a doctor) is the one who administers the lethal drug.

Euthanasia, by act or omission, as well as PAS, share the common intent “to cause or hasten the patient’s death.”<sup>3</sup> The intent also distinguishes euthanasia and PAS from stopping what is sometimes characterized as “overly aggressive therapy[, which is the] exaggeratedly stubborn struggle against inevitable death.”<sup>4</sup> Sometimes prolonging treatment is disproportionately burdensome on the patient, with no prospect of improvement. Such futile treatment can be withdrawn at the request of a patient. There is a long-standing medical and legal tradition supporting the rights of patients to refuse unwanted treatment, even though this

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<sup>1</sup> EUR. PARL. ASS. RES. 1859, ¶ 5, Council of Europe (Jan. 25, 2012).

<sup>2</sup> Lois Snyder Sulmasy & Paul S. Mueller, *Ethics and the Legalization of Physician-Assisted Suicide: An American College of Physicians Position Paper*, 167 ANNALS INTERNAL MED. 576, 578 (2017).

<sup>3</sup> GIACOMO PERICO, PROBLEMI DI ETICA SANITARIA 138 (1992).

<sup>4</sup> ETIENNE MONTERO, EUROPEAN INSTITUTE OF BIOETHICS, ETHICAL POINTS OF REFERENCE IN CARING FOR PEOPLE NEARING THE END OF LIFE 2 (2010) available at <https://www.ieb-eib.org/fr/document/ethical-points-in-caring-for-people-nearing-end-of-life-260.html>.

refusal may hasten death,<sup>5</sup> accepting “death as a natural consequence of the underlying disease progression.”<sup>6</sup>

On other occasions, the doctor can administer pain killers with the primary intent to alleviate the patient’s pain, even though death can occur as an unintended consequence. In both cases, there is no primary intention to hasten the patient’s death and in both cases the physician’s action is not the cause of death. Therefore, these actions should be clearly distinguished from euthanasia by omission as defined above.

Finally, in some cases of severe suffering, the person can be sedated to alleviate pain. In this case, “a physician uses sedatives to reduce or take away the consciousness of a patient until death follows.”<sup>7</sup> The intent behind the action also plays the crucial role. If the primary goal is to alleviate pain, while accepting death as a possible consequence, and the act is termed “palliative sedation.”

This paper does not offer a rule on which interventions constitute overly aggressive or futile therapy, as the advancement of medical technology, the nature and progression of the condition, how the intervention works, and other factors all influence perceptions of them.<sup>8</sup> Rather, it encourages early communication and thoughtful decision-making that respects the dignity of the person and human life as a fundamental good.

## II. Assisted Suicide and Euthanasia in Law

### A. International law

Much of the discussion surrounding assisted suicide and euthanasia is framed in the context of rights, such as a right to die, and in attempting to frame euthanasia as a human right. Meanwhile, those countries which permit assisted suicide or euthanasia have received criticism from international bodies because of the potential abuse of human rights. This conflict of views invites closer examination of human rights law and its views on the topic.

International human rights are created by treaty and by custom.<sup>9</sup> Treaties are binding agreements between States.<sup>10</sup> The United Nations’ explicit commitment to human rights and the recent memory of large-scale violations of these rights led to the drafting and adoption of numerous human rights treaties in the first few decades of the UN’s existence, and several more in ensuing years. States parties to the treaties participate by submitting reports to treaty

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<sup>5</sup> See *Cruzan v Director, Mo. Dep’t of Health*, 497 US 261, 305-06 (1990) (Brennan, J., concurring); *Washington v. Glucksberg*, 521 U.S. 706, 726 (1997).

<sup>6</sup> Liliana De Lima et al., *International Association for Hospice and Palliative Care Position Statement: Euthanasia and Physician-Assisted Suicide*, 20 J. PALLIATIVE MED. 8, 14 (2017).

<sup>7</sup> Kasper Raus et al., *Is Continuous Sedation at the End of Life an Ethically Preferable Alternative to Physician-Assisted Suicide?*, 11 AM. J. BIOETHICS 32, 32 (2011).

<sup>8</sup> Distinctions between “medical” and “nonmedical” interventions, or “ordinary” and “extraordinary” means of care are often not clean cut or universally agreed on. See NEIL M. GORSUCH, *THE FUTURE OF ASSISTED SUICIDE AND EUTHANASIA* 209 (2006).

<sup>9</sup> DAVID J. BEDERMAN, *THE SPIRIT OF INTERNATIONAL LAW* 33 (2006); Statute of the International Court of Justice art. 38(1), June 26, 1945, 33 U.N.T.S. 993.

<sup>10</sup> Vienna Convention on the Law of Treaties arts. 2(1)(a), 11, *opened for signature* May 23, 1969, 1155 U.N.T.S. 331, 333.

monitoring bodies who offer non-binding<sup>11</sup> recommendations to assist them in meeting their treaty obligations.<sup>12</sup>

The right to life is recognized in several human rights treaties.<sup>13</sup> Under treaty law, the terms are understood according to their ordinary meaning in light of the context and purpose of the treaty, and parties may only invoke supplementary materials in cases of ambiguity.<sup>14</sup> No human rights treaty includes a provision creating a “right to die” or a “right to assistance in dying.” Article 6 of the International Covenant on Civil and Political Rights (ICCPR) expressly protects the right to life, but does not mention a right to die,<sup>15</sup> and no similar right to die or control the manner of one’s death is expressly listed in any treaty.<sup>16</sup>

The United Nations Human Rights Committee has expressed concern at the ease of access to and increasing requests for assisted suicide, particularly in light of the right to life.<sup>17</sup> The Committee on the Rights of the Child has similarly encouraged the Netherlands, a country where child euthanasia is legal, to strictly monitor its practice and consider prohibiting it.<sup>18</sup> Moreover, the Committee on the Rights of Persons with Disabilities began an inquiry in May 2019 upon application from the parents and siblings of a quadriplegic French man whose food and water were removed at the request of his wife in line with France’s passive euthanasia law.<sup>19</sup>

However, some have interpreted a right to life broadly, to include a right to control the end of life, specifically through assisted suicide and/or euthanasia. In October 2018, the U.N. Human Rights Committee adopted a General Comment which suggested that, while suicide generally should be prevented, assisted suicide for those with serious illness does not violate

<sup>11</sup> TMBs have only limited authority granted by the treaties which create them, which does not include the authority to create rights. *See, e.g.*, International Covenant on Civil and Political Rights art. 40-42, *opened for signature* Dec. 19, 1966, 999 U.N.T.S. 171 [hereinafter ICCPR]; International Covenant on the Elimination of All Forms of Racial Discrimination part II, art. 8-9, *opened for signature* Mar. 7, 1966, 660 U.N.T.S. 195; Convention on the Elimination of All Forms of Discrimination against Women arts. 17-22, *opened for signature* Mar 1, 1980, 1249 U.N.T.S. 13; Convention on the Rights of the Child arts. 42-45, *opened for signature* Nov. 20, 1989, 1577 U.N.T.S. 3 [hereinafter CRC]; Convention on the Rights of Persons with Disabilities art. 34, *opened for signature* Dec. 13, 2006, 2515 U.N.T.S. 3 [hereinafter CRPD].

<sup>12</sup> Office of the High Comm’r for Hum. Rts., The United Nations Human Rights Treaty System: An Introduction to the Core Human Rights Treaties and the Treaty Bodies 21, [www.ohchr.org/Documents/Publications/FactSheet30Rev1.pdf](http://www.ohchr.org/Documents/Publications/FactSheet30Rev1.pdf) (last visited Sept. 25, 2018).

<sup>13</sup> *See, e.g.*, ICCPR, *supra* note 11, art. 6; CRC, *supra* note 11, art. 6; CRPD, *supra* note 11, art. 10.

<sup>14</sup> Vienna Convention on the Law of Treaties, *supra* note 10, arts. 31-32.

<sup>15</sup> ICCPR, *supra* note 11, art. 6.

<sup>16</sup> *See id.*; CRC, *supra* note 11, art. 6; CRPD, *supra* note 11, art. 10.

<sup>17</sup> U.N. Human Rights Committee, Consideration of Reports Submitted by States Parties Under Article 40 of the Covenant, Concluding observations of the Human Rights Committee—NETHERLANDS ¶ 7, U.N. DOC. CCPR/C/NLD/CO/4 (Aug. 25, 2009)

<sup>18</sup> U.N. Comm. on the Rts. of the Child, *Concluding observations on the fourth periodic report of the Netherlands* ¶¶ 28-29, U.N. DOC. CRC/C/NLD/CO/4 (July 16, 2015). This is especially troubling in light of statements by a Dutch teenaged survivor of sexual assault that her country had no specialized mental health facilities for teenagers; she requested euthanasia but was refused and later died by refusing to eat or drink. Jon Henley, *Dutch girl was not ‘legally euthanized’ and died at home*, GUARDIAN (June 5, 2019), <https://www.theguardian.com/world/2019/jun/05/noa-pothoven-netherlands-girl-not-legally-euthanised-died-at-home>. Although authorities refused euthanasia in this case, at least one Dutch woman in her 20s was allowed euthanasia on the basis of mental illness following childhood sexual abuse. Diana Tourjée, *Sexual Abuse Victim in Her 20s Allowed Suicide by Doctors in Netherlands*, VICE (May 11, 2016), [https://www.vice.com/en\\_us/article/mgm8b3/sexual-abuse-victim-in-her-20s-allowed-suicide-by-doctors-in-netherlands](https://www.vice.com/en_us/article/mgm8b3/sexual-abuse-victim-in-her-20s-allowed-suicide-by-doctors-in-netherlands).

<sup>19</sup> *UN body weighs in on French right-to-die case*, THELOCAL.FR (May 5, 2019), <https://www.thelocal.fr/20190505/un-body-weighs-in-on-french-right-to-die-case>. Vincent Lambert, the patient, was not dying, and food and water constitute essentials needed for life, unlike higher level interventions that maintain organ function, for example, without which the patient would die. Lambert died after several days without nutrition.

the international right to life, but requires safeguards and regulation to prevent coercion.<sup>20</sup> Although this comment is not binding, as it comes from a treaty monitoring body, it is influential as a statement of the committee’s interpretation of the right to life. As the committee has now accepted that a right to die may be part of the right to life, it is unlikely to examine whether assisted suicide poses unique risks or problems, regardless of the concerns raised by various international and national bodies. These concerns include the state’s interest in protecting life, preventing abuse and coercion, particularly of the vulnerable, and maintaining the integrity of the medical profession. These interests were cited in several of the court cases discussed below, and are also addressed in subsequent sections.

The issues of assisted suicide and euthanasia have come before the European Court of Human Rights several times. The court has generally refused to overrule practices in Member States related to the end of life, leaving matters, including bans on assisted suicide and withdrawal of sustenance, to national legislatures and procedures. The case of *Pretty v. United Kingdom* involves the fullest examination to date of whether a right to die exists under European human rights law.

In that case, a British woman with motor neuron disease challenged the United Kingdom’s prohibition on assisted suicide, arguing that it violated her rights under the European Convention of Human Rights (ECHR).<sup>21</sup> If her disease had not physically prevented her, she could have ended her life herself, but because of her inability to do so, she challenged the criminal provisions which prevented her husband from ending her life for her.<sup>22</sup> *Pretty* argued that the ECHR article 2 right to life included “a right to choose whether or not to go on living... not life itself.”<sup>23</sup> The court flatly rejected the idea that there is a negative right (to die) implied in article 2.<sup>24</sup>

The court also rejected the assertion that failure to allow her aid in ending her life constituted torture, inhuman, or degrading treatment under ECHR article 3, which has been understood to ban direct ill-treatment by authorities.<sup>25</sup> While acknowledging that quality of life and end of life concerns, including choosing the manner of one’s death, could fall within the

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right to private and family life under ECHR article 8,<sup>26</sup> the court ultimately held that the UK government was within its authority to ban assisted suicide based on its interest in protecting the vulnerable and that therefore the interference was justified.<sup>27</sup> The court also rejected the idea that a belief in assisted suicide for herself constituted a belief within the scope of the ECHR article 9 protections for freedom of religion or belief.<sup>28</sup> Finally, the court was not persuaded that *Pretty*’s inability to end her own life meant that a

<sup>20</sup> Human Rights Committee General comment No. 36 on article 6 of the International Covenant on Civil and Political Rights, on the right to life, U.N. Doc. CCPR/C/GC/36 (Oct. 30, 2018). The comment mentions terminally ill patients as an example of “afflicted adults.” *Id.* It does not suggest that the practice should be provided to children.

<sup>21</sup> *Pretty v. United Kingdom*, No. 2346/02 §§ 7, 32, Eur. Ct. H.R., Apr. 29, 2000.

<sup>22</sup> *Id.* §§ 8-10.

<sup>23</sup> *Id.* § 35.

<sup>24</sup> *Id.* §§ 39-40.

<sup>25</sup> *Id.* §§ 52-53.

<sup>26</sup> *Id.* §§ 65, 67.

<sup>27</sup> *Id.* §§ 74, 78.

<sup>28</sup> *Id.* §§ 82-83.

difference in legal treatment of suicide (not a crime under UK law) and assisted suicide (a crime) constituted unlawful or even avoidable discrimination, or that the aim of the ban (protecting the vulnerable) could be preserved while carving out an exception for cases like hers.<sup>29</sup>

The European Court of Human Rights has had several rulings since then. Despite its previous caution, in *Haas v. Switzerland*, the court suggested that its *Pretty* decision *had* found that the right to respect for private life does include the choice to avoid an undignified death, as long as the person ending their life was of sound mind.<sup>30</sup> Even so, the court upheld a law requiring a prescription for a lethal dose of medication, recognizing the state's interest in protecting life and preventing abuse.<sup>31</sup> In a subsequent case, *Koch v. Germany*, a man brought a case because his wife was denied access to a lethal dose of narcotics to end her life where they lived in Germany.<sup>32</sup> His wife, who was paralyzed, eventually endured a challenging transport to Switzerland, where she ended her life with the assistance of the pro-assisted suicide organization Dignitas.<sup>33</sup> Despite its earlier statement in *Haas*, in *Koch* the court recognized a wide "margin of appreciation" in the application of Article 8 rights with respect to assisted suicide, noting that only four member states allowed the practice and it did not enjoy consensus among states parties to the treaty.<sup>34</sup> It required Germany to thoroughly examine the claim domestically,<sup>35</sup> but not necessarily to permit the requested action.

*Gross v. Switzerland*, in which a plaintiff sued the state for not being prescribed a lethal medication, led to a further development of this principle, when the court held that a lack of clear guidelines regarding the provision of lethal prescriptions for those without terminal diseases did violate her Article 8 right to respect for private and family life.<sup>36</sup> However, the judgment was rendered by a divided court (four judges in favor, three against), and included a strong dissent from the interpretation of Article 8.<sup>37</sup> The decision was voided after it emerged that the plaintiff had committed suicide by lethal prescription a year and a half before the original decision was handed down and concealed her death with the help of a spiritual advisor in order for her case to continue.<sup>38</sup>

These cases do not produce a firm rule so much as the application of principles of law to particular legal frameworks. While the European Court of Human Rights has not expressly held that allowing assisted suicide violates rights under the European Convention on Human

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Rights, it has found state interests in the protection of life and prevention of abuse to be compelling reasons justifying bans on the practice. In the Swiss cases, given the legality of assisted suicide, it has both upheld restrictions on lethal medications and, in the voided decision, suggested that legal requirements have to be clear so that those

<sup>29</sup> *Id.* § 88.

<sup>30</sup> *Haas v. Switzerland*, No. 31322/07, §§ 50-51, Eur. Ct. H.R., Jan. 6, 2011.

<sup>31</sup> *Id.* §§ 56-58.

<sup>32</sup> *Koch v. Germany*, No. 497/09 §§ 9, 11, Eur. Ct. H.R., Dec. 12, 2012.

<sup>33</sup> *Id.* § 12.

<sup>34</sup> *Id.* §§ 69-70.

<sup>35</sup> *Id.* § 71.

<sup>36</sup> *Gross v. Switzerland*, No. 67810/10 §§ 67-69, Eur. Ct. H.R., May 14, 2013 (2d Section), *voided by* *Gross v. Switzerland*, No. 67810/10, Eur. Ct. H.R., Sept. 30, 2014 (Grand Chamber).

<sup>37</sup> *See* *Gross v. Switzerland*, No. 67810/10 Dissent §§ 6-9, Eur. Ct. H.R., May 14, 2013 (2d Section) (JJ. Raimondi, Jočiene, and Karakaş, dissenting), *voided by* *Gross v. Switzerland*, No. 67810/10, Eur. Ct. H.R., Sept. 30, 2014 (Grand Chamber).

<sup>38</sup> *Gross v. Switzerland*, No. 67810/10 §§ 29-34, 37, Eur. Ct. H.R., Sept. 30, 2014 (Grand Chamber).

seeking assistance to end their lives understand the requirements to do so. This disparate treatment suggests that the court is applying the provisions and principles of the Convention in line with the nature and purposes of the laws of each country, rather than assessing whether European human rights law requires or bans assisted suicide, limiting itself in recognition of the margin of appreciation on areas of law lacking consensus.

Just as international law does not require assisted suicide, there is also no customary law giving the right to die or end one's life as one likes. Customary international law arises from the practices of states acting out of a sense of legal obligation (*opinio juris*).<sup>39</sup> There are two key elements of customary law. The first involves questions such as whether the rule has been followed, and how consistent and how long the practice has been in place.<sup>40</sup> The second element requires an assessment of whether a practice has been accepted as law—indicating that states believe it is an obligation, rather than simply a beneficial option.<sup>41</sup> It is the harder element to establish of the two. As the vast majority of countries do not allow the practice, general practice does not exist. This also implies that states do not believe that they have an obligation to permit it. Moreover, in the *Pretty* case discussed above, the European Court of Human Rights rejected the argument that its acceptance of assisted suicide in one country meant that laws banning the practice in another country had to be overturned.<sup>42</sup>

## **B. National and subnational laws permitting euthanasia and/or assisted suicide**

Switzerland decriminalized the practice of assisted suicide when done without “selfish motives” in 1918,<sup>43</sup> although it failed to create a clear legislative framework around the practice.<sup>44</sup> In 2001, the Netherlands became the first country to adopt national legislation legalizing assisted suicide and euthanasia, after tolerating the practice for some years.<sup>45</sup> In 1997, Colombia decriminalized both PAS and euthanasia by Constitutional Court decision, although the government failed to provide regulations for some time.<sup>46</sup> The U.S. state of Oregon began allowing PAS for adults in 1997,<sup>47</sup> following a U.S. Supreme Court decision

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<sup>39</sup> BEDERMAN, *supra* note 9, at 33.

<sup>40</sup> *Id.*

<sup>41</sup> *Id.* at 33, 36.

<sup>42</sup> *Pretty*, No. 2346/02 § 41.

<sup>43</sup> Saima A. Hurst & Alex Mauron, *Assisted suicide and euthanasia in Switzerland: allowing a role for non-physicians*, 326 BRIT. MED. J. 271, 271 (2003). As the title suggests, although doctors may participate, such as through lethal medications, people without medical training can also help others' suicide, and organizations exist for this purpose. *See, e.g., Exit at a Glance*, EXIT, available at <https://exit.ch/en/who-is-exit/>.

<sup>44</sup> *See* Gross, No. 67810/10 §§ 67-69, Eur. Ct. H.R., May 14, 2013 (2d Section), *voided by* Gross v. Switzerland, No. 67810/10, Eur. Ct. H.R., Sept. 30, 2014 (Grand Chamber).

<sup>45</sup> Jacqui Wise, *Netherlands, first country to legalise euthanasia*, 79 BULL. WORLD HEALTH ORG. 580, 580 (2001).

<sup>46</sup> Corte Constitucional [C.C.], mayo 20, 1997, Sentencia C-239/97, §§ II(C)(3), III available at <http://www.corteconstitucional.gov.co/relatoria/1997/c%2D239%2D97.htm>.

<sup>47</sup> William Claiborne, *'Death With Dignity' Measure May Make Oregon National Battlefield*, Washington Post, June 27, 1997, at A19. Oregon's legislature passed a bill in 2019 amending its act to facilitate assisted suicide through means besides swallowing, which some argue blurs the line between assisted suicide and euthanasia as it could require more active involvement from a second person to administer the lethal medication. Markian Hawryluk, *Bill reopens debate over assisted suicide in Oregon*, BEND BULLETIN (Apr. 27, 2019), <https://www.bendbulletin.com/localstate/7117862-151/bill-reopens-debate-over-assisted-suicide-in-oregon>. As of writing, the Oregon legislature has considered expanding the means of assisted suicide to include injections for patients unable to swallow, which some consider a gradual inching towards euthanasia as it requires greater participation from medical professionals to set up the lethal dose. Kristian Foden-Vencil, *Oregon Considers*

which found no right to assisted suicide, but did not prohibit the states from allowing the practice.<sup>48</sup>

Since then, both assisted suicide and euthanasia have been implemented in more jurisdictions, and some have expanded it by law or in practice beyond terminally ill, mentally competent adults. The Dutch legislation had required that the predicate medical condition have no chance of improvement, but not that it be terminal, and allows it for children without parental approval, including those as young as twelve, if they are considered to understand the nature of the action.<sup>49</sup> In fact, even seriously ill or disabled infants can be euthanized under the Groningen Protocol at the parents' request.<sup>50</sup> Moreover, at least one young Dutch woman's euthanasia request was granted on the basis of mental illness following childhood sexual abuse.<sup>51</sup> Belgium legalized euthanasia for those with incurable conditions in 2002,<sup>52</sup> and in 2014 extended it to minors of any age following a psychological assessment that they understand the nature of their request and if they experience incurable physical pain.<sup>53</sup> Luxembourg passed a law allowing assisted suicide and euthanasia for terminally ill adults in 2009.<sup>54</sup>

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The U.S. states of Washington (2009), Vermont (2013), California (2016), Colorado (2016), Hawaii (2019), New Jersey (2019), and Maine (2019), and the District of Columbia (2017) have legalized assisted suicide for adults with incurable conditions, and Montana's state supreme court decriminalized assisting suicide in 2009, although its legislature has not passed implementing legislation.<sup>55</sup> Colombia's Constitutional Court definitively established a

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*Expanding Its Death With Dignity Law*, OR. PUB. BROADCASTING (May 10, 2019), <https://www.opb.org/news/article/oregon-assisted-suicide-death-with-dignity-expansion-bill/>.

<sup>48</sup> Glucksberg, 521 U.S. at 735.

<sup>49</sup> Wet van 12 april 2001 toetsing levensbeëindiging op verzoek en hulp bij zelfdoding [Law of 12 April 2001 on termination of life on request and assisted suicide], Stb. 2001 p. 194 (Neth).

<sup>50</sup> Matthew Schofield, *Newborns at the heart of Dutch euthanasia debate*, EDMONTON J., Oct. 20, 2004 at A15; Eduard Verhagen & Pieter J.J. Sauer, *The Groningen Protocol—Euthanasia in Severely Ill Newborns*, 352 NEW ENG. J. MED. 959, 961 Table 2 (2005).

<sup>51</sup> See Tourjée, *supra* note 18.

<sup>52</sup> Loi du 28 mai 2002 relative à l'euthanasie [Law of 28 May 2002 on euthanasia] of May 28, 2002, MONITEUR BELGE [M.B.] [Official Gazette of Belgium], June 22, 2002.

<sup>53</sup> Loi modifiant la loi du 28 mai 2002 relative à l'euthanasie, en vue d'étendre l'euthanasie aux mineurs [Law amending the law of 28 May 2002 on euthanasia, with a view to extending euthanasia to minors] of Feb. 28, 2014, MONITEUR BELGE [M.B.] [Official Gazette of Belgium], Mar. 12, 2014. The amended law requires a child psychiatrist or psychologist to assess whether the child understands the nature of his or her illness and request; it does not include an age limit. [Law of 28 May 2002 on euthanasia] § 3.

<sup>54</sup> Loi du 16 mars 2009 sur l'euthanasie et l'assistance au suicide [Law of 16 March 2009 on euthanasia and assisted suicide], Memorial A No. 46 Journal Officiel du Grand-Duché de Luxembourg 615 [Official Gazette of Luxembourg] available at <http://legilux.public.lu/eli/etat/leg/memorial/2009/46>.

<sup>55</sup> Catharine Paddock, *Washington State Legalizes Assisted Suicide*, MED. NEWS TODAY (Mar. 6, 2009), <https://www.medicalnewstoday.com/articles/141318.php>; Terri Hallenbeck, *Vermont governor signs end-of-life bill*, USA TODAY (May 20, 2013), <https://www.usatoday.com/story/news/politics/2013/05/20/vermont-physician-assisted-death-bill/2343481/>; Brakkton Booker, *California Governor Signs Physician-Assisted Suicide Bill Into Law*, NPR (Oct. 5, 2015), <https://www.npr.org/sections/twotwo-way/2015/10/05/446115171/california-governor-signs-physician-assisted-suicide-bill-into-law>; Jennifer Brown, *Colorado passes medical aid in dying, joining five other states*, DENVER POST (Nov. 8, 2016), <https://www.denverpost.com/2016/11/08/colorado-aid-in-dying-proposition-106-election-results/>; Wayne Yoshioka, *"Death with Dignity" Signed Into Law*, HAW. PUB. RADIO (April 5, 2018), <http://www.hawaiipublicradio.org/post/death-dignity-signed-law>; Nicholas Pugliese, *NJ legalizes assisted*

constitutional right to “death with dignity” in 2014<sup>56</sup> and extended this to minors, potentially as young as six, in 2017.<sup>57</sup>

Canada’s Supreme Court also found a right to assisted suicide within its Charter of Rights and Freedoms in 2015,<sup>58</sup> and the government adopted a law allowing assisted suicide and euthanasia for suffering adults whose deaths are reasonably foreseeable.<sup>59</sup> The law also requiring the government to investigate the possibility of providing assisted suicide to “mature minors” and those suffering from mental illness.<sup>60</sup> Australia does not have national assisted suicide legislation, but the parliament of the state of Victoria passed “voluntary assistance in dying” legislation in 2017,<sup>61</sup> with the law taking effect in 2019.<sup>62</sup>

The modern euthanasia movement often utilizes “rights” argumentation, asserting that there should be a “right to die” or a “right to die with dignity” recognized by international law. According to some authors, this right stems from the right of the human person to choose what he or she considers to be a good life, and consequently also what constitutes a good death. The advocates argue that the respect for individual autonomy also implies the right to choose how one wants to die.<sup>63</sup> Besides respect for the autonomy of dying patients, advocates for the legalization of euthanasia and assisted suicide usually present them as acts of compassion for persons who are suffering and nearing death. As many countries and regions have campaigns promoting the adoption or judicial imposition of assisted suicide,<sup>64</sup> claims that it is a right and various arguments used to support it warrant further attention. A discussion of those issues, as well as risks inherent in the practices and dignity-centered solutions to end-of-life care, follows.

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*suicide as Gov. Phil Murphy signs contentious bill into law*, NorthJersey.com (Apr. 12, 2019), <https://www.northjersey.com/story/news/new-jersey/2019/04/12/nj-legalizes-assisted-suicide-murphy-signs-contentious-bill-into-law/3446698002/>; Marina Villeneuve, *Maine becomes 8<sup>th</sup> state to legalize assisted suicide*, AP (June 12, 2019), <https://www.apnews.com/7f0fe9d789294a02852c1669c892f382>; *Baxter v. State*, 2009 MT 449, ¶¶ 5-6, 354 Mont. 234, 224 P.3d 1211; Fenit Nirappil, *A year after D.C. passed its controversial assisted suicide law, not a single patient has used it*, WASH. POST (Apr. 10, 2018), [https://www.washingtonpost.com/local/dc-politics/a-year-after-dc-passed-its-assisted-suicide-law-only-two-doctors-have-signed-up/2018/04/10/823cf7e2-39ca-11e8-9c0a-85d477d9a226\\_story.html?utm\\_term=.2de5d8f8d809](https://www.washingtonpost.com/local/dc-politics/a-year-after-dc-passed-its-assisted-suicide-law-only-two-doctors-have-signed-up/2018/04/10/823cf7e2-39ca-11e8-9c0a-85d477d9a226_story.html?utm_term=.2de5d8f8d809); Mike Dennison, *House passes bill to outlaw physician-assisted suicide in Montana*, MISSOULIAN (Mar. 16, 2015), [https://missoulian.com/news/state-and-regional/montana-legislature/house-passes-bill-to-outlaw-physician-assisted-suicide-in-montana/article\\_c6facb27-78c0-59be-a5fa-a8686ac7964f.html](https://missoulian.com/news/state-and-regional/montana-legislature/house-passes-bill-to-outlaw-physician-assisted-suicide-in-montana/article_c6facb27-78c0-59be-a5fa-a8686ac7964f.html); *Montana Lawmakers Reject Criminalizing Physician-Assisted Suicide*, MTPR NEWS (Mar. 1, 2017), <http://www.mtpr.org/post/montana-lawmakers-reject-criminalizing-physician-assisted-suicide>.

<sup>56</sup> Corte Constitucional [C.C.], diciembre 15, 2014, Sentencia T-1970/14, § II(5), available at <http://www.corteconstitucional.gov.co/relatoria/2014/t%2D970%2D14.htm>.

<sup>57</sup> Ministerio de Salud y Protección Social, Res. No. 0825 de 2018, arts. 2(2.4)-(2.6), 3 paragrafo, 10.

<sup>58</sup> *Carter v. Canada* (Attorney General), [2015] S.C.R. 331, 335-36 (Can.).

<sup>59</sup> An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying), S.C. 2016, c. 3 §§ 2(227), 3(241.1), 3(241.2)(1)-(2) (Can.).

<sup>60</sup> *Id.* § 8(9.1).

<sup>61</sup> *Voluntary Assisted Dying Act 2017*, no. 61 of 2017 (Austl., Vic.)

<sup>62</sup> Jean Edwards, *Euthanasia: Victoria becomes the first Australian state to legalise voluntary assisted dying*, ABC NEWS (Nov. 29, 2017, 4:19AM), available at <https://www.abc.net.au/news/2017-11-29/euthanasia-passes-parliament-in-victoria/9205472>.

<sup>63</sup> GORSUCH, *supra* note 8, at 99.

<sup>64</sup> See, e.g., Sibilla Bondolfi, *Death by Choice: The global fight for assisted suicide*, SWISSINFO.CH (Nov. 14, 2018), [https://www.swissinfo.ch/eng/business/death-by-choice\\_the-global-fight-for-assisted-suicide/44543634](https://www.swissinfo.ch/eng/business/death-by-choice_the-global-fight-for-assisted-suicide/44543634); *Noticias Internacional*, DERECHO A MORIR DIGNAMENTE, <https://derechoamorrir.org/category/noticias-internacional/>; *Take Action*, COMPASSION & CHOICES, <https://compassionandchoices.org/take-action>.

### III. “Death with Dignity”: Common rationales for permitting assisted suicide and euthanasia

Within human rights law, “dignity” has a precise meaning: the value an individual human being has simply by virtue of being human.<sup>65</sup> This value is intrinsic, inherent, and universal;<sup>66</sup> it does not decrease or increase in proportion to any personal characteristic,

**No one loses his dignity because he has become reliant on others for care, or experiences suffering. To suggest otherwise suggests that human life does not have objective value, which would undermine not only laws banning assisted suicide, but the foundation of human rights itself.**

experience, or action. That includes manners of dying: no one loses his dignity because he has become reliant on others for care, or experiences suffering. To suggest otherwise suggests that human life does not have objective value, which would undermine not only laws banning assisted suicide, but the foundation of human rights itself.

“Death with dignity” and its variations are popular slogans among PAS advocates, even though the terms are inherently vague.<sup>67</sup> This phrase pits

autonomy against an unknown hour and manner of death, and suggest that the suffering and pain experienced by many at the end of life is undignified and therefore should be avoided. Numerous PAS advocacy organizations have framed this as a “right to die with dignity,” suggesting a legal obligation despite most courts finding that no right to die, in any manner, exists.<sup>68</sup>

This concept is inherently problematic, regardless of whether euthanasia is included in the concept of “dying with dignity” or not. It suggests that there could equally be a situation in which a person could die “without dignity”. One scholar summarizes it thus: “Death with dignity, either alone or with others, is certainly preferable to death without dignity, whether it be lingering or rather sudden.”<sup>69</sup> This view is radically mistaken, because a human person is never “without” his or her dignity. This confusion in semantics suggests that the elderly, suffering, disabled or terminally ill may be deprived of their dignity, which undermines the fundamental equality of all persons. No matter how difficult the end of life may be, no manner of death can be without dignity because no person is ever without dignity. That dignity must be respected throughout life, including in the provision of care for the dying.

Equally wrong are the terms of “dignified death” and “dignity of death.” Death is the moment in which human life ends. Death itself, considered biologically, is “the degradation of the biological dimension of the human being, nothing dignified.”<sup>70</sup> In all the other aspects (psychological, emotional, social and mental) death also indicates the disintegration of the human being. Since life is a fundamental value for a person (there can be no non-living person; a dead body is a corpse and not a dead person) and death signifies the moment in which this fundamental value ceases to exist, there is nothing of dignity in the death per se.

<sup>65</sup> See Universal Declaration of Human Rights, G.A. Res. 217A, Preamble, art. 1, U.N. GAOR, 3d Sess., 1st plen. Mtg., U.N. Doc. A/810 (Dec. 12, 1948).

<sup>66</sup> *Id.* at Preamble (“Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family...”).

<sup>67</sup> KEVIN YULL, ASSISTED SUICIDE: THE LIBERAL, HUMANIST CASE AGAINST LEGALIZATION 13-15 (2015).

<sup>68</sup> GORSUCH, *supra* note 8, at 45 (2006).

<sup>69</sup> Jordan J. Paust, *The Human Right to Die With Dignity: A Policy-Oriented Essay*, 17 HUM. RTS. Q. 463 (1995).

<sup>70</sup> Valentin Pozaić, *Palliative care and the human dignity of patients*, 5 GLAS. PUL. BOLN. 153, 154 (2009).

Thus, concepts of “dignified death” and the “dignity of death” should be abandoned. Rather, the focus should be on respect for dignity in end-of-life care. The process of dying can be more or less in accordance with human dignity, and thus can be more or less respectful of human dignity. Society should aim for end-of-life care which respects human dignity for those who are dying, so that this care is understood as a process of dying in accordance with human dignity—a process of dying worthy of the human person.

“Death with dignity” arguments typically present as arguments related to choosing the manner of one’s own death (autonomy) and avoiding suffering. Deeper examinations of each aspect of arguments for “death with dignity” follow.

### A. Autonomy

One of the most common arguments in favor of legalizing euthanasia and assisted suicide is the argument from autonomy and self-determination. According to this argument, mentally competent and terminally ill adults should have the right to decide how and when to end their lives. This argument suggests that the State should protect that right by not interfering with and prohibiting others from interfering with one’s autonomous decision.

However, what the argument essentially misses is that legalizing euthanasia and assisted suicide is not a solitary action, but one that requires a doctor’s participation in the suicide *and* social acceptance of the act. “Euthanasia is not a private matter of self-determination. It is an act that requires two people to make it possible, and a complicit society to make it acceptable.”<sup>71</sup> Self-determination in the case of euthanasia can only be achieved “by the moral and physical assistance of another. Euthanasia is thus no longer a matter only of self-determination, but of a mutual, social decision between two people.”<sup>72</sup>

The autonomy argument is clearly expressed in the decision of the United States Supreme Court in *Planned Parenthood v. Casey*: “At the heart of liberty is the right to define one’s own concept of existence, of meaning, of the universe, and of the mystery of human life.”<sup>73</sup> Applying this principle in *Compassion in Dying v. Washington*, the federal district court for the state of Washington reasoned that “the decision of a terminally ill person to end his or her life involves the most intimate and personal choices a person may make in a lifetime and constitutes a choice central to personal dignity and autonomy.”<sup>74</sup>

Individual autonomy, however important it may be, is always limited by the protection of the fundamental goods of society. One such good is the life of a human being, which should be always protected; therefore, the intentional taking of the life of another should be always prohibited. The principle of the inviolability of life is a fundamental principle of common law,<sup>75</sup> and this principle has been enshrined in numerous human rights conventions.<sup>76</sup> It is grounded in an “understanding of each human being as having an intrinsic and inviolable dignity. The essence of the principle is the prohibition on the intentional taking of human life, intention used in its ordinary sense of aim or purpose.”<sup>77</sup> The Canadian House of Lords Select Committee on Medical Ethics described the prohibition on intentional killing as “the cornerstone of law and

<sup>71</sup> Daniel Callahan, *When Self-Determination Runs Amok*, 22 HASTINGS CTR. REP. 52, 53 (1992).

<sup>72</sup> *Id.* at 52.

<sup>73</sup> *Planned Parenthood v. Casey*, 505 U.S. 833, 851 (1992)

<sup>74</sup> *Compassion in Dying v. Washington*, 850 F. Supp. 1454, 1459-60 (Wash. 1994).

<sup>75</sup> John Keown, *A Right to Voluntary Euthanasia? Confusion in Canada in Carter*, 28 NOTRE DAME J.L. ETHICS & PUB. POL’Y 1, 5 (2014) [hereinafter Keown, *Voluntary Euthanasia*]

<sup>76</sup> See ICCPR, *supra* note 11, art. 6; European Convention on Human Rights art. 2, *opened for signature* Nov. 4, 1950, E.T.S. No. 5, 213 U.N.T.S. 221; American Convention on Human Rights art. 4, Nov. 21, 1969, 1144 U.N.T.S. 143; African Charter on Human and Peoples’ Rights art. 4, *opened for signature* June 27, 1981, 1520 U.N.T.S. 217.

<sup>77</sup> Keown, *Voluntary Euthanasia*, *supra* note 75, at 5.

of social relationships” which “protects each one of us impartially, embodying the belief that all are equal.”<sup>78</sup> As numerous court decisions indicate, the State has a legitimate interest in preserving life.<sup>79</sup>

England’s Court of Appeal has observed that some cases present an apparent conflict between the patient’s interest in “self-determination” and society’s interest in “upholding the concept that all human life is sacred.”<sup>80</sup> While acknowledging that the right of self-determination is of “paramount” importance, the court held that in cases where doubt exists about whether the individual is actually exercising that right, “that doubt fails to be resolved in favour of the preservation of life for if the individual is to override the public interest, [she] must do so in clear terms.”<sup>81</sup> Similarly, the European Court of Human Rights stressed that “the concept that ‘everyone’s life shall be protected by law’ enjoins the state not only to refrain from taking life ‘intentionally’ but, further, to take appropriate steps to safeguard life.”<sup>82</sup> In the Case *Pretty v. United Kingdom*, the court underlined that it has always placed “consistent emphasis . . . [on] the obligation of the State to protect life.”<sup>83</sup>

Moreover, the patient’s autonomy, which proponents of the legalization of euthanasia and PAS claim these practices protect, is in fact illusory, because the final decision rests in the hands of the doctor, not the patient. “The physician decides when the patient is suffering intolerably enough to use the last resort. The physician controls the availability of the medication and its dose. The physician makes a judgment about the quality of the patient’s life and suffering and what is good for the patient.”<sup>84</sup> Thus, as some authors have argued, making physicians the arbiters of assisted suicide and euthanasia is a return to one of the most severe forms of paternalism, not a victory for patient autonomy.<sup>85</sup> Therefore, the justification of voluntary euthanasia rests

**Making physicians the arbiters of assisted suicide and euthanasia is a return to one of the most severe forms of paternalism, not a victory for patient autonomy.**

fundamentally not on the patient's autonomous request *but on the doctor's judgment that the request is justified because the patient no longer has a life “worth” living*. If a doctor can make this judgment in relation to an autonomous patient, he can, logically, make it in relation to an incompetent patient. Moreover, if death is a ‘benefit’ for competent patients suffering certain conditions, why should it be denied incompetent patients suffering from the same conditions?<sup>86</sup>

Numerous cases of non-voluntary and involuntary euthanasia worldwide testify to this. In the Netherlands by 1990, there were 1,000 cases (0.8% of all deaths) where physicians

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<sup>78</sup> *Id.* at 6.

<sup>79</sup> GORSUCH, *supra* note 8, at 10.

<sup>80</sup> *Id.* at 187.

<sup>81</sup> *Id.*

<sup>82</sup> L.C.B. v. United Kingdom, App. No. 23413/94 § 36, Eur. Ct. H.R., June 9, 1998; *see generally* Ass’n of Parents v. United Kingdom, No. 7154/75, Eur. Ct. H.R., July 12, 1978.

<sup>83</sup> *Pretty*, No. 2346/02 § 39.

<sup>84</sup> Edmund D. Pellegrino, *Compassion Is Not Enough*, in *THE CASE AGAINST ASSISTED SUICIDE* 48 (Kathleen Foley & Herbert Hendin, eds., 2002).

<sup>85</sup> *Id.*

<sup>86</sup> John Keown, *Euthanasia in the Netherlands: Sliding down the Slippery Slope*, 9 NOTRE DAME J. L., ETHICS & PUB. POL’Y 407, 408 (2002) (emphasis in original).

administered a drug hastening the end of life “without an explicit request of the patient,”<sup>87</sup> and in 4,000 cases physicians “withdrew or withheld treatment without request” with the explicit intent to shorten life.<sup>88</sup> The number remained high in 1995, with 900 cases of *active* euthanasia without the explicit request of the patient.<sup>89</sup> Replication studies in Australia and Belgium both found incidence of ending life without the explicit request of the patient to be over 3%.<sup>90</sup> Dutch studies show that in 8% of the cases in which “a life-terminating act was performed without explicit request of the patient,” other treatment alternatives still existed.<sup>91</sup> Physicians justified their actions on the grounds that the suffering was considered unbearable, standard medical care failed to help, and death would occur most likely within a week.<sup>92</sup>

The numbers are even more alarming when they include death by deliberate act of omission. Dutch numbers show that there were 15,528 cases (59%) of intentionally terminating life without any explicit request in 1995.<sup>93</sup> The numbers for the United States show that 54% of the patients who received a lethal injection did not make the request for euthanasia themselves.<sup>94</sup> According to a Dutch study from 2001, 16% of patients whose lives were ended without request were fully competent, raising the question of why a request to die was not obtained.<sup>95</sup> A previously-made request is now acceptable without restatement in the Netherlands: in the first trial of a doctor who performed euthanasia since legalization,<sup>96</sup> a Dutch court found that doctors do “not have to verify the current desire to die” for patients who have previously requested euthanasia but due to dementia are no longer mentally competent to make the request.<sup>97</sup>

One survey of critical care nurses calculated that at least 7% of the nurses interviewed had at least once carried out euthanasia without a request from either the patient or a surrogate.<sup>98</sup> Another 4% had hastened a patient’s death by only pretending to provide the life-sustaining treatment ordered by a physician. Some nurses reported engaging in these practices without a request or advance knowledge of physicians.<sup>99</sup> In another Dutch study, the researchers went so far as to suggest that “the person responsible for avoiding involuntary termination of life is the patient” and that “the person who does not wish to have his or her life terminated should declare this clearly, in advance, orally and in writing, preferably in the form of a living will.”<sup>100</sup>

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<sup>87</sup> *Id.* at 417.

<sup>88</sup> *Id.* at 418.

<sup>89</sup> Gerrit van der Wal & P. J. van der Maas, *Empirical Research on Euthanasia and Other Medical End-of-Life Decisions and the Euthanasia Notification Procedure*, in ASKING TO DIE 171 (David C. Thomasma, et al., eds., 1998).

<sup>90</sup> Raphael Cohen-Almagor, *Non-voluntary and Involuntary Euthanasia in the Netherlands: Dutch Perspectives*, 18 ISSUES IN L. & MED. 239, 241 (2003).

<sup>91</sup> *Id.* at 242.

<sup>92</sup> *Id.*

<sup>93</sup> John Finnis, *Euthanasia, Morality and Law*, 31 LOY. L. A. L. REV. 1123, 1128 (1998).

<sup>94</sup> Diane E. Meier et al., *A National Survey of Physician-Assisted Suicide and Euthanasia*, 338 NEW ENG. J. MED. 1193, 1200 (1998).

<sup>95</sup> ANTONIA GRUNDMANN, DAS NIEDERLÄNDISCHE GESETZ ÜBER DIE PRÜFUNG VON LEBENSBEENDIGUNG 210 (2004).

<sup>96</sup> Raf Casert & Aleksandar Furtula, “Landmark euthanasia trial opens in the Netherlands,” MED. XPRESS (Aug. 26, 2019), <https://medicalxpress.com/news/2019-08-landmark-euthanasia-trial-netherlands.html>.

<sup>97</sup> Mike Corder & Maria Cheng, “Dutch court clears doctor in landmark euthanasia trial,” MED. XPRESS (Sept. 11, 2019), <https://medicalxpress.com/news/2019-09-dutch-court-doctor-landmark-euthanasia.html>.

<sup>98</sup> David A. Asch, *The Role Of Critical Care Nurses in Euthanasia and Assisted Suicide*, 334 NEW ENG. J. MED. 1374 (1996).

<sup>99</sup> *Id.*

<sup>100</sup> Herbert Hendin, *The Dutch Experience*, in THE CASE AGAINST ASSISTED SUICIDE 117 (Kathleen Foley & Herbert Hendin, eds., 2002) [hereinafter Hendin, *The Dutch Experience*].

Finally, euthanasia for mentally competent terminally ill persons raises the problem of diagnosing and estimating how much time people have left until the end of life. Doctors often report problems with determining whether the disease is terminal and how much time is left for the person. One study from 2011 conducted on 1622 patients found that physicians accurately estimated the duration of the patient's survival in only 34% of the cases.<sup>101</sup> In a 1996 survey approximately half of Oregon physicians acknowledged a lack of confidence in their own ability to predict whether patients have more or less than six months to live."<sup>102</sup> A 1999 survey of Oregon physicians showed that "one in six were not confident about finding reliable lethal prescribing information, and one in four were not confident in determining six-month life expectancy."<sup>103</sup> The problem with medical prognoses is that they are based on statistical averages, which are nearly useless in determining what will happen to an individual patient.<sup>104</sup>

## B. Pain and Suffering

One common and persuasive argument for PAS is that laws banning the practice force people to suffer. This argument draws on the feeling of empathy experienced in response to suffering, as well as fears of future suffering among supporters. It raises challenging questions of what compassion means and whether society meets the needs of those in grave pain or distress. For proponents of PAS, a desire for suicide is a reasonable response to grave suffering, and compassion for those suffering requires us to aid them in ending their lives.

Pain and fear of pain are a major concern at the end of life, even though concerns about autonomy or being a burden may rank more highly among those seeking assisted suicide.<sup>105</sup> There is evidence to suggest that many patients have inadequate pain management<sup>106</sup> (which some healthcare providers may "treat" with euthanasia<sup>107</sup>). The most vulnerable patients, such as members of minority groups and the elderly, may receive less pain treatment than other groups.<sup>108</sup> Many physicians report that they lack necessary knowledge to control pain effectively.<sup>109</sup>

Assisted suicide is a final and unchangeable response to suffering which may well be poorly managed or under treated. It may also be less a request for help ending one's own life as much as a call for meaningful assistance at the end of life. A program at Memorial Sloan Kettering Cancer Hospital, a leading New York City hospital, found that patients expressing a desire for suicide were notably more fatigued than those who did not, and often used their request to "ensure that the listener understood the depth of their suffering."<sup>110</sup> When these

<sup>101</sup> Debbie Selby et al., *Clinician Accuracy When Estimating Survival Duration: The Role of the Patient's Performance Status and Time-Based Prognostic Categories*, 42 J. PAIN & SYMPTOM MGMT. 578 (2011).

<sup>102</sup> Melinda A. Lee, et al., *Legalizing Assisted Suicide—Views of Physicians in Oregon*, 334 NEW ENG. J. MED. 310, 334 (1996).

<sup>103</sup> Linda Ganzini, et al., *Oregon physicians' attitudes about and experiences with end-of-life care since passage of the Oregon Death with Dignity Act*, 285 JAMA 2363, 2368 (2001).

<sup>104</sup> Marilyn Golden & Tyler Zoanni, *Killing us softly: the dangers of legalizing assisted suicide*, 2 DISABILITY & HEALTH J. 16, 21 (2010).

<sup>105</sup> See, e.g., OREGON PUBLIC HEALTH DIVISION, OREGON DEATH WITH DIGNITY ACT 2018 DATA SUMMARY 12 (2019) [hereinafter OREGON 2018 DATA SUMMARY].

<sup>106</sup> Kathleen Foley, *Compassionate Care, Not Assisted Suicide*, in THE CASE AGAINST ASSISTED SUICIDE at 298 (Kathleen Foley & Herbert Hendin, eds. 2002) [hereinafter Foley, *Compassionate Care*]

<sup>107</sup> Dutch physician Zbigniew Zylicz recounts instances of referrals to his palliative care clinic of patients whose doctors had or would have euthanized patients for pain and discomfort which they did not realize could be ameliorated. Zbigniew Zylicz, *Palliative Care and Euthanasia in the Netherlands: Observations of a Dutch Physician*, in THE CASE AGAINST ASSISTED SUICIDE at 127, 139-40 (Kathleen Foley & Herbert Hendin, eds. 2002).

<sup>108</sup> *Id.*

<sup>109</sup> *Id.*

<sup>110</sup> *Id.* at 300.

conversations took place, healthcare providers were able to address key concerns and ensure better patient care, with the result that none of the patients in that report ended their lives.<sup>111</sup> Reports from Oregon and the Netherlands suggest that effective palliative care interventions can lead to a significant number of patients changing their minds about assisted suicide.<sup>112</sup> Addressing these gaps through physician education, improved pain management, and holistic palliative care should take priority over acts that deliberately end lives.

Physical suffering can also cause or contribute to mental and emotional distress. Patients' desires to live can fluctuate over time, impacted by factors like depression, anxiety, and physical symptoms.<sup>113</sup> Patients requesting PAS often cite loss of autonomy and fear of being a burden, not only physical pain,<sup>114</sup> which can reflect or intensify their psycho-social concerns. Depression, rather than pain, is related to patients stockpiling medications to end their lives.<sup>115</sup> Older patients and patients with serious illnesses experience depression and anxiety, which can affect their medical decision-making.<sup>116</sup> And clinical depression and psychological distress in patients correlates with their support for PAS.<sup>117</sup>

Although symptoms of serious illness and serious depression can overlap, research has shown that there are ways to evaluate patient depression, including simply asking if they often feel depressed.<sup>118</sup> These conditions can sometimes be organic in nature (caused by injury or disease), but even those that are purely psychiatric suggest that the issue of competent decision-making deserves additional scrutiny.<sup>119</sup> Researchers also found a stronger correlation between hopelessness and a desire for suicide than even depression and suicide.<sup>120</sup>

Proponents of assisted suicide often portray it as compassionate towards those experiencing suffering.<sup>121</sup> This reflects an emotivist ethic: that emotions and sympathy are the key factor in determining whether an action is moral.<sup>122</sup> Suffering can provoke feelings of empathy—and a desire to end that suffering, even if it means helping to end the life of the sufferer.<sup>123</sup> Yet emotions can provoke both good and bad responses, and varied responses among different people; they do not prove themselves morally correct simply by virtue of being a natural response, but must be examined with reason.<sup>124</sup>

The compassion offered by PAS collapses under deeper examination. The word “compassion” comes from the Latin verb meaning “to suffer with.”<sup>125</sup> Yet assisted suicide requires little of society, least of all sharing in the suffering of our most vulnerable at the final

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<sup>111</sup> *Id.* at 300-01.

<sup>112</sup> Linda Ganzini et al., *Physicians' Experiences with the Death with Dignity Act*, 342 NEW ENG. J. MED. 557, 560, 562 (2000). In Oregon, nearly half of patients who received substantive interventions changed their minds. *Id.* at 560.

<sup>113</sup> Harvey M. Chochinov & Leonard Schwartz, *Depression and the Will to Life in the Psychological Landscape of Terminally Ill Patients*, in THE CASE AGAINST ASSISTED SUICIDE at 267 (Kathleen Foley & Herbert Hendin, eds. 2002).

<sup>114</sup> OREGON 2018 DATA SUMMARY, *supra* note 105, at 10; DISEASE CONTROL & HEALTH STATISTICS DIVISION, WASH. STATE DEPT. HEALTH 2017 DEATH WITH DIGNITY ACT REPORT 8 (2018) [hereinafter WASH. 2017 REPORT], available at <https://www.doh.wa.gov/portals/1/Documents/Pubs/422-109-DeathWithDignityAct2017.pdf>; GUENTER LEWY, ASSISTED DEATH IN EUROPE AND AMERICA: FOUR REGIMES AND THEIR LESSONS 33-34 (2017).

<sup>115</sup> Chochinov & Schwartz, *supra* note 113, at 269.

<sup>116</sup> Foley, *Compassionate Care*, *supra* note 106, at 299.

<sup>117</sup> Chochinov & Schwartz, *supra* note 113, at 263.

<sup>118</sup> *Id.* at 265-66.

<sup>119</sup> *Id.* at 266.

<sup>120</sup> *Id.* at 268.

<sup>121</sup> YUILL, *supra* note 67, at 41.

<sup>122</sup> Pellegrino, *supra* note 84, at 43.

<sup>123</sup> *Id.* at 43-44.

<sup>124</sup> *Id.* at 44-45.

<sup>125</sup> *Id.* at 42.

moments, when they end their lives by themselves.<sup>126</sup> This in turn points to a more fundamental problem with using this supposed compassion for suffering as a guide: its resistance to limits.<sup>127</sup> If feeling compassion for suffering is a reasonable basis to permit assisted suicide, why should it only apply to physical pain among mentally competent, terminally ill adults?<sup>128</sup> If ending suffering is inherently a moral good, should euthanasia be allowed? Does it even need to be requested? One assisted suicide critic has characterized the argument for PAS from compassion

**Assisted suicide requires little of society, least of all sharing in the suffering of our most vulnerable at the final moments, when they end their lives by themselves.**

as essentially a projection of supporters' future fears onto those suffering now, and one that lacks courage, because if it were true it would tend to support euthanasia, even without request, not assisted suicide.<sup>129</sup> As he writes, "What kind of compassionate person refuses to take action herself and instead simply says to the suffering person: 'It's your choice'?" An act of compassion is an action waiting around to see what a suffering person wants."<sup>130</sup>

Though advocates deride the "slippery slope," or simply refuse to engage it,<sup>131</sup> there is cause for concern. The Netherlands now euthanizes disabled and severely ill infants on the grounds that ending their lives is more compassionate than the speculated suffering they will endure.<sup>132</sup> Middle-aged deaf twin brothers in Belgium requested and received assisted suicide upon learning that they were going blind, rather than be unable to see each other or placed in institutional care.<sup>133</sup> Colombia issued rules for euthanasia for adults, and, within two years, for children, even as young as six.<sup>134</sup> In a case that made headlines, a rape victim suffering mental illness from her trauma ended her life with a lethal prescription in the Netherlands.<sup>135</sup> If ending suffering is a moral imperative, it becomes difficult to limit it, or draw a bright line between which forms of suffering are bad enough to warrant helping someone end his life and which are not.

<sup>126</sup> YUILL, *supra* note 67, at 41. Yuill calls this "a compassion of the most cowardly variety that prefers to hand the gun to the suffering individual rather than take responsibility for the action itself." *Id.*

<sup>127</sup> YUILL, *supra* note 67, at 46; Pellegrino, *supra* note 84, at 46.

<sup>128</sup> YUILL, *supra* note 67, at 46; Pellegrino, *supra* note 84, at 46.

<sup>129</sup> YUILL, *supra* note 67, at 46.

<sup>130</sup> *Id.*

<sup>131</sup> Benjamin T. Jones, *Singer and Fisher preach to their flocks in euthanasia debate*, CONVERSATION (Bos.), Aug. 13, 2015, available at <https://theconversation.com/singer-and-fisher-preach-to-their-flocks-in-euthanasia-debate-45880> ("For much of the debate, the two did not address the other's arguments. Singer kept a small target, advocating voluntary euthanasia only for competent adults with a terminal illness."). Singer's decision not to engage the argument that assisted suicide laws tend to loosen over time could be considered, as the article puts it, remaining focused on what he supports, or as a failure to engage a central claim of assisted suicide opponents: that the narrow circumstances he expressed his support for assisted suicide are where the laws begin, but not where they end. The entire debate may be viewed online on the YouTube channel of the Sydney University Catholic Society, which co-sponsored the event ([https://www.youtube.com/watch?v=kZLS5L\\_Iknc](https://www.youtube.com/watch?v=kZLS5L_Iknc)).

<sup>132</sup> *Netherlands grapples with euthanasia of babies*, NBC NEWS, Nov. 20, 2004, available at [http://www.nbcnews.com/id/6621588/ns/health-childrens\\_health/t/netherlands-grapples-euthanasia-babies/#.W\\_I\\_yi3MywA](http://www.nbcnews.com/id/6621588/ns/health-childrens_health/t/netherlands-grapples-euthanasia-babies/#.W_I_yi3MywA).

<sup>133</sup> Michelle Castillo, *Report: Twin deaf brothers going blind undergo euthanasia*, CBS NEWS (Jan. 14, 2013), <https://www.cbsnews.com/news/report-twin-deaf-brothers-going-blind-undergo-euthanasia/>.

<sup>134</sup> Ministerio de Salud y Protección Social, Res. No. 0825 de 2018, art. 3 *paragrafo*.

<sup>135</sup> Matt Payton, *Sex abuse victim in her 20s allowed by doctors to choose euthanasia due to 'incurable' PTSD*, INDEPENDENT (London), May 11, 2016, available at <https://www.independent.co.uk/news/world/europe/sex-abuse-victim-in-her-20s-allowed-by-dutch-doctors-to-undergo-euthanasia-due-to-severe-ptsd-a7023666.html>.

Compassion alone cannot justify an action; it must be evaluated by reason with the good of the person in mind.<sup>136</sup> It also demands something, both of individuals and society: actions to alleviate suffering where it can be alleviated, and to accompany the suffering. Legalizing assisted suicide will not meet the deepest needs, medical or psycho-social, of those suffering. Despite its emotional appeal, PAS represents at its most basic level the abandonment of the vulnerable to their suffering, not compassion for it, and must therefore be rejected.

## IV. Assisted Suicide and Euthanasia: Concerns and Risks

### A. Assisted suicide and disability discrimination

Disability rights groups have actively opposed assisted suicide.<sup>137</sup> Some, such as Not Dead Yet and its local affiliates, focus specifically on opposing assisted suicide from a disability rights perspective.<sup>138</sup> For these activists, assisted suicide is a clear threat to their health and lives. They raise compelling concerns about the influence of disability prejudice on medical care, how quality of life is assessed, and the problem in resisting “help” dying when help living is hard to get.

Advocates for PAS argue that laws contain sufficient safeguards and that disability concerns should not limit what options are available to those who do want to end their lives.<sup>139</sup> Yet, as disability advocates point out, legalization of assisted suicide creates a system where “some people who say they want to die will receive suicide intervention, and others will receive suicide assistance.”<sup>140</sup> A powerful cartoon by Amy Hasbrouck, Director of Toujours Vivant/Not Dead Yet Canada, illustrates this: it features a wheelchair user between two doors, one requiring stairs to enter and labeled “Suicide Prevention Program” and one at the top of a ramp, labeled “Assisted Suicide.”<sup>141</sup> A doctor’s perceptions of quality of life, suffering, and likely prognosis can funnel patients to one door or the other, without necessarily engaging in conscious bias. The use of euthanasia under the Groningen Protocol and several cases where parents and doctors opted to starve infants with disabilities, including non-life-threatening conditions, underline the very real danger these attitudes pose to the life and well-being of persons with disabilities.<sup>142</sup>

There is reason to believe that medical providers and patients with disabilities perceive problems related to care differently. People with disabilities tend to rate their quality of life much higher than their healthcare providers do, and similar to how people without disabilities assess their own quality of life.<sup>143</sup> In one survey, medical providers tended to identify barriers to care for people with disabilities in terms of finances, booking and attending appointments, and difficulty explaining to and understanding staff.<sup>144</sup> On the other hand, patients with disabilities in focus groups identified other concerns: “lack of preventative care, financial

<sup>136</sup> Pellegrino, *supra* note 84, at 45.

<sup>137</sup> Coleman, *Not Dead Yet*, in *THE CASE AGAINST ASSISTED SUICIDE* 213 (Kathleen Foley & Herbert Hendin, eds., 2002).

<sup>138</sup> See *Who We Are*, NOT DEAD YET, <http://notdeadyet.org/about> (last visited Nov. 18, 2018).

<sup>139</sup> Coleman, *supra* note 137, at 222; Alicia Ouellette, *Barriers to Physician Aid in Dying for People with Disabilities*, 6 *LAWS* no. 23, at 3 (2017) (articles are individually paginated in this journal).

<sup>140</sup> Coleman, *supra* note 137, at 221.

<sup>141</sup> TOUJOURS VIVANT/NOT DEAD YET CANADA, <https://tvndy.ca/en/> (last visited Nov. 18, 2018). (Scroll down on main page to view cartoon.)

<sup>142</sup> See Verhagen & Sauer, *supra* note 50, at 959; GORSUCH, *supra* note 8, at 191-94.

<sup>143</sup> Nancy Sharby et al., *Decreasing Health Disparities for People with Disabilities through Improved Communication Strategies and Awareness*, 12 *INT’L J. ENVTL. RES. & PUB. HEALTH* 3301, 3313 (2015).

<sup>144</sup> *Id.* at 3310-11.

barriers, and dissatisfaction with the care they received.”<sup>145</sup> They expressed concern about poor communication, inattentiveness, negative attitudes, and lack of training, which could have negative health outcomes, especially if they have complex medical needs.<sup>146</sup>

PAS does not resolve those problems, which take an investment of time, money, and training, but it might push already vulnerable people towards ending their lives. Surveys of those ending their lives under assisted suicide legislation reflect fears of loss of function, autonomy, and being a burden—in short, fears about living with a disability.<sup>147</sup> Similarly, safeguards are often much more limited than they seem, with few checks on doctors’ reports, filed after patients’ deaths by PAS, to ensure that no abuses occurred.<sup>148</sup> Moreover, at least one jurisdiction, Oregon, has taken such an expansive view of what constitutes a terminal illness for the purposes of the assisted suicide law that it includes conditions which with treatment would be manageable and chronic rather than terminal.<sup>149</sup>

Disability activists also raise concerns that assisted suicide may create a duty to die. Accessibility, assistive devices, medical care, and other things people with disabilities need to live their lives fully can become extremely costly. Although couched in language of choice, some assisted suicide advocates have identified the expenses of care as a path forward for their movement.<sup>150</sup> Roger Foley, a chronically ill Canadian man who needs extensive assistance, has filed suit against a hospital, healthcare officials, and the government after claiming that he was refused the quality care he needed to live at home, but advised of his options related to a “medically assisted death.”<sup>151</sup> Sean Tagert, a forty-one year old father with amyotrophic lateral sclerosis (also known as motor neuron disease), was offered insufficient hours of care at the home where he had partial custody of his son.<sup>152</sup> Without support from health authorities to receive the medically-indicated twenty-four hour care, and believing that the care he could receive in a facility would shorten his life and remove him from his son, Tagert ended his life under Canada’s medically assisted dying process.<sup>153</sup>

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<sup>145</sup> *Id.* at 3311.

<sup>146</sup> *Id.*

<sup>147</sup> Coleman, *supra* note 137, at 225. See also OREGON 2018 DATA SUMMARY, *supra* note 105, at 12; WASH. 2017 REPORT, *supra* note 114, at 8.

<sup>148</sup> See, e.g., REGIONAL EUTHANASIA REVIEW COMMITTEES, REGIONAL EUTHANASIA REVIEW COMMITTEES RTE: ANNUAL REPORT 2017 at 8, 17, 19 (English version), available at <https://english.euthanasiecommissie.nl/the-committees/documents/publications/annual-reports/2002/annual-reports/annual-reports> (reporting only twelve findings of a doctor “not acting in accordance with due care criteria” out of 6,585 reports filed by doctors, and 80% of cases found to be “straightforward” on initial review from reports submitted by doctors); Xavier Symons, *Dutch authorities to prosecute euthanasia doctor*, BIOEDGE (Nov. 11, 2018), <https://www.bioedge.org/bioethics/dutch-authorities-to-prosecute-euthanasia-doctor/12889> (reporting on the first prosecution of a doctor in the Netherlands, who euthanized a patient with advanced dementia in 2016). This is also troubling in light of the way that civil authorities and the general public seem to take abuse of people with disabilities less seriously, as evidenced by much lighter sentences for caregivers who commit murder than for those who murder able-bodied people. Coleman, *supra* note 137, at 232.

<sup>149</sup> See generally FABIAN STAHL, OREGON HEALTH AUTHORITY REVEALS HIDDEN PROBLEMS WITH THE OREGON ASSISTED SUICIDE MODEL 1-2 (Jan. 2018), available at <https://drive.google.com/file/d/1xOZfLFrVUQcaZzFudEncp2b18NrUo/view>. Mr. Stahl is an independent researcher in Sweden whose report quotes correspondence between him and state health officials.

<sup>150</sup> Coleman, *supra* note 137, at 227.

<sup>151</sup> *Chronically ill man releases audio of hospital staff offering assisted death*, CTV NEWS (Aug. 2, 2018), <https://www.ctvnews.ca/health/chronically-ill-man-releases-audio-of-hospital-staff-offering-assisted-death-1.4038841?cache=yes%3FautoPlay%3Dtrue%3FautoPlay%3Dtrue>. Foley also alleged that his condition had deteriorated due to substandard care provided by his assigned caregivers.

<sup>152</sup> *B.C. man with ALS chooses medically assisted death after years of struggling to fund 24-hour care*, CBC NEWS (Aug. 13, 2019), <https://www.msn.com/en-ca/news/canada/bc-man-with-als-chooses-medically-assisted-death-after-years-of-struggling-to-fund-24-hour-care/ar-AAFKuYa?li=AAggNb9&%253Bsrcref=rss>.

<sup>153</sup> *Id.*

Improvements in medicine have led to more people living longer who might otherwise have died, all at an increased financial and even emotional burden on society.<sup>154</sup> An already vulnerable person may “internalize the social oppression that declares severe disability to be undignified” and decide that suicide will restore their worth.<sup>155</sup> The twentieth century witnessed several efforts to limit the burden imposed on society by the poor and people with disabilities, both through proactive euthanasia and sterilization programs, and through failing to treat them, even if conditions were treatable.<sup>156</sup> The veneer of choice cannot erase this disturbing history, nor alter the context of unmet medical needs, lack of resources, and social stigma in which such “choices” will be made.

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## **B. Vulnerable groups and coercion**

Legalizing euthanasia and assisted suicide requires physicians to determine which lives can be considered unworthy of living, and inevitably leads to increased pressure on members of vulnerable groups. A right-to-die mentality has been shown to exert psychological pressure upon vulnerable persons,<sup>157</sup> and this pressure raises the question of whether any real autonomy can be exercised in these conditions.

The case of Kate Cheney, as described by both Cheney and members of her family, illustrates this point.<sup>158</sup> Kate was an eighty-five-year-old widow diagnosed with terminal stomach cancer. She wanted the option of assisted suicide “in case she was in pain or if the indignities of losing control of her bodily functions became unbearable.”<sup>159</sup> Her daughter Erika went with Kate when she made the request to her physician. Erika described the physician as “dismissive” and requested a referral to a second physician. He arranged for a psychiatric consultation, which was a standard procedure. The psychiatrist, who visited Kate at her home, found that Kate did not “seem to be explicitly pushing for [assisted suicide]” and that she lacked the “level of capacity ... to weigh options about [it].”<sup>160</sup>

Although Kate seemed to accept the assessment, her daughter became very angry. The hospital then suggested that the family obtain a second assessment from an outside consultant. The second psychologist noted that Kate had memory defects and that her “choices [might have been] influenced by her family's wishes and [that] her daughter, Erika, [might have been] somewhat coercive,” but felt Kate had the ability to make her own decision. A hospital administrator then saw Kate and decided that she was competent and was making the decision on her own. Kate received the lethal drugs, which were put under Erika's care. As time passed, Erika and her husband sent Kate to a nursing home for a week. When Erika visited, Kate always asked “when she would be going home.” On the day she returned from the nursing home, she

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<sup>154</sup> *Id.* at 228.

<sup>155</sup> *Id.* at 228.

<sup>156</sup> *Id.* at 228-29.

<sup>157</sup> LEWY, *supra* note 114, at 153.

<sup>158</sup> See Herbert Hendin & Kathleen Foley, *Physician-Assisted Suicide in Oregon: A Medical Perspective*, 106 MICH. L. REV. 1613, 1624 (2008) [hereinafter Hendin & Foley, *Oregon*].

<sup>159</sup> *Id.*

<sup>160</sup> *Id.*

told Erika and her husband that “she had considered going permanently into a nursing home but had decided to use the pills instead and asked for their help.”<sup>161</sup> Within a short time, Kate took the pills and died.

Several cases suggest that family expectations can exert pressure, not only on the patients, but also on physicians to assist in suicide even where it may not be warranted. Helen was a patient who performed aerobic exercises up until two weeks before she contacted the physician to request PAS.<sup>162</sup> She told the physician she could not do them anymore, and she was also unable to continue to garden, which had been one of her favorite activities. Apart from that, she was not bedridden, was not in great pain, and was still able to look after her own house. Helen's own physician had refused to assist in her suicide, and a second physician also refused on the grounds that Helen was depressed.

Helen's husband then called the advocacy group Compassion in Dying and was referred to a physician who would assist her. The third doctor finally approved the request. He later regretted his decision and the fact that he didn't personally discuss the case with her regular physician and had only cursory contact with Helen. He also explained the reasons behind his decisions: “The thought of Helen dying so soon was almost too much to bear.... On the other hand, I found even worse the thought of disappointing this family. If I backed out, they'd feel about me the way they had about their previous doctor, that I had strung them along, and in a way, insulted them.”<sup>163</sup>

Some studies have shown that in the Netherlands “families request euthanasia more often than patients themselves” and “the family, the doctors, and the nurses often pressured the patient to request euthanasia.”<sup>164</sup> “The relatives’ inability to cope” was also cited by physicians as a major reason (32% of cases) for terminating life without patients consent.<sup>165</sup> In 2001, Dutch doctor Wilfrid van Oijen ended the life of an 84-year-old woman at her daughters’ request, and not her own.<sup>166</sup> The woman had heart problems and was increasingly bedridden, but was not in pain and had even said that she did not want to die, but could not care for herself. She expressed the desire to be with her daughters who cared for her at home, but the care became burdensome to the daughters, so van Oijen gave her medication to hasten the process of dying.<sup>167</sup>

The legalization of PAS can also foster economic coercion, both due to financial burdens on families and in savings to society as a whole. Recently, a study was published in Canada which tried to argue that legalizing “medical assistance in dying could reduce annual health care spending across Canada by between \$34.7 million and \$138.8 million.”<sup>168</sup> Legalizing euthanasia sends a message that some groups are a burden for a society and that society would be better off without them. This inevitably leads to a utilitarian view of human persons, which allows the “sacrifice” of certain groups for the benefit of other groups who aren’t too costly to care for. As the New York State Task Force on Life and the Law, established in the early 1990s to consider the possibility of

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<sup>161</sup> *Id.* at 1625.

<sup>162</sup> *Id.* at 1616.

<sup>163</sup> Peter Reagan, *Helen*, 353 LANCET 1265, 1266 (1999), quoted in Hendin & Foley, *Oregon*, *supra* note 158, at 1619.

<sup>164</sup> Cohen-Almagor, *supra* note 90, at 249.

<sup>165</sup> GORSUCH, *supra* note 8, at 110.

<sup>166</sup> Herbert Hendin, *The Dutch Experience*, *supra* note 100, at 115.

<sup>167</sup> *Id.*

<sup>168</sup> Aaron J. Trachtenberg & Braden Manns, *Cost analysis of medical assistance in dying in Canada*, 189 CAN. MED. ASS’N J. E101, E101 (2017).

legalizing PAS, observed: “Limits on hospital reimbursement based on length of stay and diagnostic group, falling hospital revenues, and the social need to allocate health dollars may all influence physicians' decisions at the bedside... Under any new system of health care delivery, as at present, it will be far less costly to give a lethal injection than to care for a patient throughout the dying process.”<sup>169</sup>

In 2008, Randy Stroup was diagnosed with prostate cancer and he turned to the Oregon state-run health plan for coverage of his chemotherapy treatments.<sup>170</sup> Since chemotherapy is expensive, Stroup received a letter that stated his request was denied, but the State would pay for physician-assisted suicide.<sup>171</sup> Stroup had such a low chance of recovery that the state of Oregon decided he was no longer worth treating.<sup>172</sup> In another case in Oregon, a dying patient was euthanized to free a hospital bed.<sup>173</sup> As euthanasia advocate Derek Humphry predicted, “one must look at the realities of the increasing cost of health care in an aging society, because in the final analysis, economics, not the quest for broadened individual liberties or increased autonomy, will drive assisted suicide to the plateau of acceptable practice.”<sup>174</sup>

This is not a fringe position; in fact, a number of officials around the world have endorsed it more or less openly. A former governor of Colorado has openly and repeatedly defended the view that the elderly have a duty to die to make room (and save resources for) the young.<sup>175</sup> In 2014 a Lithuanian Health Minister suggested euthanasia could be a solution for poor people,<sup>176</sup> and a Japanese finance minister said that the elderly should be allowed to “hurry up and die” to relieve pressure on the state to pay for their medical care.<sup>177</sup> Baroness Warnock, a leading ethicist in the U.K., similarly suggested that dementia sufferers may have a “duty to die.”<sup>178</sup> It shouldn't surprise us then, as one poll in Ohio found that “those most likely to oppose the practice [of PAS] were black, people 65 and older, and those with low levels of income and education.”<sup>179</sup>

It is for this reason that numerous bodies have rejected the legalization of assisted suicide. The British House of Lords concluded in 2001 that a prohibition against the practice was justified precisely because of the possibility that “vulnerable people—the elderly, lonely, sick or distressed—would feel pressure, real or imagined, to request early death . . . [and] the message which society sends to vulnerable and disadvantaged people should not, however obliquely, encourage them to seek death, but should assure them of our care and support in

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<sup>169</sup> NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT 123 (1994) [hereinafter NYS TASK FORCE ON LIFE AND THE LAW], available at [https://www.health.ny.gov/regulations/task\\_force/reports\\_publications/when\\_death\\_is\\_sought](https://www.health.ny.gov/regulations/task_force/reports_publications/when_death_is_sought).

<sup>170</sup> Zachary D. Smoll, *Physician-Assisted Suicide Tells People Like Me That Our Lives Are No Longer Worth Living*, THE PUB. DISCOURSE (May 8, 2017), available at <http://www.thepublicdiscourse.com/2017/05/19163/>.

<sup>171</sup> *Id.*

<sup>172</sup> *Id.*

<sup>173</sup> R.J.D. George, et al., *Legalised euthanasia will violate the rights of vulnerable patients*, 331 BRIT. MED. J. 684, 685 (2005).

<sup>174</sup> DEREK HUMPHRY & MARY CLEMENT, FREEDOM TO DIE: PEOPLE, POLITICS, AND THE RIGHT-TO-DIE MOVEMENT 313 (1998).

<sup>175</sup> GORSUCH, *supra* note 8, at 131.

<sup>176</sup> *Euthanasia could be option for poor, says Lithuanian health minister*, BIOEDGE (Jul 26, 2014), available at [https://www.bioedge.org/bioethics/euthanasia\\_could\\_be\\_option\\_for\\_poor\\_says\\_lithuanian\\_health\\_minister/11071](https://www.bioedge.org/bioethics/euthanasia_could_be_option_for_poor_says_lithuanian_health_minister/11071).

<sup>177</sup> *Let elderly people 'hurry up and die', says Japanese minister*, GUARDIAN (Jan 22, 2013), available at <https://www.theguardian.com/world/2013/jan/22/elderly-hurry-up-die-japanese>.

<sup>178</sup> *Baroness Warnock: Dementia sufferers may have a 'duty to die'*, TELEGRAPH (Sept 18, 2008), available at <https://www.telegraph.co.uk/news/uknews/2983652/Baroness-Warnock-Dementia-sufferers-may-have-a-duty-to-die.html>.

<sup>179</sup> GORSUCH, *supra* note 8, at 126.

life.”<sup>180</sup> The New York State Task Force similarly explained in 1992 that they had “unanimously concluded that legalizing assisted suicide and euthanasia... will pose the greatest risks to those who are poor, elderly, members of a minority group, or without access to good medical care.”<sup>181</sup> Similarly, an Australian euthanasia bill from 1996 was repealed by the Commonwealth Parliament in 1997, with the consideration that it “had an unacceptable impact on the attitudes of the Aboriginal community towards health services,”<sup>182</sup> and that “evidence was received that hospitals had become feared as places in which Aborigines could be killed without their consent.”<sup>183</sup> The poor, elderly, sick, members of minority groups, and people with disabilities already face barriers to healthcare without further undermining their trust that medical providers will provide the same quality of care to them as to everyone else.

### C. Assisted suicide changes the role of the doctor

Legalizing euthanasia and assisted suicide creates a new set of problems for the medical profession, by distorting the doctor-patient relationship and undermining the integrity of medicine. Medicine always operated under the ethical framework expressed in the Hippocratic Oath. In its original form, the Hippocratic Oath stated: “I will give no deadly medicine to any one if asked, nor suggest any such counsel.”<sup>184</sup> Today’s version of the oath, called the Declaration of Geneva, also says: “I will maintain the utmost respect for human life... I will not use my medical knowledge to violate human rights and civil liberties, even under threat.”<sup>185</sup>

Medicine has always operated under the basic principles that life should be preserved and that promoting and restoring health is a natural goal of medicine.<sup>186</sup> Whenever possible, the disease should be cured and pain relieved: “Healing is thus the central core of medicine: to heal, to make whole, is the doctor’s primary business.”<sup>187</sup> Any society that legalizes euthanasia or assisted suicide undermines these basic principles and necessarily endangers the integrity of the medical profession. As the American Geriatric Society states,

Legalization of physician-assisted suicide would create a moral dilemma for geriatricians. Most elderly persons experience serious and progressive illness for extended periods before death and need significant social, financial and medical supports. These resources too often are not available, are of inadequate quality, are not covered by insurance, and are not provided by public entitlement programs. By collaborating in causing early deaths, when continuing to live has been made so difficult, geriatricians would become complicit in a social policy which effectively conserves community resources by eliminating those who need services. By refusing to assist with suicides because a patient’s relative poverty and disadvantaged social situation is seen as coercive, geriatricians would condemn their

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<sup>180</sup> Regina v. Director of Public Prosecutors & Sec’y of State for the Home Dept., [2001] 1 A.C. 800 (H.L.) § 29 (U.K.), quoted in GORSUCH, *supra* note 8, at 46.

<sup>181</sup> NYS TASK FORCE ON LIFE AND THE LAW, *supra* note 169, at 120.

<sup>182</sup> David W. Kissane, *Deadly Days in Darwin*, in THE CASE AGAINST ASSISTED SUICIDE 206 (Kathleen Foley & Herbert Hendin, eds., 2002).

<sup>183</sup> *Id.* at 205.

<sup>184</sup> *Hippocratic Oath*, ENCYCLOPAEDIA BRITANNICA, available at <https://www.britannica.com/topic/Hippocratic-oath>.

<sup>185</sup> World Medical Association Declaration of Geneva, adopted Sept. 1948, available at <https://www.wma.net/policies-post/wma-declaration-of-geneva/>.

<sup>186</sup> Leon R. Kass, *Neither for Love nor Money: Why Doctors Must Not Kill*, 95 PUB. INT. 25, 29 (1989).

<sup>187</sup> *Id.* at 39.

patients, and themselves, to live through the patient's undesired difficulties for the time remaining.<sup>188</sup>

Legalizing euthanasia or assisted suicide also undermines the trust between patients and the doctor, as discussed above. The Court in *Washington v. Glucksberg* found that "Physician assisted suicide could . . . undermine the trust that is essential to the doctor-patient relationship by blurring the time honored line between healing and harming."<sup>189</sup> Medical ethicist Dr. Leon Kass illustrates this vividly:

Imagine the scene: you are old, poor, in failing health, and alone in the world; you are brought to the city hospital with fractured ribs and pneumonia. The nurse or intern enters late at night with a syringe full of yellow stuff for your intravenous drip. How soundly will you sleep? It will not matter that your doctor has never yet put anyone to death; that he is legally entitled to do so—even if only in some well-circumscribed areas—will make a world of difference.<sup>190</sup>

The majority of medical associations worldwide have consistently opposed the practice, including the World Health Organization, the American Medical Association (AMA), the American College of Physicians, the Canadian Medical Association, the British Medical Association, the Royal College of Physicians, the German Medical Association, and over 20 others.<sup>191</sup> The World Medical Association (WMA) has repeatedly highlighted its "strong belief that euthanasia is in conflict with basic ethical principles of medical practice," even though it is allowed by law in some countries. The WMA's Declaration on Euthanasia, adopted by the 38th World Medical Assembly, Madrid, Spain, October 1987, states: "Euthanasia, that is the act of deliberately ending the life of a patient, even at the patient's own request or at the request of close relatives, is unethical."<sup>192</sup>

**"Euthanasia, that is the act of deliberately ending the life of a patient, even at the patient's own request or at the request of close relatives, is unethical."**

**-WMA Declaration on Euthanasia**

The WMA Statement on Physician-Assisted Suicide, adopted by the 44th World Medical Assembly, Marbella, Spain, September 1992, likewise states: "Physicians-assisted suicide, like euthanasia, is unethical and must be condemned by the medical profession. Where the assistance of the physician is intentionally and deliberately directed at enabling an individual to end his or her own life, the physician acts unethically."<sup>193</sup> At the same time, the AMA recognizes that "withdrawing or withholding of life-sustaining treatment is not

<sup>188</sup> Felicia Cohn & Joanne Lynn, *Vulnerable People: Practical Rejoinders to Claims in Favor of Assisted Suicide*, in *THE CASE AGAINST ASSISTED SUICIDE* 250 (Kathleen Foley & Herbert Hendin, eds., 2002), quoting Joanne Lynn et al., *American Geriatrics Society on Physician-Assisted Suicide: Brief to the United States Supreme Court*, 45 J. AM. GERIATRICS SOC'Y. 489 (1997).

<sup>189</sup> *Glucksberg*, 521 U.S. at 731.

<sup>190</sup> Kass, *supra* note 186, at 35.

<sup>191</sup> Carter Snead, *Carter Snead lecture "Physician Assisted Suicide: Objections in Principle and in Prudence"*, FACULTY LECTURES & PRESENTATIONS Paper 26, at 46-48 (2014). available at [http://scholarship.law.nd.edu/law\\_faculty\\_lectures/26](http://scholarship.law.nd.edu/law_faculty_lectures/26).

<sup>192</sup> World Medical Association Declaration on Euthanasia (Oct. 1987), available at <https://www.wma.net/policies-post/wma-declaration-on-euthanasia>.

<sup>193</sup> World Medical Association Statement on Physician-Assisted Suicide (Sept. 1992), available at <https://www.wma.net/policies-post/wma-statement-on-physician-assisted-suicide/>.

inherently contrary to the principles of beneficence and non-maleficence,” while assisting suicide always is, because the latter involves intentionally using the tools of medicine to kill.<sup>194</sup>

The final question raised by the legalization of euthanasia or assisted suicide is the threat to the rights of conscience of the doctors who would refuse to participate in such practices. If there is a right to assisted suicide, then a doctor will have to take actions to ensure that right can be exercised. Many contemporary advocates of legalization of euthanasia and assisted suicide are, in fact, openly discussing putative professional and legal “duties” for doctors to perform those acts.<sup>195</sup> Under a legal regime which grants a right to assisted suicide, “what would happen to the medical care professionals who fail to act? Might they open themselves up to suits in negligence by families upset that their relatives suffered needlessly because a doctor or nurse did not advocate their death? Might we eventually have a ‘wrongful life’ cause of action?”<sup>196</sup> Even though some courts have noted that “a patient has no right to compel a health-care provider to violate generally accepted professional standards,”<sup>197</sup> there is no obvious reason why the patients and the courts would not have the right to compel a doctor to perform a certain practice contrary to his conscience, if the “professional standards” change in such a way to make these practices a part of a standard medical care.

## V. Dignity-respecting healthcare at the end of life

Physician-assisted suicide and euthanasia do not address the needs their proponents claim they do. Ending a life does not resolve inadequate pain management, distress, anguish, or loss of meaning. Moreover, both practices, even with patient request, carry a significant risk of coercion and abuse, alter the practice of medicine away from its purpose, and undermine the relationship between doctor and patient. When deliberately taking life is considered a valid avenue of treatment, other, less drastic options become costly in time and resources by comparison.

Banning assisted suicide and euthanasia may, therefore, call out greater creativity in, and commitment to, the care of those suffering at the end of life. But prohibitions alone are not sufficient. With many parts of the world experiencing population ageing,<sup>198</sup> improvements in care cannot wait. Healthcare providers, families, and society as a whole must ensure that no one nearing the end of their life’s path walks alone. This includes the provision of the basic necessities of life for those who are not in danger of death due to their condition, but rely on others to provide them with food and water.

To offer technical guidance on specific treatments is beyond the scope of this paper, particularly as medicine continues to advance. Different interventions may be considered more or less invasive based on the advancement of medical technology, the nature and progression of the condition, how the intervention works, and other factors.<sup>199</sup> This approach recognizes

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<sup>194</sup> American Med. Ass’n, Council on Ethical and Judicial Affairs, *Decisions Near the End of Life*, 267 JAMA 2229, 2230, 2233 (1992). In June 2019, the AMA adopted a report from its Council on Ethical and Juridical Affairs which recommended maintaining opposition to assisted suicide, following a request from Oregon physician members to adopt a neutral position on assisted suicide. Joyce Frieden, *Physician-Assisted Suicide Once Again Divides AMA Members*, MEDPAGE TODAY (June 11, 2019), <https://www.medpagetoday.com/meetingcoverage/ama/80384>.

<sup>195</sup> GORSUCH, *supra* note 8, at 130.

<sup>196</sup> *Id.*

<sup>197</sup> *Id.* at 184.

<sup>198</sup> WORLD HEALTH ORGANIZATION, WORLD REPORT ON AGEING AND HEALTH 43-45 (2015).

<sup>199</sup> For example, seriously ill people may wish to avoid or prolong use of a ventilator based on their perceptions of their likelihood of recovery, Kwon Ivo et al., *A survey of the perspectives of patients who are seriously ill regarding end-of-life decisions in some medical institutions of Korea, China, and Japan*, 38 J. Med. Ethics 310, 312 (2012), indicating that some see it as an intensive, extraordinary means of life support, where in fact

life as a basic good, while also understanding that other considerations should be taken into account.<sup>200</sup> Life need not be prolonged under all circumstances or for as long as possible, but it should not be intentionally ended.<sup>201</sup> This is particularly important when the patient cannot make her own decisions, and in the care and options presented to members of other vulnerable groups. Care grounded in the dignity of the person requires a commitment to meet the physical, psychosocial, and palliative needs of all terminally ill patients.

**Care grounded in the dignity of the person requires a commitment to meet the physical, psychosocial, and palliative needs of all terminally ill patients.**

**A. The physician-patient relationship and goals for end-of-life care**

Unlike in previous eras, which lacked the ability to treat illnesses ranging from infection to cancer, most people today will live longer than those a century before. Healthcare providers can solve many problems, but not the last one: while death may be delayed, it cannot be avoided forever. Each patient will have to decide what matters to him or her about his or her own death, whether to prolong life, or accept its progression. Yet the patient is in a vulnerable position due to illness, factors associated with old age, and potentially, disability. Ensuring that patients receive care in line with their goals requires a doctor-patient relationship of trust and good communication.

Patients who know they are terminally ill are more likely to discuss end-of-life care with doctors than those who do not know that their condition is terminal.<sup>202</sup> Terminal patients are also more likely to direct their care towards symptom management than prolongation of life.<sup>203</sup> A patient's desires can shift due to changes in their healthcare, and non-medical factors, such as relative youth or having young children, can also affect how a patient wants to direct his or her care.<sup>204</sup> Evidence suggests that patients who discuss their wishes with their doctors are more likely to receive care in line with what they want.<sup>205</sup>

There is also reason to believe that many patients who receive life-extending care would prefer symptom-directed care.<sup>206</sup> One study found that patients tended to choose default options when presented with different versions of advance directives,<sup>207</sup> highlighting the risk of inadvertent influence. That same study notes that a common end-of-life care questionnaire in the U.S. has life-extending options as a default,<sup>208</sup> potentially influencing patient decisions towards unwanted medical interventions. Communication should be ongoing and personal to avoid losing sight of patients' wishes.

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increasing numbers of people with chronic respiratory failure use respirators at home, Sarah Masfield et al., *Attitudes and preferences of home mechanical ventilation users from four European countries: an ERS/ELF survey*, 3 EUR. RESPIRATORY J. OPEN ACCESS No. 2 at 2 (2017).

<sup>200</sup> GORSUCH, *supra* note 8, at 157-58.

<sup>201</sup> See generally GORSUCH, *supra* note 8, 157-180 (Chapter 9).

<sup>202</sup> Jennifer W. Mack et al., *End-of-Life Discussions, Goal Attainment, and Distress at the End of Life: Predictors and Outcomes of Receipt of Care Consistent with Preferences*, 28 J. CLINICAL ONCOLOGY 1203, 1205 (2010).

<sup>203</sup> *Id.* at 1205, 1208.

<sup>204</sup> *Id.* at 1207, 1203.

<sup>205</sup> *Id.* at 1205.

<sup>206</sup> *Id.* at 1208.

<sup>207</sup> Scott D. Halpern et al., *Default Options In Advance Directives Influence How Patients Set Goals for End-Of-Life Care*, 32 HEALTH AFFAIRS 408, 412-13 (2013).

<sup>208</sup> *Id.* at 408.

Yet goals of care discussions may not happen when patients do not understand that their health is declining, or because both sides find such conversations difficult,<sup>209</sup> or expect each other to bring up various elements, such as pain, depression, or other symptoms.<sup>210</sup> A survey of American hematologic oncologists found that many believed the timing of their end-of-life care conversations with patients was often “too late,” and the discussions themselves were held at less than ideal times.<sup>211</sup>

Some interventions and innovations to promote goals of care conversations have been tested with promising results.<sup>212</sup> Holding these conversations early can increase quality of life, including through referrals to other services, such as palliative care for those whose conditions often cause great suffering.<sup>213</sup> Palliative care can be started early, even concurrently with life-prolonging treatments, to ensure quality of life.<sup>214</sup>

Doctors who elicit patients’ goals may be surprised to learn that what matters to them is not necessarily directly related to death at all. American doctor Mitch Kaminski recalled his surprise when a patient’s goal was simply to walk without falling, and to stay at home rather than receive inpatient care.<sup>215</sup> By taking the time to find out what the patient wanted, he was able improve his patient’s quality of life in a meaningful way. This care made such an impression on the family that the man’s widow, herself approaching the end of life, later sought Kaminski out for her own care.<sup>216</sup> In both cases, a proper understanding of patient autonomy led to patient-centered care that led to better quality of life and a better experience of dying for patient and family.

It is worth noting that some patients may express a desire for hastened death. Within jurisdictions that allow PAS and/or euthanasia, that desire may be taken as normal. However, there are varying reasons why someone might want to hasten their death. These have been categorized as reflecting an exit plan (and therefore control over one’s fate), an expression of despair (a state of psychosocial distress), or letting go (not so much a desire to hasten one’s death as an acceptance of approaching death).<sup>217</sup>

For patients whose desire to hasten their death reflects despair, this despair may not be a constant state, but may vary related to pain and adaptation to the circumstances of illness.<sup>218</sup> Those wanting to exercise control over their death may do so out of a desire to avoid experiences they expect will be painful and undignified,<sup>219</sup> potentially reflecting and reinforcing stigma about disability. This underlines the need for society to promote an understanding of dignity as distinct from a feeling of being dignified, as discussed above. More practically, however, in addition to discussions about care, there are options available which

<sup>209</sup> Ardith Z. Doorenbos et al., *An Intervention to Enhance Goals-of-Care Communication Between Heart Failure Patients and Heart Failure Providers*, 52 J. PAIN & SYMPTOM MGMT. 353, 354 (2016); Foley, *Compassionate Care*, supra note 106, at 300.

<sup>210</sup> Kurt Kroenke et al., *The Association of Depression and Pain with Health-Related Quality of Life, Disability, and Health Care Use in Cancer Patients*, 40 J. PAIN & SYMPTOM MGMT. 327, 335 (2010).

<sup>211</sup> Oreofe O. Odejide et al., *Timeliness of End-of-Life Discussions for Blood Cancers: A National Survey of Hematologic Oncologists*, 176 JAMA 263, 263 (2016).

<sup>212</sup> See, e.g., Doorenbos, supra note 209, at 357.

<sup>213</sup> *Id.* at 358. The study also notes that “[m]any patients for whom palliative care could significantly improve quality of life do not have access to such care services. Instead of palliative care, patients at end-of-life often receive intensive and costly care even when it may not contribute significantly to prolonging life.” *Id.* at 354 (citations omitted).

<sup>214</sup> See, e.g., Thomas W. LeBlanc, *Addressing End-of-Life Quality Gaps in Hematologic Cancers: The Importance of Early Concurrent Palliative Care*, 176 JAMA INTERNAL MED. 265, 265-66 (2016).

<sup>215</sup> Mitch Kaminski, *What one patient taught a physician*, WASH. POST, Mar. 10, 2015, at E1.

<sup>216</sup> *Id.*

<sup>217</sup> Rinat Nissim et al., *The desire for hastened death in individuals with advanced cancer: A longitudinal qualitative study*, 69 SOC. SCIENCE & MED. 165, 168-69 (2009).

<sup>218</sup> *Id.*

<sup>219</sup> *Id.* at 168.

can help address these concerns, and what is driving them, without the irrevocable step of ending the patient's life.

## B. Palliative care

Palliative care seeks to alleviate pain and suffering in a way that is respectful of human dignity. Dame Cicely Saunders created the palliative care approach in 1967 in the United Kingdom.<sup>220</sup> She argued for the approach of “total care“ which aims to address all aspects of the pain a patient is experiencing. The term palliative care refers to the “medical skill of an optimized expert use of drugs intended to remove or diminish pain, or to put it simple [sic] to improve the life quality. The combination of medical palliative care and human hospice care produces a complete human care and love for the sick and the dying.”<sup>221</sup> It is generally understood that while curative medicine seeks to cure disease, palliative medicine seeks to alleviate pain and suffering.<sup>222</sup> Palliative care has an essential role to play in end-of-life care; cancer, a leading cause of death worldwide,<sup>223</sup> often causes pain for patients, but that pain is largely treatable.<sup>224</sup>

The World Health Organization defines palliative care as

an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. Palliative care:

- provides relief from pain and other distressing symptoms;
- affirms life and regards dying as a normal process;
- intends neither to hasten or postpone death;
- integrates the psychological and spiritual aspects of patient care;
- offers a support system to help patients live as actively as possible until death;
- offers a support system to help the family cope during the patient's illness and in their own bereavement;
- uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated;
- will enhance quality of life, and may also positively influence the course of illness;
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.<sup>225</sup>

<sup>220</sup> Anica Jušić, *Eutanazija*, 9 REV. SOC. POLIT. 301, 307 (2002).

<sup>221</sup> Pozaić, *supra* note 70, at 153.

<sup>222</sup> See generally Morana Brkljačić, *Bioetika i bioetički aspekti palijativne medicine*, 44 MEDICINA 149 (2008).

<sup>223</sup> *Cancer*, WORLD HEALTH ORG., <https://www.who.int/news-room/fact-sheets/detail/cancer> (Sept. 12, 2018).

<sup>224</sup> Kroenke et al., *supra* note 210, at 328.

<sup>225</sup> *Palliative Care*, WORLD HEALTH ORGANIZATION, available at <http://www.who.int/cancer/palliative/definition/en/>.

Palliative care is always interdisciplinary in its approach and includes the patient, the family, and the community within its scope. It tends to the patient at the most basic level: that of providing for the needs of the patient wherever he or she is cared for, either at home or in the hospital.<sup>226</sup> Among its core principles are respect for the patient's autonomy, good communication with the patient, collaboration with and support of family and caregivers, respect for personal, cultural, and religious beliefs and values, and an understanding that its purpose is neither to hasten nor postpone death.<sup>227</sup>

Some authors have introduced a model of “*integral* palliative care, in which euthanasia is considered as another option at the end of a palliative care pathway,”<sup>228</sup> since neither seeks to cure the disease, and, they suggest, both seek to alleviate pain. This view does not hold up in light of the difference in intent. Euthanasia has the “intent to cause or hasten patient's

**The fundamental difference in purpose reflects the basic difference in the approach: palliative care seeks to relieve suffering at the end of life; euthanasia seeks to end life itself.**

death.”<sup>229</sup> On the other hand, palliative care “intends neither to hasten or postpone death.”<sup>230</sup> The fundamental difference in purpose reflects the basic difference in the approach: palliative care seeks to relieve suffering at the end of life; euthanasia seeks to end life itself.

For this reason, most palliative care organizations, such as the European Association for Palliative Care (EAPC), reject euthanasia as a part of the palliative care approach. Rather, they “stress the importance of refocusing attention onto the responsibility of all societies to provide care for their older, dying and vulnerable citizens. A major component in achieving this is the establishment of palliative care within the mainstream healthcare systems... supported by appropriate finance, education and research.”<sup>231</sup>

### C. Psychosocial care

The commitment to the whole person and easing suffering must go beyond the management of physical pain. Depression in seriously ill patients has been connected with an increased desire for hastened death.<sup>232</sup> Physical pain and psychological wellbeing are interconnected: they often overlap both in cancer patients and those with other medical conditions, and have “reciprocal adverse effects on one another and on quality of life and functioning.”<sup>233</sup> Depression is known to impact quality of life among sufferers in the general population, and a 2017 study found a strong association between depression and quality of life

<sup>226</sup> Lukas Radbruch et al., *White Paper on standards and norms for hospice and palliative care in Europe: part 1. Recommendations from the European Association for Palliative Care*, 17 EUR. J. PALLIATIVE CARE 278, 280 (2009).

<sup>227</sup> *Id.* at 283.

<sup>228</sup> Jan L. Bernheim, et al., *Development of palliative care and legalisation of euthanasia: antagonism or synergy?* 336 Brit. Med. J. 864, 867 (2008) (emphasis added).

<sup>229</sup> PERICO, *supra* note 3, at 138.

<sup>230</sup> Tania Pastrana et al., *A matter of definition: key elements identified in a discourse analysis of definitions of palliative care*, 22 PALLIATIVE MED. 222, 223 (2008).

<sup>231</sup> Lukas Radbruch et al., *Euthanasia and physician-assisted suicide: A white paper from the European Association for Palliative Care*, 30 PALLIATIVE MED. 1, 11 (2016).

<sup>232</sup> William Breitbart et al., *Depression, Hopelessness, and Desire for Hastened Death in Terminally Ill Patients with Cancer*, 284 JAMA. 2907, 2909 (2000).

<sup>233</sup> Kroenke et al., *supra* note 210, at 334. See also David J. Hallford et al., *Depression in palliative care settings: The need for training for nurses and other health professionals to improve patients' pathways to care*, 32 NURSE ED. TODAY 556 (2012).

in patients with advanced cancer.<sup>234</sup> “Depression is prevalent among people with advanced cancer,”<sup>235</sup> but is often under-diagnosed and therefore left untreated.<sup>236</sup>

For those suffering from mental distress, other interventions are needed. One study found that depression had stronger effects on quality of life and function in cancer patients than pain did.<sup>237</sup> Yet studies have found that it often goes undetected in palliative care settings, which may be due to lack of training, but is probably at least partly due to the similarities between depressive symptoms and disease symptoms.<sup>238</sup> Moreover, given perceptions of despair as a natural reaction to a challenging diagnosis, and their prevalence, medical caregivers “often underestimate the level of depressive symptoms in patients,” and are “more likely to make false-negative than false-positive errors in detecting depression.”<sup>239</sup>

Simple screening tools which are easily incorporated into palliative practice can be highly effective in signalling the need for more in depth diagnosis, but they are rarely used in practice.<sup>240</sup> Doctors, nurses, and other palliative caregivers can find it difficult to bring up depression and mental anguish with patients, which contributes to low rates of mental intervention.<sup>241</sup> However, additional training can help nurses and other professional caregivers build the knowledge and confidence to incorporate depression screening into their regular practice.<sup>242</sup> Patients experiencing depression at the end of life must be screened for depression and receive appropriate interventions.

Similarly, demoralization, a form of existential distress associated with a loss of meaning and purpose, has also “been associated with a desire for hastened death.”<sup>243</sup> Demoralization can be associated with depression, but patients can experience it without meeting criteria for depression.<sup>244</sup> Depending on the assessment tool used, studies have found rates of demoralization ranging from 13-33% of patients experiencing cancer or another progressive illness.<sup>245</sup> As with depression, demoralization is linked with physical symptoms and quality of life concerns.<sup>246</sup>

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<sup>234</sup> Kjersti S. Grotmol et al., *Depression—A Major Contributor to Poor Quality of Life in Patients With Advanced Cancer*, 54 J. PAIN & SYMPTOM MGMT. 889, 893 (2017).

<sup>235</sup> *Id.*

<sup>236</sup> Kroenke et al., *supra* note 210, at 328.

<sup>237</sup> *Id.* at 336.

<sup>238</sup> Hallford et al., *supra* note 233 at 556-57.

<sup>239</sup> *Id.* at 557.

<sup>240</sup> *Id.*

<sup>241</sup> *Id.* at 557-58.

<sup>242</sup> *Id.* at 558-59; Kroenke et al., *supra* note 210, at 335.

<sup>243</sup> Sophie Robinson et al., *A Systematic Review of the Demoralization Syndrome in Individuals With Progressive Disease and Cancer: A Decade of Research*, 49 J. PAIN & SYMPTOM MGMT. 595, 595-96, 604 (2015). The study argues for demoralization as an adjustment disorder. *Id.* at 606. It also notes that due to different assessment tools the definition is not completely established, *id.* at 608, but was able to draw some conclusions about demoralization via systematic review despite a split in which assessment tool was used.

<sup>244</sup> *Id.* at 605. The fifth edition of *The Diagnostic and Statistic Manual of Mental Disorders (DSM-5)* does not include meaning and purpose in its discussion of depressive disorders. *Id.* at 606.

<sup>245</sup> *Id.* at 606. Studies focused on measuring dimensions of “clinically significant” demoralization found smaller proportions, in the range of 13-18% of patients. *Id.*

<sup>246</sup> *Id.*

Meaning and purpose are key factors in seriously ill patients' ability to cope with their illness and approaching death. "[H]opelessness, worthlessness, meaninglessness, and shame are the potential mediators of suicidal thinking."<sup>247</sup> Conversely, a sense of meaning and purpose helps patients to deal with their illness.<sup>248</sup> One study observed that a lack of meaning and purpose was more strongly correlated with a desire for hastened death than physical symptoms, loss of function, or even other psychological factors.<sup>249</sup> Therefore, interventions designed to foster a sense of meaning and purpose can lead to reducing patients' desire for hastened death.<sup>250</sup>

**Therefore, interventions designed to foster a sense of meaning and purpose can lead to reducing patients' desire for hastened death.**

One such intervention which has been being developed is meaning-centered psychotherapy based on the work of psychiatrist (and Holocaust survivor) Viktor Frankl, who wrote *Man's Search for Meaning*.<sup>251</sup> Studies have targeted spiritual wellbeing<sup>252</sup> through both group and individual therapy.<sup>253</sup> Although these interventions are still in development, they have shown promise as a treatment avenue.

A pilot study comparing meaning-centered group psychotherapy (MCGP) with supportive group psychotherapy found higher rates of attendance and a greater impact on spiritual wellbeing among those undergoing MCGP than those receiving supportive group therapy.<sup>254</sup> A more recent study focused on individuals divided into groups receiving enhanced usual care (EUC), supportive psychotherapy (SP), and individual meaning-centered psychotherapy (IMCP).<sup>255</sup> Although overall IMCP's efficacy compared to SP was not significantly greater, the impact was higher when comparing those who had attended more sessions, suggesting overall that IMCP is an effective invention.<sup>256</sup> These and other interventions testify to the treatability of despair and hopelessness which many experience at the end of life.

## VI. Conclusion

Physician-assisted suicide and euthanasia may seem like an answer to the possibility of a painful or difficult death, loss of function, or poor quality of life. There is no right under international law to assistance in ending one's life, and most countries and jurisdictions ban the practice. Such bans have been upheld in most national and international courts. Places

<sup>247</sup> *Id.*

<sup>248</sup> Mariona Guerrero-Torrelles et al., *Meaning in Life as a Mediator Between Physical Impairment and the Wish to Hasten Death in Patients With Advanced Cancer*, 56 J. PAIN & SYMPTOM MGMT. 826, 827 (2017).

<sup>249</sup> *Id.* at 830.

<sup>250</sup> *Id.* at 830-31.

<sup>251</sup> William Breitbart et al., *Individual Meaning-Centered Psychotherapy for the Treatment of Psychological and Existential Distress: A Randomized Controlled Trial in Patients with Advanced Cancer*, 124 CANCER 3231, 3232 (2018) [hereinafter Breitbart et al., *IMCP*].

<sup>252</sup> "Spiritual wellbeing" in this context reflects existential elements of wellbeing, such as meaning and purpose. William Breitbart, et al., *Meaning-centered group psychotherapy for patients with advanced cancer: a pilot randomized controlled trial*, 19 PSYCHO-ONCOLOGY 21, 21-22 (2010) [hereinafter Breitbart et al., *Meaning-centered group psychotherapy*].

<sup>253</sup> See generally Breitbart et al., *IMCP*, *supra* note 251; Breitbart et al., *Meaning-centered group psychotherapy*, *supra* note 252.

<sup>254</sup> Breitbart et al., *Meaning-centered group psychotherapy*, *supra* note 252, at 24-25.

<sup>255</sup> See generally Breitbart et al., *IMCP*, *supra* note 251.

<sup>256</sup> *Id.* at 3236-37.

which allow the practices have adopted expansive interpretations of rules that go far beyond the common refrain that assistance in ending their lives should be allowed for terminally ill, mentally competent adults.

Permitting these practices also corrupts the practice of medicine, fundamentally changing the doctor-patient relationship. They offer less social and legal protection to those with disabilities or experiencing serious illness, which is particularly troubling in light of patient vulnerability and the risk of coercion. Society must resist these practices, which may well exacerbate existing gaps in care and place the already vulnerable at greater risk.

The ultimate answer to pain, suffering, and dependency at the end of life is to accompany the dying person. This requires adequate treatments, such as those discussed above, to be available to all, but it also requires that caregivers, healthcare providers, and society as a whole affirm the value of every person. No one goes through life entirely autonomous or without difficulties. A culture that cherishes human dignity eases that suffering through affirming that we care about people for *who they are*, not for what they can or cannot do. That care and concern must then direct our efforts towards ensuring medical and psychosocial care that upholds the fundamental dignity of each person at the end of life without exception.

# Appendix: Jurisdictions with Laws Permitting Direct Euthanasia and Assisted Suicide

## June 2020

By Nadja Wolfe, Hrvoje Vargić, Lillian Quinones, & Mislav Barišić,  
with assistance from Andrea Suarez.

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Many proponents of assisted suicide and euthanasia suggest that it will be used in very limited cases. An examination of the laws in place, however, paints a different picture; thus, this appendix serves as a useful supplement to the white paper. Many assisted suicide and euthanasia laws are far more expansive in nature and scope than is popularly understood, even among those considered more restrictive.

Taking each country or state in turn, the appendix provides a clear summary of the laws in each, and highlights developments, news, and key figures from official reports, complementing and supplementing the white paper's arguments. It also shows how easily the reasons used to justify assisted suicide and euthanasia for mentally competent, terminally ill adults turn into reasons to justify expanding the practice to those who are not likely to die soon, those whose suffering is based in mental illness, and even children. It also demonstrates the lack of safeguards: despite the finality of the act, authorities review only doctors' own reports, almost entirely after the fact, when nothing can be changed. Lastly, health authorities' own reports are illustrative: some for demonstrating the inadequacy of checks, several for how little information they contain, and a few for rare data about suicidal patients' motivations, which show that autonomy concerns, more than pain and suffering, are a primary factor in the decision of many to end their lives with doctors' assistance.

## **Switzerland (1918)**

Switzerland has the longest history of assisted suicide, dating to 1918, when the federal penal code decriminalized assisting suicide except when done with "selfish motives."<sup>1</sup> Under Article 115 of the Swiss Penal Code, encouraging or helping someone to commit suicide is punishable by up to five years in prison if done out of self-interest.<sup>2</sup> The Federal Supreme Court of Switzerland requires that the person seeking suicide demonstrate "faculty of judgment, due consideration, constancy of request, autonomy, and personal agency,"<sup>3</sup> but the practice is largely unregulated otherwise.

Two prominent legal cases heard by the European Court of Human Rights challenged Swiss practices. The plaintiff in *Haas v Switzerland* was a 57-year-old Swiss man with a history of bipolar disorder.<sup>4</sup> As a member of Dignitas, Haas requested a lethal prescription from a number of psychiatrists but was unsuccessful.<sup>5</sup> When his petitions were also rejected by both the Federal Department of Public Health and the Health Department of the Canton of Zürich, Haas filed a petition with the European Court of Human Rights on the basis that Article 8 of the Convention for the Protection of Human Rights and Fundamental Freedoms guaranteed his right to privacy and that the State was interfering with his right to die.<sup>6</sup> The European Court of Human Rights ruled

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<sup>1</sup> Saima A. Hurst & Alex Mauron, *Assisted suicide and euthanasia in Switzerland: allowing a role for non-physicians*, 326 BRIT. MED. J. 271, 271 (2003).

<sup>2</sup> Amanda Carmichael, *Switzerland's Shocking Assisted-Suicide Laws: A Brief Overview*, MICH. STATE. U. INT'L L. REV. LEGAL FORUM (Mar. 22, 2018), <https://www.msuilr.org/msuilr-legalforum-blogs/2018/3/22/switzerlands-shocking-assisted-suicide-laws-a-brief-overview>.

<sup>3</sup> FAQ, EXIT, <https://www.exit.ch/en/en/faq/> (last visited May 28, 2020).

<sup>4</sup> *Haas v. Switzerland*, No. 31322/07, §§ 56-58, Eur. Ct. H.R., Jan. 6, 2011.

<sup>5</sup> *Id.* § 7.

<sup>6</sup> *Id.* §§ 17-18.

that the Swiss government's regulations to protect against coercion in line with Article 2 did not violate the right to privacy and in fact were necessary.<sup>7</sup>

In *Gross v Switzerland*, Gross was a 79-year-old Swiss woman who was refused a lethal prescription in the absence of a terminal or fatal illness.<sup>8</sup> The Swiss government defended its position that Gross had not met the requirements, such as having a terminal illness, to receive a lethal prescription.<sup>9</sup> The Second Section of the European Court of Human Rights dismissed most of her claims, but found, by a narrow vote, that a lack of clarity regarding the extent of the right to die constituted a violation of Gross's right to private life.<sup>10</sup> However, when the Grand Chamber of the court discovered that Gross had obtained a lethal prescription and died in 2011, between her 2010 filing with the court and its 2013 decision, the ruling in her favor was declared null and void.<sup>11</sup> It was later discovered that Gross had taken steps deliberately to keep her death secret so that the court proceedings could continue.<sup>12</sup>

In 2018, the Swiss Academy of Medical Sciences released new end-of-life guidelines for healthcare professionals. Revised from their 2014 edition, these guidelines inform physicians that they may assist their patients in committing suicide if the legal requirements are met.<sup>13</sup> Many Swiss physicians condemned the new guidelines as harming the medical profession by normalizing assisted suicide,<sup>14</sup> a concern voiced by the director of the Federation of Swiss Doctors, Jürg Schlup, who said, "This new guideline is vague and could lead to misinterpretations within the Deontology Commission. This is particularly serious for such an irreversible decision."<sup>15</sup>

Under Swiss law, the act of handing over (although not prescribing) lethal medication to the patient to self-administer does not require a physician or medical professional, but instead can be carried out by any individual. As a result, right-to-die organizations receive the majority of assisted suicide requests, for both Swiss residents and foreigners.<sup>16</sup> Statistics reveal an increasing number of individuals dying by assisted suicide, while euthanasia remains a crime.<sup>17</sup> The two largest suicide assistance organizations are EXIT and Dignitas.

Founded in 1982, EXIT remains the largest right-to-die organization and operates from two locations, EXIT Deutsche Schweiz, based in German-speaking Zurich, and EXIT Suisse

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<sup>7</sup> *Id.* §§ 54, 58, 61.

<sup>8</sup> *Gross v. Switzerland*, No. 67810/10, §§ 10-16, Eur. Ct. H.R., Sept. 30, 2014 (Grand Chamber).

<sup>9</sup> *Id.* §§ 14-15.

<sup>10</sup> *Gross v. Switzerland*, No. 67810/10, §§ 60-68, §74(2) (holding) Eur. Ct. H.R., May 14, 2013 (2d Section), *voided by* *Gross v. Switzerland*, No. 67810/10, Eur. Ct. H.R., Sept. 30, 2014 (Grand Chamber). The court did not, however, suggest that Switzerland had to provide lethal prescription in cases like that of Gross.

<sup>11</sup> *Gross v. Switzerland*, No. 67810/10, §§ 30, 35, 37 Eur. Ct. H.R., Sept. 30, 2014 (Grand Chamber) (finding that, given that the previous judgment was not final, and the applicant had abused the right of application, the application was inadmissible and therefore the previous judgment was voided).

<sup>12</sup> *Woman misled human rights court over Swiss suicide law*, RTE (Oct. 1, 2014), *available at* <https://www.rte.ie/news/2014/0930/649015-swiss-suicide-law/>.

<sup>13</sup> SWISS ACADS. ARTS & SCIENCES, *MEDICAL ETHICAL GUIDELINES: MANAGEMENT OF DYING AND DEATH* 22 (2018).

<sup>14</sup> *See generally* Ned Stafford, *Swiss doctors object to new suicide guidance*, 361 *BRIT. MED. J.* 2661 (2018).

<sup>15</sup> *Easing Medical Stipulations for Assisted Suicide in Switzerland*, ALLIANCE VITA (June 14, 2018), *available at* <https://www.alliancevita.org/en/2018/06/easing-medical-stipulations-for-assisted-suicide-in-switzerland/>.

<sup>16</sup> GUENTER LEWY, *ASSISTED DEATH IN EUROPE AND AMERICA: FOUR REGIMES AND THEIR LESSONS* 100 (2010).

<sup>17</sup> *Assisted suicide increasingly popular in Switzerland*, THELOCAL.CH (Nov. 15, 2017), <https://www.thelocal.ch/20171115/assisted-suicide-increasingly-popular-in-switzerland>.

Romande, in French-speaking Geneva.<sup>18</sup> Its services extend beyond assisted suicide, and include living wills, patient advocacy, end-of-life counseling, suicide prevention, and palliative care.<sup>19</sup> The use of its services requires an annual membership fee of 45 Swiss francs, or 1,100 Swiss francs for lifetime membership.<sup>20</sup> Only adults who provide proof of Swiss permanent residency or citizenship may apply for membership.<sup>21</sup> As of the end of 2019, EXIT reported a membership of 130,000 annual, 23,000 of whom are lifetime members.<sup>22</sup>

Under EXIT'S own rules, the individual requesting suicide must present with "hopeless prognoses, or with unbearable symptoms, or with unacceptable disabilities,"<sup>23</sup> although this includes conditions of old age as of 2014.<sup>24</sup> An end-of-life assistant who determines that an individual requesting suicide meets the criteria contacts a physician for a lethal prescription.<sup>25</sup> The physician may be the individual's attending physician, a general practitioner, or physician regularly consulted by EXIT.<sup>26</sup> The assistant keeps the prescription until the day of the suicide and "ensures that the ambience is appropriate for the occasion."<sup>27</sup> In the presence of family and friends, if desired, the individual administers the drug themselves, either through opening the intravenous line or swallowing the dissolved barbiturate.<sup>28</sup>

The second largest, nonprofit right-to-die organization, Dignitas, was founded by an original board member of EXIT in 1998.<sup>29</sup> Dignitas asserts a right to assisted suicide as necessary for human dignity; its motto is "to live with dignity, to die with dignity."<sup>30</sup> Generally considered to follow less rigorous criteria compared to its predecessor, Dignitas also provides its services to foreigners, giving Switzerland a reputation as a destination for "suicide tourism."<sup>31</sup> Although he was acquitted in 2018, the founder of Dignitas was charged with profiteering and selfish motives<sup>32</sup> after amassing a personal fortune through his work.<sup>33</sup>

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<sup>18</sup> Roberto Andorno, *Nonphysician-Assisted Suicide in Switzerland*, 22 CAMBRIDGE Q. HEALTHCARE ETHICS 246, 248 (2013).

<sup>19</sup> *Exit at a Glance*, EXIT, <https://www.exit.ch/en/exit-at-a-glance/>.

<sup>20</sup> *FAQ*, EXIT, <https://www.exit.ch/en/faq/> (last visited May 28, 2020).

<sup>21</sup> *Id.*

<sup>22</sup> *Exit at a Glance*, EXIT, <https://www.exit.ch/en/exit-at-a-glance/>.

<sup>23</sup> *FAQ*, EXIT, <https://www.exit.ch/en/faq/>.

<sup>24</sup> *Swiss group Exit considers extending right-to-die to elderly in good health*, THELOCAL.CH (June 19, 2017), <https://www.thelocal.ch/20170619/swiss-group-exit-looks-to-extend-right-to-die-to-elderly-in-good-health>.

<sup>25</sup> *FAQ*, EXIT, <https://www.exit.ch/en/faq/>.

<sup>26</sup> *Id.*

<sup>27</sup> *Id.*

<sup>28</sup> *Id.*

<sup>29</sup> Bruce Falconer, *Death Becomes Him*, ATLANTIC, Mar. 2010, available at <https://www.theatlantic.com/magazine/archive/2010/03/death-becomes-him/307916/>.

<sup>30</sup> Dignitas, *DIGNITAS: To live with dignity-To die with dignity* 1 (14th ed., 2018), available at <http://www.dignitas.ch/images/stories/pdf/informations-broschuere-dignitas-e.pdf> [hereinafter Dignitas Brochure].

<sup>31</sup> Julie Beck, 'Going to Switzerland' Is a Euphemism for Assisted Suicide, ATLANTIC (August 27, 2014), <https://www.theatlantic.com/health/archive/2014/08/going-to-switzerland-is-a-euphemism-for-assisted-suicide/379182/>.

<sup>32</sup> *Dignity boss found not guilty of profiteering*, SWISSINFO.CH (June 1, 2018), [https://www.swissinfo.ch/eng/society/assisted-suicide-\\_dignitas-founder-found-not-guilty-of-profiteering/44160762](https://www.swissinfo.ch/eng/society/assisted-suicide-_dignitas-founder-found-not-guilty-of-profiteering/44160762).

<sup>33</sup> *Dignitas founder is millionaire*, TELEGRAPH (June 24, 2010), <https://www.telegraph.co.uk/news/worldnews/europe/switzerland/7851615/Dignitas-founder-is-millionaire.html>.

Members pay a registration fee of 200 francs and an annual fee of 80 francs to utilize Dignitas' services.<sup>34</sup> It requires an upfront fee of 4,000 francs for the assisted suicide application and process, regardless of whether it is approved.<sup>35</sup> Additional fees bring the total to 7,500 francs if funeral arrangements are settled independently or 10,500 francs with funeral arrangements included.<sup>36</sup> Dignitas had 9,822 members in one hundred countries as of the end of 2019, only 794 of whom were Swiss.<sup>37</sup>

Under Dignitas' own rules, members requesting suicide assistance must have sound judgment, sufficient mobility to self-administer the lethal medication, "disease which will lead to death (terminal illness) and/or an unendurable incapacitating disability, and/or unbearable and uncontrollable pain."<sup>38</sup> Following approval, which can take three months,<sup>39</sup> a physician prescribes the lethal medication, a fatal dose of 15 grams of sodium pentobarbital, either dissolved in water to be drunk or intravenously delivered.<sup>40</sup> A Dignitas representative delivers the medication to the individual, typically at their home.<sup>41</sup> In 2008, Dignitas began offering assisted suicide through the use of helium gas and a plastic bag.<sup>42</sup>

Dignitas also engages in assisted suicide advocacy abroad. Claiming to act only where the local population wants assisted suicide, it has engaged in or supported court proceedings before the European Court of Human Rights, weighed in on public consultations in foreign countries, and presented both to policymakers and the public around the world.<sup>43</sup> With its German counterpart, Dignitas Deutschland, it was a plaintiff in one of the German cases which led to the ban on assisted suicide in Germany being struck down.<sup>44</sup>

Assisted suicide in Switzerland raised public attention and debate with the assisted suicide of Australian scientist David Goodall in May 2018. The 104-year-old scientist traveled to a Dignitas clinic in Switzerland in generally good health despite declining eyesight and reduced mobility, and stated his motivations to end his own life as being "tired of life."<sup>45</sup> Goodall's highly

<sup>34</sup> Dignitas Brochure, *supra* note 30, at 1, 5.

<sup>35</sup> *Id.* at 14.

<sup>36</sup> *Id.*

<sup>37</sup> DIGNITAS, DIGNITAS – TO LIVE WITH DIGNITY – TO DIE WITH DIGNITY MEMBERS AS OF 31 DECEMBER 2019, COUNTRIES OF RESIDENCE (2020), available at <http://www.dignitas.ch/images/stories/pdf/statistik-mitglieder-wohnsitzstaat-31122019.pdf>. Membership statistics may also be found by visiting the home page, selecting "Knowledge" and then "Statistics."

<sup>38</sup> Dignitas Brochure, *supra* note 30, at 7.

<sup>39</sup> *Id.* at 6.

<sup>40</sup> *Id.* at 7.

<sup>41</sup> *Id.*

<sup>42</sup> *Euthanasia group Dignitas films gas and plastic bag deaths*, DAILY MAIL (Mar. 19, 2008), <https://www.dailymail.co.uk/news/article-539929/Euthanasia-group-Dignitas-films-gas-plastic-bag-deaths.html>.

<sup>43</sup> Sibilla Bondolfi, *Death by Choice: The Global Fight for Assisted Suicide*, SWISSINFO.CH (Nov. 14, 2018), [https://www.swissinfo.ch/eng/death-by-choice\\_the-global-fight-for-assisted-suicide/44543634](https://www.swissinfo.ch/eng/death-by-choice_the-global-fight-for-assisted-suicide/44543634).

<sup>44</sup> Press Release, Dignitas, The German Federal Constitutional Court declares void § 217 of the German Criminal Code "geschäftsmässige Förderung der Selbsttötung" (prohibition of repeated and thus professional assistance in suicide) – an important step towards true self-determination and freedom of choice at the end of life; now it's about the "how" (Feb. 2, 2020), available at <http://www.dignitas.ch/images/stories/pdf/medienmitteilung-26022020-e.pdf>.

<sup>45</sup> *David Goodall ends his life at 104 with a final powerful statement on euthanasia*, ABC NEWS (May 11, 2018), available at <http://www.abc.net.au/news/2018-05-10/david-goodall-ends-life-in-a-powerful-statement-on-euthanasia/9742528>.

publicized journey to Switzerland from Australia highlight concerns expressed by the Swiss government regarding their country's reputation for suicide tourism.<sup>46</sup>

In 2009, the Swiss cabinet drafted proposals for review in 2010 that demanded more stringent stipulations for right-to-die organizations.<sup>47</sup> Describing the Federal Council's motivations, Swiss justice minister Eveline Widmer-Schlumpf said, "We have no interest, as a country, in being attractive for suicide tourism."<sup>48</sup> However, the Federal Council did not succeed in passing their proposals or modifying the penal code.<sup>49</sup>

Assisted suicide remains popular among Swiss citizens, as shown by the results of a referendum of Zurich voters in May 2011. Eighty-five percent of voters rejected the petition to end assisted suicide, and 78% voted down a ban on foreigners from utilizing Switzerland assisted suicide clinics.<sup>50</sup> A survey taken by EXIT Deutsche Schweiz of 1,036 people living in the German-speaking part of Switzerland found that 63 percent of respondents over 50 had considered ending their life through assisted suicide.<sup>51</sup>

According to the Swiss National Cohort, a longitudinal study of the Swiss population from the period of 2003-2014, the number of assisted suicides tripled from 3.60 to 11.21 per 100,000 persons.<sup>52</sup> Assisted suicide accounted for 1.3 percent of all deaths in 2014, with a total of 3,941 deaths by assisted suicide.<sup>53</sup> Although Dignitas' annual reports of suicides remain relatively low, both EXIT organizations have increased year on year.<sup>54</sup> Membership in Swiss assisted suicide organizations is also growing among those abroad: the number of members joining Dignitas from the UK, where assisted suicide is prohibited, rose 39%, from 821 to 1139 between 2012 and 2016.<sup>55</sup> In 2019, Exit reported 1,214 suicides assisted, and Dignitas reported 256, for a total of 1470 deaths by suicide, a three percent increase over the previous year.<sup>56</sup>

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<sup>46</sup> *Switzerland aims to stop 'suicide tourism,'* TELEGRAPH (Oct. 29, 2009), <https://www.telegraph.co.uk/news/worldnews/europe/switzerland/6456747/Switzerland-aims-to-stop-suicide-tourism.html>.

<sup>47</sup> *Organised assisted suicide to be regulated,* FED. COUNCIL (Oct. 28, 2009), <https://www.admin.ch/gov/en/start/documentation/media-releases.msg-id-29751.html>.

<sup>48</sup> Helen Pidd, *'Death tourism' leads Swiss to consider ban on assisted suicide,* GUARDIAN (Oct. 28, 2009), available at <https://www.theguardian.com/society/2009/oct/28/swiss-consider-ban-assisted-suicide>.

<sup>49</sup> Sandra Burkhardt, *Debates about Assisted Suicide in Switzerland,* AM. J. FORENSIC MED. & PATHOLOGY 33 (2012), available at <https://insights.ovid.com/pubmed?pmid=23099546>.

<sup>50</sup> *Switzerland: Zurich votes to keep assisted suicide,* BBC NEWS (May 15, 2011), <https://www.bbc.com/news/world-europe-13405376>.

<sup>51</sup> *Majority of over 50s consider assisted suicide,* THELOCAL.CH (Sept. 21, 2016), <https://www.thelocal.ch/20160921/majority-of-over-50s-consider-assisted-suicide>.

<sup>52</sup> Nicole Steck et al., *Increase in assisted suicide in Switzerland: did the socioeconomic predictors change? Results from the Swiss National Cohort,* 8-4 BRIT. MED. J. OPEN 1, 1 (2018) (articles individually paginated in open access formatted journal).

<sup>53</sup> *Id.* at 3.

<sup>54</sup> *Id.* at 4.

<sup>55</sup> Grace Macaskill, *Half of Brits would consider £10,000 Dignitas death as calls grow for assisted dying in the UK,* MIRROR (Nov. 11, 2017), available at <https://www.mirror.co.uk/news/uk-news/half-brits-would-consider-10000-11506163>.

<sup>56</sup> *Assisted suicides on the rise in Switzerland,* THELOCAL.CH (Feb. 27, 2020), <https://www.thelocal.ch/20200227/increase-in-assisted-suicides-in-switzerland-in-2019>.

## **The Netherlands (2001)**

The Netherlands became the first country to adopt national legislation legalizing assisted suicide and euthanasia in 2001, after tolerating the practice for some years.<sup>57</sup> The Dutch Termination of Life on Request and Assisted Suicide (Review Procedures) Act of 12 April 2001 legalized euthanasia and assisted suicide for patients who make a voluntary and carefully considered request, experience unbearable suffering, without prospect of improvement.<sup>58</sup> The attending physician must inform the patient about his or her situation and prognosis, and come to the conclusion, together with the patient, that there is no reasonable alternative in the light of the patient's situation.<sup>59</sup> The patient's suffering does not need to be physical or even proven: the doctor need only show that he or she "held the conviction" that the patient endured some sort of suffering.<sup>60</sup> The request does not need to be in writing, nor is a waiting period required.<sup>61</sup> The physician must consult at least one other, independent physician, who must have seen the patient and given a written opinion on the due care criteria referred to above, and must terminate the patient's life or provided assistance with suicide with due care.<sup>62</sup>

Euthanasia now extends even to children in the Netherlands. A mentally competent patient who is a minor can request termination of life.<sup>63</sup> If the minor is aged between twelve and sixteen, then the consent of his or her parents or guardian is required.<sup>64</sup> If the patient is sixteen or seventeen, his or her parents or guardian must be involved in the decision, but their consent is not required.<sup>65</sup>

The law also includes a brief provision on advance requests. Under the act, physicians can end the lives of any patient aged sixteen or older who meets the criteria and made a written request for euthanasia prior to losing the ability to express his or her will.<sup>66</sup> In practice, doctors were expected to at least try to ensure that the patient still wanted euthanasia, but in the first trial of a doctor who performed euthanasia since legalization in 2019,<sup>67</sup> a Dutch court found that doctors do "not have to verify the current desire to die" for patients who have previously requested euthanasia but due to dementia are no longer mentally competent to make the request.<sup>68</sup>

Infants with disabilities or short life expectancies can also be euthanized at the request of their parents in the Netherlands. Two court cases in the 1990s established that this could be legal, although no legislation followed.<sup>69</sup> Prosecutors decided against charges in a further twenty-two

<sup>57</sup> Jacqui Wise, *Netherlands, first country to legalise euthanasia*, 79 BULL. WORLD HEALTH ORG. 580, 580 (2001).

<sup>58</sup> Wet van 12 april 2001 toetsing levensbeëindiging op verzoek en hulp bij zelfdoding [Law of 12 April 2001 on termination of life on request and assisted suicide] art. 2 § 1, Stb. 2001 p. 194 (Neth).

<sup>59</sup> *Id.*

<sup>60</sup> NEIL M. GORSUCH, *THE FUTURE OF ASSISTED SUICIDE & EUTHANASIA* 106 (2006).

<sup>61</sup> *Id.*

<sup>62</sup> Wet van 12 april 2001 toetsing levensbeëindiging op verzoek en hulp bij zelfdoding [Law of 12 April 2001 on termination of life on request and assisted suicide] art. 2 § 1.

<sup>63</sup> *Id.* art. 2 §§ 3-4.

<sup>64</sup> *Id.* art. 2 § 4.

<sup>65</sup> *Id.* art. 2 §3.

<sup>66</sup> *Id.* art. 2 § 2.

<sup>67</sup> Raf Casert & Aleksandar Furtula, *Landmark euthanasia trial opens in the Netherlands*, MED. XPRESS (Aug. 26, 2019), <https://medicalxpress.com/news/2019-08-landmark-euthanasia-trial-netherlands.html>.

<sup>68</sup> Mike Corder & Maria Cheng, *Dutch court clears doctor in landmark euthanasia trial*, MED. XPRESS (Sept. 11, 2019), <https://medicalxpress.com/news/2019-09-dutch-court-doctor-landmark-euthanasia.html>.

<sup>69</sup> Eduard Verhagen & Pieter J.J. Sauer, *The Groningen Protocol—Euthanasia in Severely Ill Newborns*, 352 NEW ENG. J. MED. 959, 960 (2005).

reported cases on the basis of “the presence of hopeless and unbearable suffering and a very poor quality of life, parental consent, consultation with an independent physician and his or her agreement with the treating physicians, and the carrying out of the procedure in accordance with the accepted medical standard.”<sup>70</sup> Data suggest that these reported cases were only 15-20% of actual infant euthanasia.<sup>71</sup>

In 2004, The Groningen Protocol for the euthanasia of newborns was drafted at the University Hospital of Groningen in close collaboration with a district attorney,<sup>72</sup> and was “ratified” by the Dutch National Association of Pediatricians.<sup>73</sup> It requires that the physician and an independent physician confirm a certain diagnosis and prognosis and “hopeless and unbearable suffering,” that both parents consent, and that medical standards are followed in carrying out the procedure.<sup>74</sup> A 2006 study found that 16% of the cases of infant euthanasia were not discussed with the parents during the year 2000.<sup>75</sup>

The Dutch data show an overall increase in euthanasia cases. In 2012, there were 4,188 reported cases of euthanasia<sup>76</sup> and the number rose to 6,585 in 2017.<sup>77</sup> There was a slight modest in 2018, in which authorities received 6,126 notifications of euthanasia,<sup>78</sup> but rose again in 2019 to 6,361 deaths.<sup>79</sup> This means that reported deaths by euthanasia increased by about 50% over the course of a decade. Notably, 2018 was “the first time in years that there [had] been a decline in the number of notifications, both in absolute terms and in relation to the total number of deaths.”<sup>80</sup>

The percentage of euthanasia cases in all deaths rose from 1.7% in 1990 to 4.5% in 2015,<sup>81</sup> with reported cases representing 4.2% of all deaths in 2019.<sup>82</sup> Also, in 2017, there were 32 more cases of assisted suicide involving people with dementia than in 2016 and 60 cases involving people with severe psychiatric problems.<sup>83</sup> Cases for psychiatric reasons grew from just two people

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<sup>70</sup> *Id.* at 961.

<sup>71</sup> *Id.*

<sup>72</sup> *Id.*

<sup>73</sup> Hilde Lindemnn & Marian Verkerk, *Ending the Life of a Newborn: The Groningen Protocol*, 38 HASTINGS CTR. REP. 42, 42 (2008).

<sup>74</sup> Verhagen & Sauer, *supra* note 69, at 961.

<sup>75</sup> Veerle Provoost, et. al., *Consultation of parents in actual end-of-life decision-making in neonates and infants*, 165 EUR. J. PEDIATRICS 859 (2006).

<sup>76</sup> Daniel Boffey, ‘Any taboo has gone’: Netherlands sees rise in demand for euthanasia, GUARDIAN (Nov. 9, 2017), <https://www.theguardian.com/world/2017/nov/09/any-taboo-has-gone-netherlands-sees-rise-in-demand-for-euthanasia>.

<sup>77</sup> *More euthanasia in the Netherlands, nearly all cases in line with the rules*, DUTCH NEWS (Mar. 7, 2018), <https://www.dutchnews.nl/news/2018/03/more-euthanasia-in-the-netherlands-nearly-all-cases-in-line-with-the-rules/>.

<sup>78</sup> REGIONAL EUTHANASIA REVIEW COMMITTEES, ANNUAL REPORT 2018 3 (Neth. 2019, English version) [hereinafter DUTCH 2018 REPORT]. The Regional Euthanasia Review Committees publish partial translations in English online.

<sup>79</sup> REGIONAL EUTHANASIA REVIEW COMMITTEES, JAARVERSLAG 2019 [ANNUAL REPORT 2019] 9 (Neth. 2020) [hereinafter DUTCH 2019 REPORT]. English version not available at time of writing.

<sup>80</sup> DUTCH 2018 REPORT, *supra* note 78, at 3.

<sup>81</sup> Agnes van der Heide, et al., *End-of-Life Decisions in the Netherlands over 25 Years*, 377 NEW ENG. J. MED. 492, 492 (2017).

<sup>82</sup> DUTCH 2019 REPORT, *supra* note 79, at 9.

<sup>83</sup> *More euthanasia in the Netherlands, nearly all cases in line with the rules*, DUTCH NEWS, *supra* note 77.

in 2010<sup>84</sup> to 60 in 2016 (300% growth), and dementia cases rose from 25 in 2010<sup>85</sup> to 169 in 2017<sup>86</sup> (576% growth). The most recent report has similar numbers, recording 162 deaths where dementia was the qualifying condition and 68 for psychiatric causes.<sup>87</sup> According to Dutch experts, in the beginning 98% of cases concerned terminally ill patients with few days to live; that number has since decreased to 70%.<sup>88</sup>

In a number of cases, the due care requirements were not followed,<sup>89</sup> and several recent instances of euthanasia also involved patients who were “tired of life” without any physical suffering or terminal illness.<sup>90</sup> There is also a significant number of cases of euthanasia without patients explicit request, as well as the problem of non-reporting.<sup>91</sup> In 2010, an estimated 23% of cases went unreported.<sup>92</sup> Lack of physician training in palliative care and pain management meant that euthanasia was sometimes proposed for the cases in which treatable pain was the primary cause of “unbearable suffering.”<sup>93</sup>

## **Belgium (2002)**

Belgium legalized euthanasia in 2002.<sup>94</sup> The law defines euthanasia as an intentional life-ending act by a physician at a person’s explicit request.<sup>95</sup> The law was amended in 2014 to allow euthanasia for minors.<sup>96</sup> Before the law’s adoption, there was some evidence that a small number

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<sup>84</sup> Senay Boztas, *Netherlands sees sharp increase in people choosing euthanasia due to 'mental health problems'*, TELEGRAPH (May 11, 2016), <https://www.telegraph.co.uk/news/2016/05/11/netherlands-sees-sharp-increase-in-people-choosing-euthanasia-du/>.

<sup>85</sup> *Id.*

<sup>86</sup> *More euthanasia in the Netherlands, nearly all cases in line with the rules*, DUTCH NEWS, *supra* note 77.

<sup>87</sup> DUTCH 2019 REPORT, *supra* note 79, at 12.

<sup>88</sup> *'Any taboo has gone': Netherlands sees rise in demand for euthanasia*, GUARDIAN (Nov. 9, 2017), <https://www.theguardian.com/world/2017/nov/09/any-taboo-has-gone-netherlands-sees-rise-in-demand-for-euthanasia>

<sup>89</sup> Johan Legemaate & Ineke Bolt, *The Dutch Euthanasia Act: Recent Legal Developments*, 20 EUR. J. HEALTH L. 451, 454 (2013). Thirty-six cases were found in the period 2007-2011; DUTCH 2019 REPORT, *supra* note 79, at 17, 19 (noting that 4 doctors were considered to act wrongly but also that 34 cases had both doctors assess the patient together).

<sup>90</sup> *Id.* at 459.

<sup>91</sup> Jose Pereira, *Legalizing euthanasia or assisted suicide: the illusion of safeguards and controls*, 18 CURRENT ONCOLOGY 38, 39 (2011). See generally Raphael Cohen-Almagor, *Non-voluntary and Involuntary Euthanasia in the Netherlands: Dutch Perspectives*, 18 ISSUES IN L. & MED. 239 (2003).

<sup>92</sup> Bregje Onwuteaka-Philipsen, et al., *Trends in end-of-life practices before and after the enactment of the euthanasia law in the Netherlands from 1990 to 2010: a repeated cross-sectional survey*, 380 THE LANCET 908, 908 (2012).

<sup>93</sup> Zbigniew Zylich, *Palliative Care and Euthanasia in the Netherlands: Observations of a Dutch Physician*, in THE CASE AGAINST ASSISTED SUICIDE 129 (Kathleen Foley, Herbert Hendin, eds., 2002).

<sup>94</sup> LEWY, *supra* note 16, at 74.

<sup>95</sup> Loi du 28 mai 2002 relative à l'euthanasie [Law of 28 May 2002 on euthanasia] of May 28, 2002 art. 2, MONITEUR BELGE [M.B.] [Official Gazette of Belgium], June 22, 2002, 28,515.

<sup>96</sup> *Belgium's parliament votes through child euthanasia*, BBC NEWS (Feb. 13, 2014), <https://www.bbc.com/news/world-europe-26181615>.

of patients were requesting and receiving suicide assistance or being euthanized in Belgium, but it was not commonly accepted practice, unlike the Netherlands.<sup>97</sup>

Many physicians found that the euthanasia law was “imposed on the medical profession” and that act exemplified “the intrusion of politics into the practice of medicine.”<sup>98</sup> Article 95 of the Code of Medical Deontology, governing professional conduct, prohibited doctors from providing any assistance in dying; it was modified three years after the law’s passage.<sup>99</sup> The law states that no physician can be made to participate in euthanasia, whether on reasons of conscience or health grounds.<sup>100</sup> Physicians who refuse to participate in euthanasia generally or to approve it in a particular case must notify the patient or his or her proxy and transfer records to another physician.<sup>101</sup>

The law requires the patient requesting euthanasia to be a competent adult or emancipated minor who has “medically futile condition of constant and unbearable suffering that cannot be alleviated.”<sup>102</sup> Unbearable suffering can be physical and/or mental.<sup>103</sup> The law’s broadness led to global news when middle-aged twin brothers, already deaf, chose to be euthanized after learning they would also lose their sight.<sup>104</sup> The son of a woman euthanized following a long history of mental illness brought a complaint to the European Court of Human Rights, challenges the lack of protections for her and an alleged lack of meaningful investigation into irregularities, including a donation she made to the head of the euthanasia review board.<sup>105</sup> The court agreed to hear the case in 2019.<sup>106</sup>

The amendments passed in 2014 extend euthanasia to unemancipated minors if they are able to understand the nature of their request, as determined by a specialist, experiencing severe physical pain, likely to die soon, and have parental consent.<sup>107</sup> The capacity assessment and

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<sup>97</sup> LEWY, *supra* note 16, at 80-82.

<sup>98</sup> *Id.* at 82.

<sup>99</sup> *Id.*

<sup>100</sup> Loi du 28 mai 2002 relative à l’euthanasie [Law of 28 May 2002 on euthanasia] of May 28, 2002 art. 14.

<sup>101</sup> *Id.* Although the provision requires that the medical reasons be noted in the file, this does not prevent euthanasia-minded patients from “doctor shopping.” There have also been some disputes related to hospitals as a religious character, such as a network of psychiatric hospitals founded by the Brothers of Charity but administered by a separate corporation, which voted to allow euthanasia within the facilities in Belgium. *See CDF: Belgian Brothers of Charity hospitals must drop Catholic identity over euthanasia*, CATHOLIC NEWS AGENCY (May 4, 2020), <https://www.catholicnewsagency.com/news/cdf-belgian-brothers-of-charity-hospitals-must-drop-catholic-identity-over-euthanasia-53889>.

<sup>102</sup> Loi du 28 mai 2002 relative à l’euthanasie [Law of 28 May 2002 on euthanasia] of May 28, 2002 art. 3 § 1.

<sup>103</sup> *Id.*

<sup>104</sup> Michael Winter, *Deaf twins going blind choose to be euthanized*, USA Today (Jan. 14, 2013), <https://www.usatoday.com/story/news/world/2013/01/14/deaf-belgian-twins-going-blind-euthanized/1834199/>.

<sup>105</sup> Maria Cheng, *Europe top rights court to hear Belgian euthanasia case*, ASSOC. PRESS (Jan. 8, 2019), <https://apnews.com/8217108af4f841b3a2d551ca73eeeb9c>.

<sup>106</sup> *Id.*

<sup>107</sup> Loi modifiant la loi du 28 mai 2002 relative à l’euthanasie, en vue d’étendre l’euthanasie aux mineurs [Law amending the law of 28 May 2002 on euthanasia, with a view to extending euthanasia to minors] of Feb. 28, 2014 art. 2(c)-(d), MONITEUR BELGE [M.B.] [Official Gazette of Belgium], Mar. 12, 2014, 21053.

parental consent serve in place of a set age limit.<sup>108</sup> When a minor requests euthanasia, parents or legal guardians must consent to the procedure, but the process is otherwise the same.<sup>109</sup>

The patient's request has to be in writing and it has to be voluntary, well considered and sustained through multiple conversations with the doctor.<sup>110</sup> Physicians must inform the patient about their condition, life expectancy, and other options such as therapies or palliative care.<sup>111</sup> In a terminal stage of illness, one independent physician must examine the patient and advise the physician who received the initial request.<sup>112</sup>

If the patient is not in a terminal stage of illness, a second independent physician is required to examine the patient and also give advice regarding the request.<sup>113</sup> There is a required one month waiting period between the written request and carrying out euthanasia.<sup>114</sup> In the case of psychiatric illness, the second physician needs to be a psychiatrist.<sup>115</sup> The law does not include a "palliative filter" or requirement that the patient be provided with advice by a palliative care team prior to consideration of a request for euthanasia.<sup>116</sup> Cases are reviewed only retrospectively by a commission established in the law, which also collects and publishes data on the practice.<sup>117</sup>

Adult and emancipated minor patients also can request euthanasia in advance directives. These must be made or confirmed within five years previous to the loss of ability to express one's wishes and can be revoked at any time prior to that.<sup>118</sup> The document must designate one or more "person(s) taken in confidence" whose role is to inform the doctor about the patient's wish.<sup>119</sup> The physician must ensure that the patient's condition is incurable and irreversible and the patient is no longer conscious.<sup>120</sup> Doctors must also consult the patient's care team, have another physician evaluate the patient and his or her medical record, and share the consulting physician's findings with the person taken in confidence.<sup>121</sup>

Deaths by legal euthanasia increased nearly tenfold (982%) from 235 in 2003—the first full year of legalization—to 2,309 in 2017.<sup>122</sup> From 2016 to 2017, deaths by euthanasia increased

<sup>108</sup> Cour Constitutionnelle [CC] [Constitutional Court] decision no. 153/2015 art. 16(B.36(3)-(4)) and 16(B.41), Oct. 29, 2015, MONITEUR BELGE [M.B.] [Official Gazette of Belgium], Jan. 6, 2016, 204, 217-2018. This case is also available via the official website of the Constitutional Court in several languages, including English.

<sup>109</sup> The law permitting euthanasia for minors amended the prior law through the addition of non-emancipated minors, imposing an additional requirement (a capacity evaluation) but not removing any requirements. *See generally* Loi modifiant la loi du 28 mai 2002 relative à l'euthanasie, en vue d'étendre l'euthanasie aux mineurs [Law amending the law of 28 May 2002 on euthanasia, with a view to extending euthanasia to minors] of Feb. 28, 2014, MONITEUR BELGE [M.B.] [Official Gazette of Belgium], Mar. 12, 2014, 21053. This law does not amend the provisions related to advance directives.

<sup>110</sup> Loi du 28 mai 2002 relative à l'euthanasie [Law of 28 May 2002 on euthanasia] of May 28, 2002 art. 4 § 1.

<sup>111</sup> *Id.* art. 2 § 1.

<sup>112</sup> *Id.* art. 3 § 2.

<sup>113</sup> *Id.* art. 3 § 3.

<sup>114</sup> *Id.*

<sup>115</sup> *Id.* art. 3 § 2.

<sup>116</sup> Penney Lewis, *Euthanasia in Belgium Five Years After Legalisation*, 16 EUR. J. HEALTH L. 125, 134 (2009).

<sup>117</sup> Loi du 28 mai 2002 relative à l'euthanasie [Law of 28 May 2002 on euthanasia] of May 28, 2002 arts. 6-9.

<sup>118</sup> *Id.* art. 4 § 1.

<sup>119</sup> *Id.*

<sup>120</sup> *Id.*

<sup>121</sup> *Id.* art. 4 § 2.

<sup>122</sup> Richard Egan, *Euthanasia in Belgium: updates on a social experiment*, BIOEDGE (Sept. 2, 2018), <https://www.bioedge.org/indepth/view/euthanasia-in-belgium-updates-on-a-social-experiment/>.

by 13.85%.<sup>123</sup> By 2019, the number of deaths by euthanasia had risen to 2,655, an increase of 12.5% over 2018 numbers.<sup>124</sup> Officially reported deaths by euthanasia accounted for 2.1% of all deaths in Belgium in 2017.<sup>125</sup> Comparing the 2019 numbers to the average annual death rate<sup>126</sup> suggests that recorded euthanasia deaths accounted for approximately 2.5% of all deaths that year. However, the total number of euthanasia cases may be significantly higher: researchers have estimated that 50% of cases go unreported, and that less care was often taken in such cases.<sup>127</sup>

The Belgian Federal Commission for the Control and Evaluation of Euthanasia releases statistics on euthanasia in biennial reports. The most recent complete report available at the time of writing includes data from 2016 and 2017. In 2017, 16% (375) of reported euthanasia deaths were of people whose deaths were not expected in the near future.<sup>128</sup> In 2017, there were also 181 (7.83%) euthanasia deaths of reported for “polypathology”—two or more conditions neither of which is in itself sufficient ground for euthanasia—where death was not expected soon, a 69.1% increase from 2015.<sup>129</sup> In 27 (7.2%) of the cases, the mandatory one-month waiting period between the written request for euthanasia and its execution was not complied with by the doctor. The Euthanasia Evaluation and Control Commission took no action on these cases other than sending the offending doctor “a didactic letter to remind the doctor of the procedure to be followed in case of unexpected death in the short term.”<sup>130</sup>

The Federal Commission published some preliminary data for 2019 in a March 2020 press release. A majority of the 2,655 cases involved cancer (62.5%), and the proportion of patients euthanized for polypathologies rose to 17.3%.<sup>131</sup> Mental and behavioral disorders were the qualifying disease in 1.8% of cases.<sup>132</sup> Similar to 2017, nearly 17% of patients’ deaths were not expected in the short term.<sup>133</sup> One of the patients euthanized was a minor.<sup>134</sup> The communique also notes an increase in the proportion of patients requesting euthanasia in a hospital setting.<sup>135</sup>

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<sup>123</sup> *Id.*

<sup>124</sup> Belgian press release on numbers p 1

<sup>125</sup> Egan, *supra* note 122.

<sup>126</sup> See *Mortality and Causes of Death*, HEALTHY BELGIUM, <https://www.healthybelgium.be/en/health-status/mortality-and-causes-of-death> (last visited June 5, 2020) (describing mortality numbers as steady at approximately 105,000 per year). This website is affiliated with the Federal Public Service on Health, Food chain safety, and Environment, and the page was updated Dec. 19, 2019. Numbers will likely be updated each year.

<sup>127</sup> Tinne Smets, et al., *Reporting of euthanasia in medical practice in Flanders, Belgium: cross sectional analysis of reported and unreported cases*, 341 BRIT. MED. J. 819, 819 (2010).

<sup>128</sup> COMMISSION FÉDÉRALE DE CONTRÔLE ET D’ÉVALUATION DE L’EUTHANASIE [Federal Commission for the Control and Evaluation of Euthanasia], HUITIÈME RAPPORT AUX CHAMBRES LÉGISLATIVES ANNÉES 2016 – 2017 [Eight Report to the Legislative chambers 2016-2017] 3 (2018), *available at* [https://organesdeconcertation.sante.belgique.be/sites/default/files/documents/8\\_rapport-euthanasie\\_2016-2017-fr.pdf](https://organesdeconcertation.sante.belgique.be/sites/default/files/documents/8_rapport-euthanasie_2016-2017-fr.pdf) [hereinafter BELGIAN 2016-2017 REPORT]. F

<sup>129</sup> *Id.*

<sup>130</sup> *Id.* at 18.

<sup>131</sup> Press Release, Federal Commission for the Control and Assessment of Euthanasia 1 (Mar. 3, 2020) (on file with author).

<sup>132</sup> *Id.*

<sup>133</sup> *Id.*

<sup>134</sup> *Id.*

<sup>135</sup> *Id.*

According to annual reports of the federal control and evaluation commission on euthanasia in Belgium, requests for euthanasia based on “unbearable mental suffering” are rapidly increasing. Fifty-two deaths (1.5%) between 2002 and 2009 were due exclusively to neuropsychiatric disorders. In the 2010-2011 period, 58 (2.8%) euthanasia deaths.<sup>136</sup> Before 2013, the increase was particularly evident in cases with diagnoses of mood disorders.<sup>137</sup> In 2017 alone, 87 (3.76%) cases involved no physical suffering at all and 18 cases involved “polypathology.”<sup>138</sup> Apart from psychiatric conditions, psychic suffering included “addiction, loss of autonomy, loneliness, despair, loss of dignity, despair at the thought of losing ability to maintain social contacts, etc.”<sup>139</sup> Between 2014 and 2017, a total of 201 people with psychiatric disorders such as depression, bipolar disorder, dementia, Alzheimer's, and autism were euthanized in Belgium.<sup>140</sup>

## **Luxembourg (2009)**

Luxembourg's Law of 16 March 2009 on euthanasia and assisted suicide legalized voluntary euthanasia and assisted suicide under certain conditions.<sup>141</sup> A requesting patient must be a conscious and capable adult “in a terminal medical condition [experiencing] constant and unbearable physical or mental suffering without prospects of improvement.”<sup>142</sup> The patient's request must be voluntary and in writing.<sup>143</sup>

At the time of requesting euthanasia, the attending physician must inform the patient of possible therapeutic options within the scope of palliative care and their estimated life-expectancy.<sup>144</sup> The attending physician must consult with a second, independent physician who must also examine the patient and give their medical opinion to the patient.<sup>145</sup> The physician must carry out multiple conversations of this nature to ensure that the patient's suffering is persistent and their desire for hastened death enduring.<sup>146</sup> Patients can request euthanasia or assisted suicide on the basis of irremediable and unbearable suffering regardless of their life expectancies.<sup>147</sup>

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<sup>136</sup> Marc de Hert et al., Attitudes of Psychiatric Nurses about the Request for Euthanasia on the Basis of Unbearable Mental Suffering (UMS), 10(12) PLOS ONE at 2 (2015) (articles are individually paginated in this journal).

<sup>137</sup> Sigrid Dierickx et al., *Euthanasia for people with psychiatric disorders or dementia in Belgium: analysis of officially reported cases*, 17 BMC PSYCHIATRY 203, 208 (2017).

<sup>138</sup> BELGIAN 2016-2017 REPORT, *supra* note 128, at 21.

<sup>139</sup> *Id.*

<sup>140</sup> *Id.* at 46.

<sup>141</sup> Rory Watson, *Luxembourg is to allow euthanasia from 1 April*, 338 BRIT. MED. J. 738, 738 (2009).

<sup>142</sup> Loi du 16 mars 2009 sur l'euthanasie et l'assistance au suicide [Law of 16 March 2009 on euthanasia and assisted suicide] art. 2 § 1(1) and (3), Memorial A No. 46 Journal Officiel du Grand-Duché de Luxembourg [Official Gazette of Luxembourg] 615, available at <http://legilux.public.lu/eli/etat/leg/memorial/2009/46>.

<sup>143</sup> *Id.* art. 2 § 1(2) and (4).

<sup>144</sup> *Id.* art. 2 § 2(1).

<sup>145</sup> *Id.* art. 2 § 2(3).

<sup>146</sup> *Id.* art. 2 § 2(2).

<sup>147</sup> *Id.* art. 2 § 2(3). According to a guide issued by the Ministry of Health, “any disorder which gives rise to unbearable physical or mental suffering” could meet the legal requirements. MINISTÈRE DE LA SANTÉ [Ministry of Health], EUTHANASIA AND ASSISTED SUICIDE LAW OF 16 MARCH 2009: 25 QUESTIONS 25 ANSWERS 13 (2010), available at <https://sante.public.lu/fr/publications/e/euthanasie-assistance-suicide-questions-reponses-fr-de-pt-en/euthanasie-assistance-suicide-questions-en.pdf>.

Patients can make advance directives setting out conditions under which a doctor can carry out euthanasia in case of future incapacity.<sup>148</sup> To carry out the advance request for euthanasia, the physician must find the patient in an irreversible state of a serious and incurable accidental or pathological disease, and a state of unconsciousness.<sup>149</sup> If the patient is conscious and capable but physically unable to write and sign the end-of-life provisional document, he or she can designate someone to record their wishes, in the presence of two witnesses.<sup>150</sup>

Before the physician carries out the euthanasia or assisted suicide request, they are required to consult the patient's regular medical care team and the patient's appointed representative, unless the patient objects.<sup>151</sup> Finally, the physician who carries out the act of euthanasia or assisted suicide must notify the National Commission for Control and Assessment within eight days.<sup>152</sup>

The law proved controversial when Henri, Grand Duke and head of state of Luxembourg, refused to sign the law, a requirement for its passage, on the basis of his Catholic faith.<sup>153</sup> In response, the Parliament voted to remove the constitutional requirement that the king sign every law for it to be enacted.<sup>154</sup> In doing so, the Duke's signature became a formality, rather than a requirement, and laws passed by Parliament are enacted regardless.<sup>155</sup> This constitutional crisis delayed the law's formal passage by several months.<sup>156</sup>

The Parliament of Luxembourg also passed a law on palliative and end-of-life care at the same time. The Act of 16 March 2009 on palliative care, advance directive, and end-of-life care codified the right of every citizen of Luxembourg with a terminal or incurable disease to access palliative care and pain management.<sup>157</sup> The director of the National Commission for Control and Assessment, which responsible for regulating assisted suicide, stated his belief that "euthanasia is complementary to palliative care."<sup>158</sup>

Luxembourg has a population of approximately 600,000 people.<sup>159</sup> Statistics published from the Commission for Control and Assessment generally show an increase of deaths by euthanasia and assisted suicide over each two-year reporting period, from 5 in 2009-2010 to 19 in

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<sup>148</sup> Loi du 16 mars 2009 sur l'euthanasie et l'assistance au suicide [Law of 16 March 2009 on euthanasia and assisted suicide] art. 4 § 1.

<sup>149</sup> *Id.*

<sup>150</sup> *Id.* art. 4 § 2.

<sup>151</sup> *Id.* art. 2 § 2(4)-(5).

<sup>152</sup> *Id.* art. 5.

<sup>153</sup> Jeff Israely, *Luxembourg's Monarch Steps Back on Euthanasia Bill*, TIME (Dec. 12, 2008), available at <http://content.time.com/time/world/article/0,8599,1865825,00.html>.

<sup>154</sup> *Luxembourg to reduce duke's power*, BBC NEWS (Dec. 3, 2008), available at <http://news.bbc.co.uk/2/hi/europe/7763539.stm>.

<sup>155</sup> Devin Montgomery, *Luxembourg parliament limits monarch's legislative role*, JURIST (Dec. 12, 2008), <https://www.jurist.org/news/2008/12/luxembourg-parliament-limits-monarchs/>.

<sup>156</sup> Watson, *supra* note 141, at 738.

<sup>157</sup> Loi du 16 mars 2009 relative aux soins palliatifs, à la directive anticipée et à l'accompagnement en fin de vie [Law of 16 March 2009 related to palliative care, advance directives and support at the end of life] arts. 1, 3, MEMORIAL A NO. 46 JOURNAL OFFICIEL DU GRAND-DUCHÉ DE LUXEMBOURG [Official Gazette of Luxembourg] 610, available at <http://legilux.public.lu/eli/etat/leg/loi/2009/03/16/n1/jo>.

<sup>158</sup> *Slight rise in euthanasia cases for Luxembourg*, LUX. TIMES (May 29, 2017), <https://luxtimes.lu/archives/2186-slight-rise-in-euthanasia-cases-for-luxembourg>.

<sup>159</sup> *A small, but open society*, LE GOUVERNEMENT DU GRAND-DUCHÉ DE LUXEMBOURG [Government of the Grand Duchy of Luxembourg], <https://luxembourg.public.lu/en/society-and-culture/population/demographics.html>.

2017-2018, although 2018 reported fewer assisted deaths than 2017 (8 compared to 11).<sup>160</sup> The number of deaths since legalization total 71.<sup>161</sup> The largest increase occurred in the second reporting period (jumping from 5 in 2009-2010 to 14 in 2011-2012).<sup>162</sup> Of cases in the most recent reporting period, 15 had cancer, and two had neuro-degenerative disorders.<sup>163</sup> Most died at home.<sup>164</sup> The Commission determined retrospectively that all legal requirements had been met on the basis of the reports submitted.<sup>165</sup> It intends to complete a ten year survey on the law's implementation, but noted its struggles in obtaining budgetary support in comparison to “millions” spent on palliative care.<sup>166</sup>

## **Colombia (1997/2015)**

Colombia decriminalized euthanasia in some circumstances by high court ruling in 1997.<sup>167</sup> This ruling allowed direct euthanasia by doctors when a patient with a terminal illness and no medical treatments requested help ending their lives.<sup>168</sup> However, the government failed to provide any laws or regulations governing the practice until 2015, following an order from the Constitutional Court laying out principles and requiring the Ministry of Health to prepare guidelines within thirty days.<sup>169</sup>

The court order included the following requirements: that the illness must be terminal, and involve pain and suffering (as determined by the patient), the patient must exercise informed consent, healthcare institutions must have groups in place to accompany the patient and family, there must be a clear medical protocol, a limited amount of time for euthanasia to be performed following the requests, and the swift assignment of a new doctor in cases of conscientious objection by medical providers.<sup>170</sup>

The 2015 resolution by the Ministry of Health of Colombia regulating euthanasia was adopted in April 2015.<sup>171</sup> Under the regulation, a qualifying terminal illness is an illness which is progressive, irreversible, incurable, and for which the treatment will not change the prognosis.<sup>172</sup>

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<sup>160</sup> COMMISSION NATIONALE DE CONTRÔLE ET D'ÉVALUATION DE LA LOI DU 16 MARS 2009 SUR L'EUTHANASIE ET L'ASSISTANCE AU SUICIDE [National Commission for the Control and Assessment of the law of 16 March 2009 on euthanasia and assisted suicide], CINQUIÈME RAPPORT À L'ATTENTION DE LA CHAMBRE DES DÉPUTÉS (ANNÉES 2017 ET 2018) [Fifth report for the attention of the Chamber of Deputies (years 2017 and 2018)] 3 (2019), available at <https://sante.public.lu/fr/publications/r/rapport-loi-euthanasie-2017-2018/index.html> [hereinafter Luxembourg 2017-2018 Report].

<sup>161</sup> *Id.*

<sup>162</sup> *Id.*

<sup>163</sup> *Id.* at 13.

<sup>164</sup> *Id.* at 12 (prompting the commission to question whether it reflected the desire of patients or reluctance on the part of hospitals).

<sup>165</sup> *Id.* at 14.

<sup>166</sup> *Id.*

<sup>167</sup> Mike Ceaser, *Euthanasia in legal limbo in Colombia*, 371 LANCET 290 (2008).

<sup>168</sup> *Id.*

<sup>169</sup> *Los principios para regular la euthanasia*, EL ESPECTADOR (Feb. 19, 2015), <https://www.elespectador.com/vivir/los-principios-regular-eutanasia-articulo-544675>.

<sup>170</sup> *Id.*

<sup>171</sup> Ministerio de Salud y Protección Social Res. N. 1216 de 2015.

<sup>172</sup> *Id.* art. 2.

A second opinion or expert group opinion may be required when there is a dispute over whether an illness is terminal.<sup>173</sup> The regulations prioritize patient autonomy and timeliness in guaranteeing the right to die.<sup>174</sup> The regulation also guarantees a right to palliative care and to ensure that the patient is aware of its availability before ending his or her life.<sup>175</sup> Healthcare facilities must establish multidisciplinary committees to ensure that the conditions for euthanasia are met, find replacements for doctors who do not want to participate in it, verify consent, and suspend the procedure in the case of irregularities, among other tasks.<sup>176</sup>

Under the resolution, legal adults with terminal illness who believe that their suffering is unbearable may request euthanasia.<sup>177</sup> It requires free and informed consent, permits that consent to be given by advanced directive or living will, and allows those who can direct the patient's medical care to give "substitute consent" where a patient lacks capacity but previously expressed a desire for euthanasia in an advanced directive.<sup>178</sup> Doctors must inform patients of their right to palliative care and comprehensive pain relief when the request is made.<sup>179</sup> The committee reviewing euthanasia requests has ten days to review the request and patient eligibility, and give the patient a chance to reiterate the request.<sup>180</sup> Once the request is reiterated and approved, the patient must be euthanized within fifteen days of the second request.<sup>181</sup> The request can be withdrawn at any time.<sup>182</sup>

Although the requirements include requirements for palliative care, offering other options, and consent provisions, they are not very specific. This has led to complaints that the regulation is vague, making it possible to deny access to euthanasia.<sup>183</sup> In addition to the official regulations, the Ministry of Health and Social Protection also prepared a hundred and twenty page protocol and guide document offering recommended protocols for carrying out euthanasia in line with the law.<sup>184</sup> It provides medically specific guidance on topics such as what constitutes terminal illness in the case of heart or motor-neuron diseases and cancer, assessment methods, and recommends specific medications and doses to administer, among other topics.<sup>185</sup> It also includes a table covering the requirements for assisted suicide and euthanasia in the Netherlands, Belgium, Luxembourg, Oregon, Washington State, the Northern Territory of Australia, and New Zealand.<sup>186</sup> Neither this report, nor the regulation, include reporting requirements.

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<sup>173</sup> *Id.* art. 2 paragrafo.

<sup>174</sup> *Id.* art. 3.

<sup>175</sup> *Id.* art. 4.

<sup>176</sup> *Id.* arts. 5, 7.

<sup>177</sup> *Id.* art. 15.

<sup>178</sup> *Id.*

<sup>179</sup> *Id.* art. 15 paragrafo.

<sup>180</sup> *Id.* art. 16.

<sup>181</sup> *Id.*

<sup>182</sup> *Id.*

<sup>183</sup> Angélica María Cuevas Guarnizo, *Eutanasia, el debate que sigue abierto*, EL ESPECTADOR (June 30, 2015), <https://www.elespectador.com/noticias/salud/eutanasia-el-debate-sigue-abierto-articulo-569330>, available in English at <https://www.worldcrunch.com/culture-society/eutanasia-in-colombia-legal-but-still-denied>.

<sup>184</sup> See MINISTERIO DE SALUD Y PROTECCIÓN SOCIAL, PROTOCOLO PARA LA APPLICACIÓN DEL PROCEDIMIENTO DE EUTANASIA EN COLOMBIA (2015).

<sup>185</sup> *Id.* at 13-16.

<sup>186</sup> *Id.* at 56-57.

Following another Constitutional Court decision, the Ministry of Health and Social Protection produced regulations pertaining to access to euthanasia for children in 2018.<sup>187</sup> The eligibility requirements follow those for adults. The rule permits assisted suicide for children aged fourteen to seventeen without parental consent, and for children between six and fourteen with parental consent.<sup>188</sup> Children between six and twelve can be euthanized if they are determined to be capable of appreciating the nature of the decision and making the decision by a psychiatrist.<sup>189</sup> Newborns, infants, children under six, children between six and twelve who do not meet the requirements listed, those who are not fully conscious, those with intellectual disabilities, and those with diagnoses that impair their competence to make decisions are not eligible under the regulation. Children with incurable illnesses may include those with severe chronic conditions and those dependent on medical technology to live.<sup>190</sup>

## **United States**

The high court of the United States has not found right to assisted suicide in its laws. In *Washington v. Glucksberg*, the Supreme Court found that a state law prohibiting assisted suicide did not violate a fundamental right within the Fourteenth Amendment.<sup>191</sup> The case was brought by a coalition of doctors, terminally ill patients, and Compassion in Dying (renamed Compassion & Choices in 2006<sup>192</sup>), an organization which coauthored Oregon's assisted suicide law.<sup>193</sup> They argued that there was a constitutionally-protected liberty interest in the choice by a mentally competent, terminally ill adult to commit physician-assisted suicide.<sup>194</sup>

The Supreme Court found no such right, looking at the long history of prohibitions on suicide and assisted it in the common law legal tradition.<sup>195</sup> The court also distinguished between a right to refuse unwanted medical treatment, found in an earlier case, and a right to assistance in hastening one's own death.<sup>196</sup> Similarly, it rejected the idea that a previous case, although overlapping with autonomy concerns pertaining to abortion, meant any deeply personal decision was beyond state scrutiny or the subject of a fundamental right.<sup>197</sup> Therefore, states needed only to show a rational basis for bans on assisted suicide to be upheld.<sup>198</sup> The court easily concluded that the state of Washington's interests in protecting human life, discouraging suicide as a matter of public health, ensuring the integrity of the medical profession, protecting vulnerable groups, and avoiding a slide towards euthanasia, met that standard, and therefore could stand.<sup>199</sup>

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<sup>187</sup> Ministerio de Salud y Protección Social, Res. No. 0825 de 2018.

<sup>188</sup> *Id.* art. 10.

<sup>189</sup> *Id.* art. 3 paragrafo.

<sup>190</sup> *Id.* art. 2(2.4-2.6).

<sup>191</sup> *Washington v. Glucksberg*, 521 U.S. 702, 706 (1997).

<sup>192</sup> *Oregon, Compassion & Choices*, <https://www.compassionandchoices.org/oregon/> (last visited Oct. 2, 2018).

<sup>193</sup> *Id.*; *Glucksberg*, 521 U.S. at 707-08.

<sup>194</sup> *Glucksberg*, 521 U.S. at 708.

<sup>195</sup> *Id.* at 713-16, 723.

<sup>196</sup> *Id.* at 724-25.

<sup>197</sup> *Id.* at 727.

<sup>198</sup> *Id.* at 728.

<sup>199</sup> *Id.* at 728-33, 735.

Although recognizing the reasonable grounds states had to ban assisted suicide, the Supreme Court did not foreclose the “earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide.”<sup>200</sup> Thus states may ban or allow physician assisted suicide without violating constitutional rights. While most states continue to prohibit the practice, eight states and Washington, D.C., have specifically legislation allowing it, and a ninth has a court decision decriminalizing the practice. Advocacy groups such as Compassion and Choices lead efforts in a number of states, many of which have or have had pending legislation or ballot initiatives.<sup>201</sup>

Oregon has the longest standing assisted suicide provisions in the United States, has served as a model for other states, and publishes some of the most comprehensive data on citizen use of the practice. As such, it receives the most thorough legal analysis of the states below, although laws from each state or district are explained. Jurisdictions are examined in order of legalization or decriminalization. State health department reports, where available, are included to provide insight into the use of the measures in the law, such as commonalities in those seeking to end their lives, and to examine data gaps.

### *Oregon (1994)*

Oregon was the first state in the United States to legalize assisted suicide. Citizens of the state narrowly voted to adopt the Death with Dignity Act by referendum in 1994.<sup>202</sup> Following an injunction, the law came into force in 1997, following the *Glucksberg* decision discussed above and an appeals court overturning the injunction.<sup>203</sup>

As the first jurisdiction in decades to allow assisted suicide, Oregon’s legislation has become a model for other states legalizing assisted suicide,<sup>204</sup> touted for its safeguards. Under the Oregon Death With Dignity Act, legal adults with terminal diagnoses, as confirmed by their attending physician and a consulting physician, and are residents of Oregon, can request lethal medication.<sup>205</sup> A terminal disease is defined as “an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.”<sup>206</sup> The patient should first make the request orally, and then in written form at least fifteen days after the initial request, and reiterate the oral request.<sup>207</sup> The prescription must be written within 48 hours of the written request.<sup>208</sup>

In order to prevent misuse or abuse of the law, attending physicians are asked to determine that the patient is competent, understands his or her health and treatment options, is, in fact,

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<sup>200</sup> *Id.* at 735.

<sup>201</sup> See, e.g. *In Your State*, COMPASSION & CHOICES, <https://compassionandchoices.org/in-your-state> (last visited May 12, 2020).

<sup>202</sup> William Claiborne, ‘Death With Dignity’ Measure May Make Oregon National Battlefield, *Washington Post*, June 27, 1997, at A19.

<sup>203</sup> *Id.*

<sup>204</sup> Marilyn Golden & Tyler Zoanni, *Killing us softly: the dangers of legalizing assisted suicide*, 2010 *DISABILITY & HEALTH J.* 16, 20 (2010); *Frequently Asked Questions*, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/faqs/> (last visited Oct. 9, 2018) (noting their efforts to expand assisted suicide through legislation modeled on Oregon’s law).

<sup>205</sup> OR. REV. STAT. § 127.805(2.01) (2017).

<sup>206</sup> *Id.* § 127.800(1.01(12)).

<sup>207</sup> *Id.* §§ 127.840(3.06), 127.850(3.08).

<sup>208</sup> *Id.* § 127.850(3.08).

terminal, and is making an informed and voluntary choice.<sup>209</sup> The consulting physician must confirm the terminal diagnosis, and that the decision is informed and voluntary.<sup>210</sup> There must be two witnesses to the written request, one of whom cannot have a family relationship, interest in the requestor's estate, or, except where designated by a long-term care facility, own, operate, or be employed at a medical facility where the requestor lives.<sup>211</sup>

Oregon issues annual reports on the use of the assisted suicide provisions. Since 1998, the number of patients requesting life-ending drugs has steadily risen, although the number that actually used them, while also rising, is lower.<sup>212</sup> In the first year, twenty-three patients received lethal prescriptions and fifteen died after consuming them.<sup>213</sup> In 2019, 290 patients received prescriptions, 170 of those patients ingested the medication, and an additional 18 who had received prescriptions prior to 2019 also ingested it, for a total of 188 deaths by assisted suicide.<sup>214</sup> Three-quarters of those individuals were over age sixty-five, about two-thirds had a cancer diagnosis, and 14% had neurological diseases.<sup>215</sup> Over nine in ten died at home.<sup>216</sup> Men were 59% of deaths in 2019 and 53% overall, and over 96% of patients accessing assisted suicide were white both in 2019 and overall.<sup>217</sup>

Efforts to promote assisted suicide often present assisted suicide as an exercise of to end suffering. Yet the data suggest that most Oregonians committing suicide by medical means do so due to becoming reliant on others, in significantly higher numbers than those requesting due to inadequate pain management or fear of pain.<sup>218</sup> Since data collection began, 90% of those who ended their lives with lethal medication cited “loss of autonomy” as a concern, closely followed by “less able to engage in activities that make life enjoyable ” (89.3%).<sup>219</sup> Almost three-quarters stated that “loss of dignity” was an end of life concern that was important to them, and 43% were troubled by the loss or potential loss of control over bodily functions.<sup>220</sup> Many also expressed fear of being a burden on family members, including 46.7% of all patients since legalization, but rising to 59% among those who ended their lives in 2019.<sup>221</sup> The median length of time between first request and death was 45 days, but one person ended his or her life 1,503 days after the first

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<sup>209</sup> *Id.* § 127.815(3.01).

<sup>210</sup> *Id.* § 127.820(3.02).

<sup>211</sup> *Id.* § 127.810(2.02)(2)-(4).

<sup>212</sup> OREGON HEALTH AUTHORITY PUBLIC HEALTH DIVISION, OREGON DEATH WITH DIGNITY ACT 2017 DATA SUMMARY 5 (2020) [hereinafter OREGON 2019 REPORT] (also noting that 62 died of other causes). The report contains all available data, but lacks data for 58 patients prescribed under the law (about 20% of all prescriptions). *Id.* Of these, 37 have no information about either death or ingestion, and 21 are known to have died, but it is not known whether they died following ingestion or of some other cause.

<sup>213</sup> DEPARTMENT OF HUMAN SERVICES, OREGON HEALTH DIVISION, CENTER FOR DISEASE PREVENTION AND EPIDEMIOLOGY, OREGON'S DEATH WITH DIGNITY ACT: THE SECOND YEAR'S EXPERIENCE 3 (2000).

<sup>214</sup> OREGON 2019 REPORT, *supra* note 212, at 5.

<sup>215</sup> *Id.* at 6.

<sup>216</sup> *Id.*

<sup>217</sup> *Id.* at 9.

<sup>218</sup> *Id.* at 12.

<sup>219</sup> *Id.*

<sup>220</sup> *Id.*

<sup>221</sup> *Id.*

request—a period approximately eight times longer than the six month life expectancy estimate outlined in the statute.<sup>222</sup>

The experiences of end of life care and the life-ending act of those patients who used lethal medications are also instructive. Approximately 90% were enrolled in hospice care,<sup>223</sup> and a similar percentage died at home, while most of the remaining died at long-term healthcare facilities.<sup>224</sup> Only about a third of patients are known to have taken the medication with either their physician or another provider present, and about 60% of all patients committing suicide, and 66% of 2019 patients, died without any medical provider present.<sup>225</sup> Volunteers were present at about a quarter of 2019 deaths, and 4.1% of deaths since 1998.<sup>226</sup> Most patients informed their families of their decisions.<sup>227</sup>

One hundred twelve doctors wrote a total of 290 prescriptions for lethal medications, with most writing only one or two, but one doctor wrote 33 prescriptions for life-ending drugs.<sup>228</sup> The median duration of doctor-patient relationship was 14 weeks in 2019, but they ranged from 21 years to just one week.<sup>229</sup> Some doctors assess patients for assisted suicide via telemedicine,<sup>230</sup> a practice which the American Clinicians Academy on Medical Aid in Dying prepared guidelines for in light of the 2020 coronavirus pandemic.<sup>231</sup> Only one patient in 2019 was referred for psychiatric evaluation.<sup>232</sup> One doctor was referred to the medical board for failure to comply with legal requirements.<sup>233</sup> Due to changes in availability and costs for barbiturates typically used in the 100 pill protocol for assisted dying,<sup>234</sup> patients in 2019 received prescriptions for two new drug combinations.<sup>235</sup>

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<sup>222</sup> *Id.* at 13.

<sup>223</sup> *Id.* at 10.

<sup>224</sup> *Id.* at 11.

<sup>225</sup> *Id.* at 12. This is likely why data on complications is missing for about half of patients since 1998, and two-thirds of all 2019 patients who ended their lives. *Id.* More data is available in the most recent report about the length of time between ingestion and death, possibly due to including information from volunteers or other non-physicians present. *See id.* at 16. In 2019, the length of time between ingestion and death was unknown for 61 out of 188 patients (32.4%). *Id.* at 13.

<sup>226</sup> *Id.* at 12.

<sup>227</sup> *Id.* at 11.

<sup>228</sup> *Id.* at 7. This suggests that doctor shopping for friendly doctors occurs, or may be facilitated by assisted suicide organizations.

<sup>229</sup> *Id.* at 12.

<sup>230</sup> Anita Hannig, *Dying virtually: Pandemic drives medically assisted deaths online*, CONVERSATION (June 2, 2020), <https://theconversation.com/dying-virtually-pandemic-drives-medically-assisted-deaths-online-139093>.

<sup>231</sup> *Telemedicine Policy Recommendations*, AMERICAN CLINICIANS ACAD. ON MED. AID IN DYING (Mar. 25, 2020), <https://www.acamaid.org/telemedicine/> (last visited June 5, 2020).

<sup>232</sup> *Id.* at 7.

<sup>233</sup> *Id.*

<sup>234</sup> *Id.* (citing increased costs at the end of 2018); Catherine Offord, *Accessing Drugs for Medical Aid-in-Dying*, *The Scientist* (Aug. 16, 2017), <https://www.the-scientist.com/bio-business/accessing-drugs-for-medical-aid-in-dying-31067> (noting effects of export bans on pentobarbital due to its use in the death penalty and a price hike by a U.S.-based manufacturer of a related drug in light of scarcity and increased demand following legalization in more states).

<sup>235</sup> OREGON 2019 REPORT, *supra* note 212, at 7. DDMA (diazepam, digoxin, morphine sulfate, and amitriptyline) was used in 46% of cases and DDMP (diazepam, digoxin, morphine sulfate, and propranolol) was used in 48% of cases. *Id.*

These data bring focus to the abstracted image of assisted suicide presented in most campaigns. While pain and suffering create a strong emotional pull to support suicide, hospice nurses in Oregon typically report that patients who request suicide have lower pain levels than those who do not.<sup>236</sup> Even though some research suggests that non-psychiatrists underdiagnose depression,<sup>237</sup> attending physicians only refer a few patients (who are expressing a desire to end their lives) for psychiatric evaluations.

In fact, Oregon's Death With Dignity Act prohibits counting medically assisted suicides as suicides under the law.<sup>238</sup> Reports suggest that doctors completing death certificates list the underlying illness, rather than the lethal prescription, as the cause of death.<sup>239</sup> The Oregon Department of Human Services as a practice also destroys all source documentation for its annual report on assisted suicide approximately one year following publication.<sup>240</sup> Therefore, even dedicated research in the future may be unable to reconstruct complete data about use of assisted suicide provisions.

Furthermore, Swedish researcher Fabian Stahle has established through a series of questions put to the Oregon Health Authority that they interpret the law's terms and requirements quite broadly. A health official confirmed that terminal illness, defined as incurable and irreversible within six months by the bill, is interpreted to mean an illness "absent further treatment,"<sup>241</sup> a much laxer standard. The same official answered further questions that a patient would qualify for assisted suicide under the act even if treatment could "a) prolong life, or b) transform a terminal illness to a chronic illness, or c) even cure the disease," or if a patient had a chronic illness, such as diabetes, but opted out of treatment.<sup>242</sup>

As Stahle points out, this means that those who could live for a long time but want to end their lives, regardless of reason, need only choose to discontinue treatment to have a "path to suicide."<sup>243</sup> Worryingly, asked if that applied to patients whose insurance refused to cover such treatments, the Oregon Health Authority stated that such a patient would be eligible for assisted suicide, "even if the treatment/medication could actually cure the disease, and the patient cannot pay for treatment."<sup>244</sup> Thus, by leaving the definitions of "incurable and irreversible" undefined, Oregon's law has created a back door for assisted suicide in many more cases than most would expect given the ordinary meaning of the law's provisions.

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<sup>236</sup> LEWY, *supra* note 16, at 137.

<sup>237</sup> *Id.* at 143-44.

<sup>238</sup> OR. REV. STAT. § 127.880(3.14)

<sup>239</sup> Margaret K. Dore, "Death with Dignity": A Recipe for Elder Abuse and Homicide (Albeit Not By Name), 11 MARQ. ELDER'S ADVISOR 387, 395 (2010).

<sup>240</sup> LEWY, *supra* note 16, at 130.

<sup>241</sup> Fabian Stahle, *Oregon Health Authority Reveals Hidden Problems with the Oregon Assisted Suicide Model 1-2* (Jan. 2018), <https://drive.google.com/file/d/1xOZfLFrVuQcaZfFudEncpZp2b18NrUo/view>.

<sup>242</sup> *Id.* at 2.

<sup>243</sup> *Id.*

<sup>244</sup> *Id.* at 3-4 (emphasis added by author removed).

*Washington (2008)*

The state of Washington voted on a ballot initiative to approve its own Death With Dignity Act in 2008 (in effect 2009), becoming the second state to allow the practice in the United States.<sup>245</sup> As the law closely tracks the provisions of Oregon’s Death With Dignity Act, and, it is unnecessary to repeat a lengthy description or analysis of its provisions. However, one difference does bear mentioning, pertaining to death certificates. While there is evidence, discussed above, that some doctors in Oregon list the underlying illness as the cause of death in official records, the law in Washington *requires* doctors completing death certificates to do so.<sup>246</sup>

Under instructions issued by the Department of Health, anyone completing the death certificate who knows that the person who has died ended his or her life via the bill’s provisions may not indicate it in any way on the death record: it must be recorded as natural, the underlying illness must be listed as the cause, and no language pertaining to suicide, assisted suicide, medications used, or other terms indicating that it was not a natural death may be used.<sup>247</sup>

Much of the data gathered by Washington health officials is similar to that found in the Oregon report in terms of patient profile, concerns leading to a request for assisted suicide, and practices.<sup>248</sup> Similar to Oregon, Washington has seen an increase in use of the law’s provisions. In 2010, the first full year of access to assisted suicide, eighty-seven patients received medications to end their lives, and fifty-one died after taking that medication.<sup>249</sup>

In 2018, 287 patients received life-ending medications, of whom 251 died.<sup>250</sup> Of those, 203 died after taking the medication, 29 died without taking it, and there is no information about whether the remaining 19 ingested the medication.<sup>251</sup> Three-quarters had cancer; other illnesses included neuro-degenerative disease (10%), heart disease (6%), and respiratory disease (5%).<sup>252</sup> Ninety-two percent were enrolled in hospice when they died, and 86% died at home.<sup>253</sup> More women than men accessed assisted suicide in 2017 (56% to 44%), and 96% were white.<sup>254</sup>

The most-cited end-of-life concern is loss of autonomy, with 85% of patients citing it; by comparison, 38% mentioned “inadequate pain control or concern about it.”<sup>255</sup> Other frequently

<sup>245</sup> Catharine Paddock, *Washington State Legalizes Assisted Suicide*, MED. NEWS TODAY (Mar. 6, 2009), <https://www.medicalnewstoday.com/articles/141318.php>.

<sup>246</sup> WASH. REV. CODE § 70.245.040(2) (2018).

<sup>247</sup> WASH. STATE DEPT. HEALTH, INSTRUCTIONS FOR PHYSICIANS AND OTHER MEDICAL CERTIFIERS FOR DEATH CERTIFICATES: COMPLIANCE WITH THE DEATH WITH DIGNITY ACT (2009), *available at* <https://www.doh.wa.gov/Portals/1/Documents/Pubs/422-151-DWDInstructionsForPhysicians.pdf>.

<sup>248</sup> *See generally* DISEASE CONTROL & HEALTH STATISTICS CENTER FOR HEALTH STATISTICS, WASH. STATE DEPT. HEALTH 2018 DEATH WITH DIGNITY ACT REPORT (2019), *available at* <https://www.doh.wa.gov/portals/1/Documents/Pubs/422-109-DeathWithDignityAct2017.pdf> [hereinafter WASHINGTON 2018 REPORT], *available at* <https://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct/DeathwithDignityData> (last visited June 5, 2020).

<sup>249</sup> WASHINGTON STATE DEPARTMENT OF HEALTH, WASHINGTON STATE DEPARTMENT OF HEALTH 2010 DEATH WITH DIGNITY ACT REPORT 3 (2011).

<sup>250</sup> WASHINGTON 2018 REPORT, *supra* note 248, at 5.

<sup>251</sup> *Id.*

<sup>252</sup> *Id.* at 9.

<sup>253</sup> *Id.* at 5.

<sup>254</sup> *Id.* at 9.

<sup>255</sup> *Id.* at 11.

cited concerns include loss of ability to engage in activities (84%), loss of dignity (69%), and burden on caregivers (51%).<sup>256</sup> Nine percent of patients who died under the act cited financial implications of treatment.<sup>257</sup> Most (92%) informed family of the decision.<sup>258</sup> Ten patients were referred for psychiatric evaluations.<sup>259</sup>

Half of patients had a relationship with their physician less than twenty-five weeks in duration, with the shortest relationship lasting less than a week.<sup>260</sup> Prescribing physicians were present when the patient ingested the medication 10% of the time, and another provider was present at ingestion in 67% of cases.<sup>261</sup> Most patients (66%) lost consciousness within 10 minutes.<sup>262</sup> Complications were reported in 4% of cases, and included regurgitation, seizures, and waking up.<sup>263</sup> Over half (54%) died within ninety minutes, but one person died thirty hours after ingestion.<sup>264</sup>

### *Montana (2009)*

In *Baxter v. State*, a man suffering from advanced cancer brought a suit challenging the legality of Montana’s application of criminal bans on homicide against physicians providing medical means to competent, terminally ill adults to end their lives.<sup>265</sup> Unlike the lower court, the state Supreme Court declined to find a right within the state constitution to assisted suicide within provisions protecting dignity and privacy.<sup>266</sup> Rather, the court focused on the concept of consent to homicide.<sup>267</sup> Under Montana law, consent of the person who has died can be a defense to homicide.<sup>268</sup> Consent is invalid under four circumstances, three of which the court set aside as “require[ing] case-by-case factual determinations.”<sup>269</sup> The remaining exception is a public policy exception.<sup>270</sup>

The court examined a previous case, *State v. Mackrill*, in which the victim’s consent to aggravated assault was determined to be against public policy and therefore not a defense to the criminal charge.<sup>271</sup> The court characterized the public policy exception in *Mackrill* as applying due to the disruption of public peace and the endangerment of others, as the “men were intoxicated,

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<sup>256</sup> *Id.*

<sup>257</sup> *Id.*

<sup>258</sup> *Id.* at 12.

<sup>259</sup> *Id.*

<sup>260</sup> *Id.* at 9.

<sup>261</sup> *Id.* at 13.

<sup>262</sup> *Id.*

<sup>263</sup> *Id.* There is no information on 8% of cases, and none were reported in the other 88%. *Id.*

<sup>264</sup> *Id.*

<sup>265</sup> *Baxter v. State*, 2009 MT 449, ¶¶ 5-6, 354 Mont. 234, 224 P.3d 1211.

<sup>266</sup> *Id.* ¶¶ 9-10.

<sup>267</sup> *Id.* ¶¶ 10-11.

<sup>268</sup> MONT. CODE ANN. § 42-2-211(1) (2017), cited in *Baxter*, 2009 MT 449, ¶ 13.

<sup>269</sup> *Baxter*, 2009 MT 449, ¶ 13. The exceptions relate to legal incompetence to authorize the conduct, inability to make a reasonable judgment about conduct consented to by reason of age, mental disease or defect, or intoxication, or the “consent” is gained under duress, force, or by deception. *Id.* quoting MONT. CODE ANN. § 42-2-211(2) (2017).

<sup>270</sup> *Baxter*, 2009 MT 449, ¶ 13.

<sup>271</sup> *Id.* ¶¶ 14-15.

brawling in a public space, and endangering others in the process.”<sup>272</sup> The court observed that other state courts applied the public policy exception in similar circumstances, to violent and disruptive events.<sup>273</sup> Although noting that the exception is not limited to assault, the court found that there was no risk of a similar breach of the peace or risk of harm to others in the private interaction between a doctor and a patient.<sup>274</sup>

Moreover, the court decided that a doctor providing medication that can end the patient’s life is not criminal as the patient makes the decision him or herself, since suicide is itself not a criminal act.<sup>275</sup> The court likened this to other exercises of patient autonomy protected by law, such as rights in making end-of-life decisions.<sup>276</sup> Characterizing the actions of providing medication and withdrawing treatment as making means available and directly withdrawing care (and therefore hastening death), respectively, and noting that the latter was already legal, the court decided that providing doctors providing life-ending medications could not violate public policy.<sup>277</sup>

*Baxter* removed criminal penalties for assisted suicide, but provided no regulations. In the years since the decision, the legislature has not passed any bills to regulate the practice. As a result, no statistics are available regarding the practice and it is impossible to tell how common it is. Legislation to declare the practice against public policy or ban it has also failed to pass.<sup>278</sup>

### *Vermont (2013)*

In 2013, Vermont became the first state to permit physician-assisted suicide by an act of the legislature rather than a voter-approved ballot initiative.<sup>279</sup> The law, the Patient Choice at End of Life Act, follows the same contours as the Oregon bill with less detail.<sup>280</sup> Unlike Oregon it requires both witnesses to the written request to be disinterested.<sup>281</sup> The bill relies on physician reports that the requirements have been met in the patients’ medical records.<sup>282</sup> The law prioritizes patient privacy to the extent that information collected regarding use of the law’s provisions is

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<sup>272</sup> *Id.* ¶ 17.

<sup>273</sup> *Id.* ¶¶ 19-20.

<sup>274</sup> *Id.* ¶¶ 21, 23.

<sup>275</sup> *Id.* ¶ 26.

<sup>276</sup> *Id.* ¶¶ 27-32.

<sup>277</sup> *Id.* ¶ 32.

<sup>278</sup> See, e.g. Mike Dennison, *House passes bill to outlaw physician-assisted suicide in Montana*, MISSOULIAN (Mar. 16, 2015), [https://missoulian.com/news/state-and-regional/montana-legislature/house-passes-bill-to-outlaw-physician-assisted-suicide-in-montana/article\\_c6facb27-78c0-59be-a5fa-a8686ac7964f.html](https://missoulian.com/news/state-and-regional/montana-legislature/house-passes-bill-to-outlaw-physician-assisted-suicide-in-montana/article_c6facb27-78c0-59be-a5fa-a8686ac7964f.html); *Montana Lawmakers Reject Criminalizing Physician-Assisted Suicide*, MTPR NEWS (Mar. 1, 2017), <http://www.mtpr.org/post/montana-lawmakers-reject-criminalizing-physician-assisted-suicide>.

<sup>279</sup> Terri Hallenbeck, *Vermont governor signs end-of-life bill*, USA TODAY (May 20, 2013),

<https://www.usatoday.com/story/news/politics/2013/05/20/vermont-physician-assisted-death-bill/2343481/>.

<sup>280</sup> See generally VT. STAT. ANN. tit. 18, §§ 5281-5293 (2018). When accessing the statutes on the respective state websites, Vermont’s printed to approximately four pages whereas Oregon’s required nine pages to print.

<sup>281</sup> *Id.* § 5283(a)(4).

<sup>282</sup> *Id.* § 5283(a). There is an implementing rule requiring the Department of Health to review all forms submitted by physicians; it is unclear how or if any auditing occurs. 13-140-079 VT. CODE R. §§ 6-7 (Lexis Advance through September 14, 2018).

exempt from public records,<sup>283</sup> which has the collateral effect of mandating that death certificates list the cause of death as the underlying illness and characterizing it as “natural.”<sup>284</sup>

In 2015, Vermont amended its law to require the state Department of Health to gather and publish statistical information on assisted suicide in the state, beginning in 2018.<sup>285</sup> The first report, published in January 2018, covers the period between May 31, 2013 and June 30<sup>th</sup>, 2017, and consists of only five pages, including the title page, table of contents, and a final page linking to appended materials such as the law itself and a health rule.<sup>286</sup> The second report covers July 1, 2017 through June 30, 2019, and consists of only three pages, including a title page.<sup>287</sup> Unlike other states, the report does not include demographic information, such as age, race, or sex, or information about reasons for seeking to medically assisted death.

During that period, thirty-four deaths “met the definition of the Act.”<sup>288</sup> From those persons, most (71%) had cancer, others (12%) had motor-neuron disease (known in the U.S. as ALS), 9% had some form of neuro-degenerative disease, and 9% had other causes.<sup>289</sup> Twenty-eight died after ingesting the lethal medication, five died of the qualifying illness, and one’s cause of death is unknown.<sup>290</sup> Local authorities were able to confirm that thirty had prescriptions under the law, and a thirty-first likely had, too, but lacked information on the remaining three people.<sup>291</sup>

### *California (2015)*

California adopted a law allowing assisted suicide in 2015 which came into effect the following year.<sup>292</sup> The California legislature had voted down previous bills, but the effort got new momentum following the death by assisted suicide of Californian Brittany Maynard, a young woman who established residency in Oregon in order to end her life following a diagnosis of terminal brain cancer.<sup>293</sup> The law generally follows the Oregon model in terms of eligibility,

<sup>283</sup> VT. STAT. ANN. tit. 18, § 5293(a). This was confirmed via email from a Vermont Department of Health Official, “As death certificates are public records in Vermont, revealing the use of Patient Choice would violate confidentiality. Listing the appropriate cause (the underlying disease) and manner of death (natural) is therefore consistent with the Act.” Email from David Englander, Senior Policy and Legal Adviser, Vermont Department of Health (Oct. 23, 2018, 15:32 EDT) (on file with author).

<sup>284</sup> DAVID ENGLANDER, VERMONT DEPT. HEALTH, REPORT CONCERNING PATIENT CHOICE AT THE END OF LIFE 4 (2018), available at <https://legislature.vermont.gov/assets/Legislative-Reports/2018-Patient-Choice-Legislative-Report-12-14-17.pdf> [hereinafter VERMONT REPORT 2013-2017].

<sup>285</sup> VT. STAT. ANN. tit. 18, § 5293(b).

<sup>286</sup> See generally VERMONT REPORT 2013-2017, *supra* note 284.

<sup>287</sup> DAVID ENGLANDER, VERMONT DEPT. HEALTH, REPORT CONCERNING PATIENT CHOICE AT THE END OF LIFE (2020), available at <https://legislature.vermont.gov/assets/Legislative-Reports/2020-Patient-Choice-Legislative-Report-2.0.pdf> [hereinafter VERMONT REPORT 2017-2019].

<sup>288</sup> *Id.* at 2. This is lower than the previous report’s 52 prescriptions and 48 deaths, but that report covers a four year period, as opposed to the two years in the latest report. VERMONT REPORT 2013-2017, *supra* note 284, at 4.

<sup>289</sup> VERMONT REPORT 2017-2019, *supra* note 287, at 2.

<sup>290</sup> *Id.* at 3.

<sup>291</sup> *Id.*

<sup>292</sup> Braktkton Booker, *California Governor Signs Physician-Assisted Suicide Bill Into Law*, NPR (Oct. 5, 2015), <https://www.npr.org/sections/thetwo-way/2015/10/05/446115171/california-governor-signs-physician-assisted-suicide-bill-into-law>.

<sup>293</sup> Iam Lovett & Richard Pérez-Peña, *California Governor Signs Assisted Suicide Bill Into Law*, NY TIMES (Oct. 5, 2015), <https://www.nytimes.com/2015/10/06/us/california-governor-signs-assisted-suicide-bill-into-law.html>.

request requirements, and procedures.<sup>294</sup> Similar to Vermont, the bill contains a privacy provision which excludes information related to assisted suicide from public record; therefore, the cause of death is listed as the underlying illness on death certificates.<sup>295</sup> Interestingly, the law will automatically repeal itself in 2026 unless the legislature adopts a law removing the sunset provision or extending the deadline.<sup>296</sup>

California’s law includes some additional details and safeguard provisions. It requires that the person seeking assisted suicide make the request him or herself, and not through any other person, even someone otherwise qualified to make medical decisions for the person, and does not permit the request to be made via advance directive by the patient.<sup>297</sup> It mandates mental health assessments by a specialist if there are “indications of a mental disorder,” and bars the provision of a lethal prescription until a specialist has determined that the requester’s judgment is not impaired.<sup>298</sup> The law directs physicians to “confirm that the qualified individual’s request does not arise from coercion or undue influence by another person.”<sup>299</sup> It also specifies that anyone present at the time of death may help prepare the medication for ingestion, but may not help the person to ingest it.<sup>300</sup>

The law also specifies information patients must receive in greater detail than the Oregon law, such as other treatment options and how self-administer the prescription, although the provisions remain substantively similar.<sup>301</sup> It bans health insurance providers from denying treatment and offering to cover assisted suicide drugs in the same letter,<sup>302</sup> although the coverage decisions may not be made more palatable for being issued separately. Stephanie Packer, a California mother with a terminal illness and opponent of assisted suicide, was denied a life-prolonging treatment by her insurance, but, upon contacting the insurer, learned she had coverage for life-ending medications.<sup>303</sup>

Under the law, the California Department of Public Health is required to produce annual reports on the use of assisted suicide for the preceding year.<sup>304</sup> The most recent report published contains information on access to physician-assisted suicide in 2018. In that year, 531 patients made two verbal requests, and 452 completed the process and received a prescription.<sup>305</sup> Of that number, 59 died from other causes; the status of 79 people who received prescriptions is

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<sup>294</sup> See CAL. HEALTH & SAFETY CODE §§ 443.2-443.6 (2018).

<sup>295</sup> *Id.* § 443.19(a).

<sup>296</sup> *Id.* § 443.215.

<sup>297</sup> *Id.* § 443.2(c).

<sup>298</sup> *Id.* §§ 443.5(a)(1)(A)(ii)-(iii). As with other states that have legalized assisted suicide, the law admits that there may be a mental health issue, but does not take suicidal ideation as inherently unhealthy under these circumstances, undercutting other presumptions about what mental wellness looks like.

<sup>299</sup> *Id.* § 443.5(a)(4).

<sup>300</sup> *Id.* § 443.14(a). This recognizes the possibility of coercion at the end of life, but as deaths may take place at home, the provision will be hard to enforce without a willing witness.

<sup>301</sup> *Id.* §§ 443.5(a)(2)-(7)

<sup>302</sup> *Id.* § 443.13(c).

<sup>303</sup> Andrea Peyser, *Terminally ill mom denied treatment coverage—but gets suicide drug approved*, NY POST (Oct. 24, 2016), <https://nypost.com/2016/10/24/terminally-ill-mom-denied-treatment-coverage-but-gets-suicide-drugs-approved/>. Following public outcry, the insurer agreed to cover the treatment. Packer has outlived her initial prognosis by several years.

<sup>304</sup> Cal. Health & Safety Code § 443.19(b) (2018),

<sup>305</sup> CAL. DEPT. PUBLIC HEALTH, CALIFORNIA END OF LIFE OPTION ACT 2018 DATA REPORT 3 (2019).

unknown.<sup>306</sup> Three hundred thirty-seven people died after ingested drugs prescribed under the law, including 23 who filled prescriptions in 2017.<sup>307</sup> A doctor or healthcare provider was present when the person took the drugs in 54% of cases; nearly a quarter had no one present, and a fifth lack information on this point.<sup>308</sup>

Most of those who died by assisted suicide had cancer (68.8%), with the second largest type of underlying illness being neurological diseases (13.1%).<sup>309</sup> The median age was 74, patients were evenly divided between men and women, and were predominantly white (88.4%).<sup>310</sup> Most (87.5%) told their family members, were enrolled in hospice care (88.1%), and died at home (92%).<sup>311</sup> The report is not required to report, and does not include, data about what concerns motivated requests to end their lives.

California's law faced legal challenges following its adoption when a group of doctors brought suit in 2016.<sup>312</sup> A district judge in California found that the law was not within the scope of authority of the special legislative session in which it was adopted and therefore was improperly adopted under California's constitution.<sup>313</sup> An appeals court issued a stay, reinstating the law and allowing assisted suicides to resume.<sup>314</sup> The court later found that the doctors could not show they were harmed by the law, as it did not require them to assist in suicides, and they therefore lacked legal standing to challenge it.<sup>315</sup>

### *Colorado (2016)*

Colorado legalized assisted suicide in 2016 by ballot initiative, with two-thirds of voters supporting the proposal modeled on Oregon's Death With Dignity Act.<sup>316</sup> As in Oregon, adult Colorado residents may request medication to end their lives if they have a terminal illness with a life expectancy of six or fewer months, have capacity and are making the request voluntarily.<sup>317</sup> The law does state that age and disability do not qualify someone to request medical help ending his or her life.<sup>318</sup> Colorado also requires that doctors must offer patients a chance to withdraw the request, regardless of mental state, before they may provide the prescription.<sup>319</sup> Attending physicians or hospice medical must sign the death certificates, naming the underlying illness as

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<sup>306</sup> *Id.* at 4.

<sup>307</sup> *Id.* at 3-4.

<sup>308</sup> *Id.* at 9.

<sup>309</sup> *Id.* at 4.

<sup>310</sup> *Id.*

<sup>311</sup> *Id.* at 7, 9.

<sup>312</sup> Scott Neuman, *Judge Overturns Assisted Suicide Law in California*, NPR (May 16, 2018),

<https://www.npr.org/sections/thetwo-way/2018/05/16/611527757/judge-overturns-assisted-suicide-law-in-california>.

<sup>313</sup> *Id.*

<sup>314</sup> Assoc. Press, *Court reinstates doctor-assisted suicide in California*, NBC NEWS (June 16, 2018),

<https://www.nbcnews.com/news/us-news/court-reinstates-doctor-assisted-suicide-california-n883851>.

<sup>315</sup> Brian Melley, *California court reverses ruling against assisted suicide*, ASSOC. PRESS, Nov. 28, 2018, available at <https://apnews.com/6705d8ae21154674a24acffa1f42ba47>.

<sup>316</sup> Jennifer Brown, *Colorado passes medical aid in dying, joining five other states*, DENVER POST (Nov. 8, 2016), <https://www.denverpost.com/2016/11/08/colorado-aid-in-dying-proposition-106-election-results/>.

<sup>317</sup> COLO. REV. STAT. 25-48-103(1) (2018).

<sup>318</sup> *Id.* § 25-48-103(2).

<sup>319</sup> *Id.* § 25-48-105.

the cause of death.<sup>320</sup> As in Vermont and California, information gathered by health authorities regarding assisted suicide is exempted from public records rules and therefore will not be included on death certificates.<sup>321</sup>

In cases where a doctor is unwilling or unable to prescribe life-ending medications to someone who qualifies for it under the law, they are required to transfer medical records to a new healthcare provider.<sup>322</sup> Health care facilities may bar doctors from writing such prescriptions on their premises, provided they do so in advance.<sup>323</sup> They must notify patients of hospital policies related to medically assisted suicide, and cannot penalize providers for acting in good faith or refusing to act under the law.<sup>324</sup> The law criminalizes forging requests, destroying withdrawals of requests, or coercing people in order to make or withdraw a request under the law's provisions.<sup>325</sup>

Colorado published its first report on use of the end of life options during 2017, the first year of its implementation. The report notes that due to the requirement to list the underlying illness as the cause of death on death certificates, the state health department cannot be sure how many people actually died following receiving a prescription for life-ending medication.<sup>326</sup> Therefore, anyone who both received a prescription and died during 2017 is included in the data summary where appropriate; in 2017, that number was sixty-nine.<sup>327</sup>

In its report on deaths under the law in 2019, Colorado noted a 38% increase in prescriptions from the previous year, from 123 to 170,<sup>328</sup> although only 130 completed written requests were filed.<sup>329</sup> Sixty percent qualified on the basis of cancer, and 18.2% based on progressive neurological disorders.<sup>330</sup> Health authorities received reports for 129 patients, and death certificates for 139, although it cannot confirm the exact cause of death.<sup>331</sup> Of patients who died, most were white (94.2%), over three-quarters were over the age of 55, and 52.5% were men.<sup>332</sup> Four in five died at home, and a similar number were known to be receiving hospice care.<sup>333</sup>

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<sup>320</sup> *Id.* § 25-48-109.

<sup>321</sup> *Id.* § 25-48-111(2)(a).

<sup>322</sup> *Id.* § 25-48-113.

<sup>323</sup> *Id.* § 25-48-118.

<sup>324</sup> *Id.*

<sup>325</sup> *Id.* § 25-48-119.

<sup>326</sup> CTR. HEALTH & ENVTL. DATA, COLO. DEPT. PUBLIC HEALTH & ENV'T, COLORADO END-OF-LIFE OPTIONS ACT, YEAR ONE 2017 DATA SUMMARY 1 (2018), noting that the Dept. of Health is not authorized to follow up with physicians to determine whether the prescription or the underlying illness caused the death.

<sup>327</sup> *Id.* at 2.

<sup>328</sup> CTR. HEALTH & ENVTL. DATA, COLO. DEPT. PUBLIC HEALTH & ENV'T, COLORADO END-OF-LIFE OPTIONS ACT, YEAR THREE 2019 DATA SUMMARY 2 (2020).

<sup>329</sup> *Id.* at 6. The report suggests that missing information for 20-40 patients (various documents missing) requires doctor education, but seems unconcerned, since "attending/prescribing forms received contained physicians' signed attestations that all requirements of the Colorado End-of-Life Options Act have been met, and that required documentation is complete and contained in patients' records." *Id.* The report also notes that the department cannot follow up to find out if the person who received the prescription actually used it, *id.* at 1, and no information related to assisted suicide is part of the public record, *id.* at 6, raising serious questions about the ability to monitor or enforce regulations.

<sup>330</sup> *Id.* at 3-4.

<sup>331</sup> *Id.* at 1-2.

<sup>332</sup> *Id.* at 4.

<sup>333</sup> *Id.* at 5.

In 2017, one patient's documents included confirmation of competence from a mental health provider; no similar documents were filed for anyone in 2018 or 2019.<sup>334</sup> As the report does not include numbers of how many were refused medication under the law, it is impossible to determine whether the mental health assessment provision is effective as a gatekeeping mechanism. At only six pages, the report does not provide much information beyond basic demographics, the underlying illnesses, documentation received, and the medications prescribed. It does not include any indications about why people have sought to end their lives.

*Washington, District of Columbia (2016)*

The Council of Washington, D.C., adopted its Death with Dignity Act in 2016, and the law went into effect in 2017.<sup>335</sup> As D.C. is not a state, its laws are subject to approval by the U.S. Congress, and its implementation was paused as Congressional Republicans opposed its implementation via budget rider and then was challenged under specific legislation to repeal the rule.<sup>336</sup> However, those efforts ultimately failed and the law came into effect in July 2017.<sup>337</sup>

The law generally follows the Oregon model, allowing physicians to prescribe life-ending drugs to adults with terminal diagnoses.<sup>338</sup> The law requires any physician involved in an assisted suicide request who thinks a patient may have psychologically impaired judgment to refer that patient to a psychiatrist or psychologist before any medications can be prescribed.<sup>339</sup> D.C. Health, the public health authority in the District, has also faced criticism from assisted suicide advocates for its training requirements for doctors and registry of doctors willing to prescribe life-ending drugs.<sup>340</sup>

D.C. has published only one report thus far, consisting of a title page and one substantive page. Three doctors wrote four prescriptions for patients who qualified that year, all on the basis of cancer diagnoses.<sup>341</sup> Two patients died of their cancers before ingesting the life-ending medication.<sup>342</sup> The two patients who died after taking the medication were both white women, one aged 81, the other 72.<sup>343</sup>

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<sup>334</sup> *Id.* at 6.

<sup>335</sup> *Death with Dignity Act of 2016*, D.C. HEALTH, <https://dchealth.dc.gov/page/death-dignity-act-2016> (last visited Nov. 20, 2018). Note that the Additional Resources section on the page links directly to assisted suicide advocacy group Compassion & Choices.

<sup>336</sup> Fenit Nirappil, *Assisted Suicide is legal in D.C.—for now*, WASH. POST (July 17, 2017), [https://www.washingtonpost.com/local/dc-politics/dc-assisted-suicide-program-goes-live-as-threat-of-congressional-interference-looms/2017/07/17/f12c5bc4-6b18-11e7-b9e2-2056e768a7e5\\_story.html?utm\\_term=.0cdee806f924](https://www.washingtonpost.com/local/dc-politics/dc-assisted-suicide-program-goes-live-as-threat-of-congressional-interference-looms/2017/07/17/f12c5bc4-6b18-11e7-b9e2-2056e768a7e5_story.html?utm_term=.0cdee806f924).

<sup>337</sup> Fenit Nirappil, *A year after D.C. passed its controversial assisted suicide law, not a single patient has used it*, WASH. POST (Apr. 10, 2018), [https://www.washingtonpost.com/local/dc-politics/a-year-after-dc-passed-its-assisted-suicide-law-only-two-doctors-have-signed-up/2018/04/10/823cf7e2-39ca-11e8-9c0a-85d477d9a226\\_story.html](https://www.washingtonpost.com/local/dc-politics/a-year-after-dc-passed-its-assisted-suicide-law-only-two-doctors-have-signed-up/2018/04/10/823cf7e2-39ca-11e8-9c0a-85d477d9a226_story.html).

<sup>338</sup> Emma Kinery, *Republicans in Congress attempt to repeal D.C. assisted suicide law*, USA TODAY (July 17, 2017), <https://www.usatoday.com/story/news/2017/07/17/d-c-assisted-suicide-law-targeted-gop/485209001/>. See also *Death With Dignity Act*, D.C. CODE § 7-661 (2018).

<sup>339</sup> *Death With Dignity Act*, D.C. CODE § 7-661.04 (2018).

<sup>340</sup> Bill McMorris, *D.C. Health Defends Assisted Suicide Implementations*, FREE BEACON (April. 25, 2018), <https://freebeacon.com/issues/d-c-health-defends-assisted-suicide-implementations/>.

<sup>341</sup> D.C. HEALTH, DISTRICT OF COLUMBIA DEATH WITH DIGNITY ACT 2018 DATA SUMMARY 2 (2019).

<sup>342</sup> *Id.*

<sup>343</sup> *Id.*

*Hawaii (2018)*

Hawaii's governor signed into law the Our Care, Our Choice law in April, 2018, which came into effect in January 2019.<sup>344</sup> This followed two decades of debate and the defeat of previous measures.<sup>345</sup> The bill essentially follows the Oregon model with some slight adjustments aimed at safeguarding patients from abuse.<sup>346</sup> Its preamble describes its protections as “the strongest of any state in the nation.”<sup>347</sup> Hawaii's law has a longer waiting period of twenty days, rather than the more common fifteen, between the two oral requests patients must make for life-ending drugs, and physicians must receive the requests directly from patients.<sup>348</sup> Doctors also cannot write prescriptions until forty-eight hours after the required written request.<sup>349</sup> It requires doctors to refer patients for counseling as part of the process.<sup>350</sup> As with other recent U.S. legislation authorizing assisted suicide, Hawaii's bill mandates that the qualifying illness be listed as the cause of death on vital records.<sup>351</sup>

Hawaii published its first report on use of the bill's provisions in late 2019. It covered the period from July 31, 2018, through December 26, 2019.<sup>352</sup> The report does not include much demographic information, such as age, sex, or race. Out of nine pages, one is a cover page, two include substantive information about use of the law's provisions, three describe activities related to the implementation and recommendations, and the final four pages contain the law itself.

Twenty-seven patients received prescriptions under the law, of whom 19 later died.<sup>353</sup> Of those who died, 15 had cancer.<sup>354</sup> Fourteen ingested the life-ending prescription, and five did not.<sup>355</sup> The report emphasizes that there were no reports of complications,<sup>356</sup> but does not mention whether any healthcare provider was present at the death to observe this, or whether it sought such information from other persons who were present. Twelve doctors wrote prescriptions, mostly for DDMP2 (a mixture of diazepam, digoxin, morphine, and propranolol), but six prescriptions were for DDMA (diazepam, digoxin, morphine, and amitriptyline).<sup>357</sup>

<sup>344</sup> Wayne Yoshioka, “Death with Dignity” Signed Into Law, HAW. PUB. RADIO (April 5, 2018), <http://www.hawaiipublicradio.org/post/death-dignity-signed-law>.

<sup>345</sup> *In historic vote, Hawaii Senate OKs bill to legalize medical ‘aid in dying’*, HAW. NEWS NOW (Mar. 29, 2018), <http://www.hawaiinewsnow.com/story/37840968/medical-aid-in-dying-bill-up-for-final-senate-vote/>.

<sup>346</sup> *See Our Care, Our Choice, Act. 2, 29<sup>th</sup> Legislative Sess., Hawaii, approved by the Governor Apr. 5, 2018, available at* <https://health.hawaii.gov/opppd/files/2018/11/OCOC-Act2.pdf>.

<sup>347</sup> *Id.* Preamble § 1.

<sup>348</sup> *Id.* § 2.

<sup>349</sup> *Id.* § 11.

<sup>350</sup> *Id.* § 4(a)(4).

<sup>351</sup> *Id.* § 4(b).

<sup>352</sup> DEPT. HEALTH OFFICE OF PLANNING, POLICY, & PROGRAM DEVELOPMENT, REPORT TO THE THIRTIETH LEGISLATURE STATE OF HAWAII 2020 PURSUANT TO ACT 2 SESSION LAWS OF HAWAII 2019 (HB2739 H.D. 1) 2 (2019) [hereinafter HAWAII 2019 REPORT]. As the law came into effect Jan. 1, 2019, it effectively covers the 2019 calendar year, which was the first year of implementation.

<sup>353</sup> *Id.*

<sup>354</sup> *Id.*

<sup>355</sup> *Id.*

<sup>356</sup> *Id.*

<sup>357</sup> *Id.* See Oregon section, *infra*, for information on cost and availability changes to the previous use of barbiturates.

The report notes that the first patient received a prescription 48 days after the initial request, the average over the year was 34 days, with a longest wait of 100 days and a shortest of 20, the statutory minimum.<sup>358</sup> The Department of Health recommendations include creating a waiver for the waiting period and allowing advance practice registered nurses to “serve as attending providers” for patients seeking physician-assisted suicide.<sup>359</sup> It notes access to healthcare providers, “especially mental health care providers” as a concern.<sup>360</sup>

### *New Jersey (2019)*

New Jersey passed the Medical Aid in Dying for the Terminally Ill in April 2019, with the bill coming into effect August 1<sup>st</sup> of that year.<sup>361</sup> Under the law, a terminally ill adult resident of New Jersey can request a lethal prescription if two physicians determine he or she is terminally ill, the patient is mentally competent (“capable”), and the request is voluntary.<sup>362</sup> A capable patient has to be able to communicate his or her wishes to a healthcare provider, but this can be done through an intermediary “familiar with the patient’s manner of communicating.”<sup>363</sup>

The patient must make two oral requests, with at least fifteen days between them, and one written request.<sup>364</sup> The written request may be made at the same time or any time after the first oral request.<sup>365</sup> Two witnesses, one of who must be disinterested and not connected to the long-term care facility, and neither of whom can be the physician, must attest to the voluntariness of the request at its signing.<sup>366</sup> The physician may not write a prescription until at least 48 hours after receiving the written request.<sup>367</sup>

Attending physicians effectively serve as the state’s check on whether the conditions are met to access assisted suicide. This includes exercises of medical judgment, such as whether the patient has a terminal condition<sup>368</sup> and is capable or requiring a capacity assessment,<sup>369</sup> contextual judgment, such as whether the request is voluntary,<sup>370</sup> offering guidance about other care options and how and when to take the medication,<sup>371</sup> the right to withdraw the request,<sup>372</sup> and

<sup>358</sup> HAWAII 2019 REPORT, *supra* note 352, at 4.

<sup>359</sup> *Id.* at 5. It identifies the waiting period as “too long” earlier in the report. *Id.* at 2.

<sup>360</sup> *Id.* at 2.

<sup>361</sup> Taylor Romine, *New Jersey will now allow terminally ill patients to end their lives*, CNN (Apr. 15, 2019), <https://www.cnn.com/2019/04/15/health/nj-assisted-suicide-terminally-ill-law-trnd/index.html>. A superior court judge blocked the law on August 14<sup>th</sup> in a case brought by a doctor who conscientiously objected to its provisions, but this was overruled on appeal and the law was back in effect by August 27<sup>th</sup>. *New Jersey court ruling lets assisted suicide law go ahead*, MODERN HEALTHCARE (Aug. 27, 2019), <https://www.modernhealthcare.com/patient-care/new-jersey-court-ruling-lets-assisted-suicide-law-go-ahead>.

<sup>362</sup> N.J. REV. STAT. § 26:16-4 (2020).

<sup>363</sup> N.J. REV. STAT. § 26:16-3 (2020).

<sup>364</sup> N.J. REV. STAT. § 26:16-10(a)(1) (2020).

<sup>365</sup> N.J. REV. STAT. § 26:16-10(a)(3) (2020).

<sup>366</sup> N.J. REV. STAT. § 26:16-5 (2020).

<sup>367</sup> N.J. REV. STAT. § 26:16-10(a)(6) (2020).

<sup>368</sup> N.J. REV. STAT. § 26:16-6(a)(1) (2020).

<sup>369</sup> N.J. REV. STAT. § 26:16-6(a)(1) and (4) (2020).

<sup>370</sup> N.J. REV. STAT. § 26:16-6(a)(1) (2020).

<sup>371</sup> N.J. REV. STAT. §§ 26:16-6(a)(6)-(7), 26:16-10(c) (2020). There is no time requirement in the statute for length of residency to be able to access assisted suicide. N.J. REV. STAT. § 26:16-11 (2020).

<sup>372</sup> N.J. REV. STAT. § 26:16-6(a)(8) (2020).

administrative tasks, such as requiring the patient to prove New Jersey residency<sup>373</sup> and completing documentation related to the act.<sup>374</sup> Doctors can dispense lethal medications directly or prescribe them.<sup>375</sup> They must refer patients they suspect lack capacity for assessment to a mental healthcare professional, and may not prescribe a life-ending drug until the patient has been assessed as capable.<sup>376</sup>

Nothing in the law requires physicians to prescribe life-ending drugs against their conscience. However, the law expressly states that referring to another physician for assisted suicide is not considered participation in providing it.<sup>377</sup> This narrow definition of participation may be at odds with the conscience rights of doctors who consider a referral to facilitate assisted suicide and therefore be participating in the act. A New Jersey appeals court reinstating the law during a legal challenge suggested that the plaintiff, a geriatrician who objected to referring to another physician for assisted suicide, would have a difficult time claiming his rights of conscience were violated by the purely administrative function of transferring records to another physician.<sup>378</sup> The case was dismissed in April 2020.<sup>379</sup>

The law expressly prohibits direct action by a physician to end the patient's life.<sup>380</sup> It also imposes reporting requirements, both for dispensing the medication and the patient's death, within thirty days after each of those events occurs.<sup>381</sup> The state health department must publish statistics annually on its website,<sup>382</sup> although the statistics for 2019 were not available at the time of writing. The New Jersey Department of Health website's Frequently Asked Questions stated that it recommends listing the underlying illness as the cause of death on death certificates, and states that actions legal under the law "shall not constitute suicide or assisted suicide."<sup>383</sup> Possessing only the authority to coordinate reporting processes and receive reports, and having encouraged doctors to omit the direct cause of death (deliberate ingestion of a lethal substance) from vital records, state officials will not be able to know for certain whether their records are accurate.

### *Maine (2019)*

Maine legalized assisted suicide when its Death with Dignity Act was signed into law in June 2019.<sup>384</sup> The bill passed by narrow margins, following a failed referendum and seven

<sup>373</sup> N.J. REV. STAT. § 26:16-6(a)(2) (2020).

<sup>374</sup> N.J. REV. STAT. §§ 26:16-6(a)(9), 26:16-10(d), 26:16-13 (2020).

<sup>375</sup> N.J. REV. STAT. § 26:16-6(b) (2020).

<sup>376</sup> N.J. REV. STAT. § 26:16-8 (2020).

<sup>377</sup> N.J. REV. STAT. § 26:16-3 (2020).

<sup>378</sup> Stacey Barchenger, *New Jersey's 'aid-in-dying' law reinstated after pair of court rulings*, NORTHJERSEY.COM (Aug. 27, 2019), <https://www.northjersey.com/story/news/2019/08/27/nj-aid-dying-law-reinstated-appeals-court/2129382001/>.

<sup>379</sup> Stacey Barchenger, *NJ aid-in-dying law upheld, judge dismisses legal challenge*, NORTHJERSEY.COM (Apr. 2, 2020), <https://www.northjersey.com/story/news/new-jersey/2020/04/02/nj-aid-dying-law-lawsuit-dismissed-death-with-dignity/5111972002/>.

<sup>380</sup> N.J. REV. STAT. § 26:16-15(a) (2020).

<sup>381</sup> N.J. REV. STAT. § 26:16-13(a)(1)-(2) (2020).

<sup>382</sup> *Id.* § 26:16-13(c) (2020).

<sup>383</sup> N.J. Dept. Health, *New Jersey Medical Aid In Dying For the Terminally Ill Act Frequently Asked Questions 3-4* (Jul. 31, 2019), available at [https://www.nj.gov/health/advancedirective/documents/maid/MAID\\_FAQ.pdf](https://www.nj.gov/health/advancedirective/documents/maid/MAID_FAQ.pdf).

<sup>384</sup> Press Release, Office of Governor Janet T. Mills, *Governor Mills Signs Death with Dignity Act* (June 12, 2019), available at <https://www.maine.gov/governor/mills/news/governor-mills-signs-death-dignity-act-2019-06-12>.

previous legislative efforts.<sup>385</sup> Similar to New Jersey’s bill, Maine’s law requires the patient to make an oral request, wait fifteen days before reiterating that request, and make a written request,<sup>386</sup> the signing of which must be witnessed by two people, one of whom must be disinterested and not connected to a care facility, and neither of whom can be the attending physician.<sup>387</sup>

Physicians are responsible for determining that a patient has a terminal disease, is a resident of Maine, informing the patient about his or her illness, prognosis, risks of, alternatives to, and outcomes from taking a lethal prescription.<sup>388</sup> They must also refer to another physician for a second opinion and competence determination, discuss the request alone with the patient to prevent coercion, discuss notifying relatives, offer guidance for taking the medication, remind the patient that they can rescind their request, and verify that the patient is making an informed decision “immediately before writing the prescription” for live-ending medications.<sup>389</sup> Doctors must also provide or prescribe the medication and complete the documentation required by the state.<sup>390</sup>

The state Department of Health and Human Services was given six months to adopt reporting rules to facilitate collecting reports from physicians, who must file for each patient within 30 days of dispensing medication and 30 days of death, and publish statistical reports annually.<sup>391</sup> The Department adopted and promulgated rules in September 2019. These provided mandatory forms for certification that the legal requirements had been met, consulting physician attestations, the prescription record, and end of life forms.<sup>392</sup> Doctors must retain all original forms in their patient records; the copies received by the health department may be destroyed after the publication of the report for the year in which the events recorded took place.<sup>393</sup> As directed by law, no personally identifying information is to become part of the public record,<sup>394</sup> likely meaning that death certificates will not list assisted suicide as the cause of death.

Maine released its first annual report in April 2020. Between the law’s adoption and the end of the year, a man over the age of 65 and suffering from prostate cancer requested, received, and died after ingesting a lethal prescription.<sup>395</sup>

## **Canada (2015)**

Canada prohibited assisted suicide in its criminal code until a 2015 court decision found that such prohibitions were incompatible with Article 7 the Canadian Charter of Rights and

<sup>385</sup> Marina Villeneuve, *Maine becomes 8<sup>th</sup> state to legalize assisted suicide*, ASSOC. PRESS (Jun. 12, 2019), <https://apnews.com/7f0fe9d789294a02852c1669c892f382>.

<sup>386</sup> ME. REV. STAT. tit. 22 § 2140(11) (2020).

<sup>387</sup> ME. REV. STAT. tit. 22 § 2140(5)(C)-(D) (2020).

<sup>388</sup> ME. REV. STAT. tit. 22 § 2140(6)(A)-(C) (2020).

<sup>389</sup> *Id.* (6)(D)-(E), (G)-(J).

<sup>390</sup> *Id.* (6)(M) and (K), (14).

<sup>391</sup> *Id.* (17)(C), (B)(1), and (D).

<sup>392</sup> 10-146-15 ME. CODE R. §§ 3(D)-(F), 4(A) (2019).

<sup>393</sup> 10-146-15 ME. CODE R. § 4(B) (2019).

<sup>394</sup> 10-146-15 ME. CODE R. § 4(C) (2019).

<sup>395</sup> ME. CTR. DISEASE CONTROL & PREVENTION, ME. DEPT. HEALTH & HUMAN SVCS., *PATIENT-DIRECTED CARE AT END OF LIFE ANNUAL REPORT 4 (2020)*, available at <https://www.maine.gov/dhhs/reports/Death-with-Dignity-Legislative-Report-050420.pdf>.

Freedoms.<sup>396</sup> In that case, *Carter v. Canada (Attorney General)*, the court heard a challenge to the criminal prohibition on assisting suicide brought by a woman with a neurodegenerative disorder, the adult child of a woman who went to Switzerland for assisted suicide, and others.<sup>397</sup> The Supreme Court found that the case raised a new legal issue and a fundamental change in circumstances since a previous decision by the court upholding a ban on assisted suicide.<sup>398</sup>

Although the court recognized that the ban on assisted suicide is generally valid, it determined that it was not valid in cases where a “competent adult ... seek[s] such assistance as a result of a grievous and irremediable medical condition that causes enduring and intolerable suffering.”<sup>399</sup> In such circumstances, the court found, prohibiting assisted suicide deprives adults of their right to life, liberty, and security of person. Rather than treat suicide as a violation of such rights, the court found that liberty and security of person relate to autonomy and quality of life, and how someone responds to an incurable medical condition is “critical to their dignity and autonomy.”<sup>400</sup> Thus, under Canadian law, liberty includes a right to decide about bodily integrity in medical care, and “leaving them to endure intolerable suffering... impinges on their security of the person.”<sup>401</sup>

The court also interpreted the purpose of the criminal prohibition on assisted suicide much more narrowly than a general protection for human life: “The object of the prohibition is not, broadly, to preserve life whatever the circumstances, but more specifically to protect vulnerable persons from being induced to commit suicide at a time of weakness.”<sup>402</sup> Because the law also prohibited assistance in dying those outside the group vulnerable to suicide, the court found that it exceeded what was necessary to achieve that legitimate aim and could not stand.<sup>403</sup>

The court issued a declaration of invalidity on the law and suspended it for one year to allow the government to amend the law.<sup>404</sup> The court also stated that declaring the prohibition on assisted suicide invalid would not obligate any physician to participate, and that patients’ and physicians’ rights would have to be reconciled.<sup>405</sup>

Under the law adopted in June 2016, the Parliament of Canada created an exception to prohibitions on assisted suicide for “medical assistance in dying.”<sup>406</sup> Under this exception, doctors,

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<sup>396</sup> *Carter v. Canada (Attorney General)*, [2015] S.C.R. 331, 335-36 (Can.). The province of Quebec legalized assisted suicide via legislation in 2014, but as the law only went into effect approximately six months before the national legislation was passed, and had to conform to its standards, this section focuses on the outcomes of the Supreme Court and the subsequent national legislation. Rhéal Séguin, *Quebec first province to adopt right-to-die legislation*, GLOBE & MAIL (June 5, 2014), available at <https://www.theglobeandmail.com/news/politics/quebec-first-province-to-adopt-right-to-die-legislation/article19009781/>.

<sup>397</sup> *Carter*, [2015] S.C.R. at 333.

<sup>398</sup> *Id.* at 334.

<sup>399</sup> *Id.* at 335.

<sup>400</sup> *Id.*

<sup>401</sup> *Id.* Provincial patients’ bills of rights already included provisions for consent and rights to refuse treatment. See Margaret Smith, Library of Parliament Research Branch Law & Government Division, Patient’s Bill of Rights – A Comparative Overview (2001), available at <http://publications.gc.ca/Collection-R/LoPBdP/BP/prb0131-e.htm>.

<sup>402</sup> *Carter*, [2015] S.C.R. at 335.

<sup>403</sup> *Id.* at 335-36.

<sup>404</sup> *Id.* at 336.

<sup>405</sup> *Id.* at 336-37.

<sup>406</sup> An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying), S.C. 2016, c. 3 § 2(227) [hereinafter Canada Medical Assistance in Dying Act].

nurses, pharmacists, and any person aiding a patient at the patient's request will not face criminal charges, including if they do so out of a "reasonable but mistaken belief" about the exemption.<sup>407</sup> Under the law, doctors and nurse practitioners may prescribe life-ending prescriptions for patient self-administration and administer life-ending to the patient directly.<sup>408</sup>

In order to be eligible for assisted suicide, a patient must be eligible for Canadian health services, over the age of eighteen, have a "grievous and irremediable medical condition," have made an unpressured request for medically assisted suicide, been informed of ways to relieve their suffering, and made an informed choice.<sup>409</sup> Unlike some other legal regimes, Canada's law does not specify an estimated time remaining, such as six months, only that their natural death must be reasonably foreseeable.<sup>410</sup> The law also applies in cases of serious and incurable disease *and* disability, requires that the patient is at an advanced stage of irreversible capability loss, and that the patient experiences physical *or* psychological suffering that they cannot tolerate and do not find other forms of relief acceptable.<sup>411</sup>

The law also required the Minister of Justice and the Minister of Health to commission independent reviews on the subjects of requests for assisted suicide by "mature minors," advanced requests for assisted suicide (analogous to advanced directives refusing treatment), and requests where the sole irremediable condition is mental illness.<sup>412</sup> The Council of Canadian Academies convened a panel with working groups on each topic.<sup>413</sup> The working group on aid in dying for mature minors includes a bioethicist for Toronto Sick Kids Hospital,<sup>414</sup> the largest children's hospital in Canada. That hospital had already drafted a policy for euthanizing patients aged eighteen and older, but also discussing how it could be applied to mature minors, potentially without advising their parents.<sup>415</sup> The final document noted a number of concerns related to capacity and vulnerability, including issues with access to pediatric palliative care.<sup>416</sup> However, it also stated that age, while important, does not determine capacity, that vulnerability should not exclude at risk youth from involvement in these decisions, and that "requirements for parental consultation or agreement are not consistent with the mature minor concept."<sup>417</sup>

The law contains several provisions designed to act as safeguards. For example, there must be two witnesses to the written request, and both must be adults who are neither potential heirs to

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<sup>407</sup> *Id.* § 3(241)(2)-(6).

<sup>408</sup> *Id.* § 3(241.1).

<sup>409</sup> *Id.* § 3(241.2)(1).

<sup>410</sup> *Id.* § 3(241.2)(2).

<sup>411</sup> *Id.*

<sup>412</sup> *Id.* § 8(9.1).

<sup>413</sup> *Medical Assistance in Dying*, COUNCIL OF CANADIAN ACADS., available at

<http://www.scienceadvice.ca/en/assessments/in-progress/medical-assistance-dying.aspx>, (last visited Oct. 17, 2018).

<sup>414</sup> *Expert Panel on Medical Assistance in Dying*, COUNCIL OF CANADIAN ACADS., available at

<http://www.scienceadvice.ca/en/assessments/in-progress/medical-assistance-dying/expert-panel.aspx>.

<sup>415</sup> Sharon Kirkey, *Toronto's Sick Kids hospital preparing policy for euthanasia for youth over 18 that could one day apply to minors*, NAT'L POST (Oct. 9, 2018), <https://nationalpost.com/health/sick-kids-preparing-policy-for-euthanasia-for-youth-over-18-that-could-one-day-apply-to-minors>.

<sup>416</sup> EXPERT PANEL WORKING GROUP ON MAID FOR MATURE MINORS, THE STATE OF KNOWLEDGE ON MEDICAL ASSISTANCE IN DYING FOR MATURE MINORS 139-140, 124-25, 133-35, 94 (2018), available at <https://cca-reports.ca/wp-content/uploads/2018/12/The-State-of-Knowledge-on-Medical-Assistance-in-Dying-for-Mature-Minors.pdf>.

<sup>417</sup> *Id.* at 139-40, 134-35, 141.

the requester, nor involved in that person's care directly or through control over the health care facility where they are being treated.<sup>418</sup> The healthcare provider is responsible to ensure that the patient requesting assisted suicide meets the law's eligibility requirements, as well as check that the patient has been fully informed of their condition, options for treatment, that their request was properly witnessed, that they can withdraw it at any time, that the patient has had ten days between the request and its granting (unless they are expected to die or lose capacity before that time has elapsed, in which case there is no minimum waiting period), provide a last-minute opportunity to withdraw the request, and obtain express consent just before providing the prescription or administering the medication.<sup>419</sup> A healthcare provider who knowingly fails to comply with these requirements faces criminal consequences.<sup>420</sup>

However, already stories have emerged suggesting that safeguards may be hard to enforce or inadequate, particularly with regards to patients with disabilities. In 2017, mother and daughter Sheila Elson and Candice Lewis raised objections to a doctor suggesting assisted suicide for Lewis, who has a number of complex medical conditions and has experienced frequent hospitalizations.<sup>421</sup> Elson stated that a doctor told her she was being selfish to not want assisted suicide for her daughter, and that Lewis was upset to hear the suggestion.<sup>422</sup>

Roger Foley, an Ontario man with an incurable neurological disease, filed suit against healthcare providers and provincial and national officials in February 2018, claiming that he was denied appropriate assisted living care while being offered assisted death.<sup>423</sup> While hospitalized following poor care from home health aides, he researched and requested programs that would allow him greater control over his own care.<sup>424</sup> His request was denied; he had an appeal pending at the time his suit was filed.<sup>425</sup> Despite his desire to live, hospital staff raised the option of assisted suicide with him.<sup>426</sup>

Additionally, Sean Tagert, a forty-one year old father with amyotrophic lateral sclerosis (also known as motor neuron disease), was offered insufficient hours of care at his home, which

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<sup>418</sup> Canada Medical Assistance in Dying Act § 3(241.2)(5).

<sup>419</sup> *Id.* § 3(241.2)(3).

<sup>420</sup> *Id.* § 3(241.3).

<sup>421</sup> Geoff Bartlett, *Mother says doctor brought up assisted suicide option as sick daughter was within earshot*, CBC (Jul. 24, 2017) <https://www.cbc.ca/news/canada/newfoundland-labrador/doctor-suggested-assisted-suicide-daughter-mother-elson-1.4218669>. Although the communication is mainly through Elson, a brief video on the page has Lewis expressing her desire to continue to live. Social workers later told Elson that Lewis would have to request it herself, as an adult capable of verbally communicating her wishes. *Id.*

<sup>422</sup> *Id.*

<sup>423</sup> Joseph Brean, *Denied 'assisted life,' chronically-ill Ontario man is offered death instead: lawsuit*, NAT'L POST (March 16, 2018), <https://nationalpost.com/news/canada/denied-assisted-life-by-hospital-ontario-man-is-offered-death-instead-lawsuit>.

<sup>424</sup> *Id.*

<sup>425</sup> *Id.*

<sup>426</sup> *Chronically ill man releases audio of hospital staff offering assisted death*, CTV NEWS (Aug. 2, 2018), <https://www.ctvnews.ca/health/chronically-ill-man-releases-audio-of-hospital-staff-offering-assisted-death-1.4038841>. The page includes clips from Foley of his raising requests for self-directed home care and staff responding that they are there to discuss assisted death.

he shared with his minor son.<sup>427</sup> Without support from health authorities to receive the medically-indicated twenty-four hour care, and believing that the care he could receive in a facility would shorten his life and remove him from his son, Tagert requested assisted suicide and ended his life under Canada’s medically assisted dying provisions in 2019.<sup>428</sup> These examples raise concerns about how healthcare providers’ assumptions about quality of life for people with disabilities may influence the care they offer, and the ways that lack of support can become indirectly coercive, in ways that safeguards may not prevent.

The law specifies that it does not compel anyone to “provide or assist in providing medical assistance in dying.”<sup>429</sup> This is important in light of concerns raised by the Canadian Society of Palliative Care Physicians (CSPCP), which expressed opposition both before and after the case legalizing it.<sup>430</sup> Although a 2018 survey of members found 22% involved in assisted suicide assessments, and 8% involved in carrying it out,<sup>431</sup> the CSPCP has continued to raise concerns about assisted suicide and its relation to its own work. It and the Canadian Hospice Palliative Care Association issued a joint statement raising concerns about the lack of availability of palliative care and the lack of a right to it, lack of clarity about palliative care and end-of-life issues due to assisted suicide, and the fundamental differences in approach to end-of-life care.<sup>432</sup>

At least one hospice facility has fallen afoul of the law despite already. In British Columbia, health authorities have demanded that a 10-bed hospice offer euthanasia and assisted suicide despite its opposition to the practice because its beds are publicly funded.<sup>433</sup> Local health authorities have threatened the facility’s lease, which is of public land, despite its construction with private funding and offer to reduce to below the 50% threshold required to avoid having to provide such services.<sup>434</sup>

The bill also includes some provisions on record keeping and documents. Destroying documents with intent to interfere with access to physician-assisted suicide or assessment of lawful request assessments bears criminal penalties.<sup>435</sup> The Ministry of Health is delegated the authority

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<sup>427</sup> *B.C. man with ALS chooses medically assisted death after years of struggling to fund 24-hour care*, CBC NEWS (Aug. 13, 2019), <https://www.msn.com/en-ca/news/canada/bc-man-with-als-chooses-medically-assisted-death-after-years-of-struggling-to-fund-24-hour-care/ar-AAFKuYa?li=AAgNb9&%253Bsrcref=rss>.

<sup>428</sup> *Id.*

<sup>429</sup> Canada Medical Assistance in Dying Act § 3(241.2)(9).

<sup>430</sup> James Downar, *Why are so many members of the palliative care community opposed to physician assisted death?*, HEALTHYDEBATE (June 24, 2015), <https://healthydebate.ca/opinions/many-members-palliative-care-community-opposed-physician-assisted-death>.

<sup>431</sup> CANADIAN SOC. PALLIATIVE CARE PHYSICIANS, CSPCP MEMBER SURVEY OCTOBER 2017 MEDICAL ASSISTANCE IN DYING (MAID) RESULTS FEBRUARY 2018 2 (Part A) (2018), *available at* <https://www.cspcp.ca/wp-content/uploads/2018/02/CSPCP-MAID-survey-report-Feb-2018.pdf>.

<sup>432</sup> Canadian Soc. Palliative Care Physicians, CHPCA and CSPCA – Joint Call to Action (Nov. 27, 2019), *available at* <https://www.cspcp.ca/joint-statement-from-chpca-and-cspcp-regarding-palliative-care-and-maid/> (on file with author).

<sup>433</sup> Alexandra Mae Jones & Ben Cousins, *Standoff between B.C. and hospice refusing to offer assisted dying*, CTV NEWS (Jan. 20, 2020), <https://www.ctvnews.ca/health/standoff-between-b-c-and-hospice-refusing-to-offer-assisted-dying-1.4773755>.

<sup>434</sup> *Id.*

<sup>435</sup> Canada Medical Assistance in Dying Act § 3(241.4)(2)-(3). By requiring intent to interfere with elements of the suicide practice, the law suggests its concern is more about the potential for those opposed, either to a particular

to oversee data collection, use, and disposal, as well as to make guidelines for how to record cause of death on death certificates.<sup>436</sup> The Ministry reporting requirements require doctors, nurse practitioners, and pharmacists to report in most cases, including determination of ineligibility, but often the reports only need to be filed after the patient has died.<sup>437</sup> The Ministry also issued guidelines for provincial health authorities to include medical suicide as the immediate cause and the underlying condition as an antecedent cause on death certificates.<sup>438</sup>

In the first six months following the legislation, 803 Canadians ended their lives via medical assistance.<sup>439</sup> Canada has issued four interim reports since the law took effect, the most recent of which covered the first ten months of 2018, although it has a gap in information on Quebec between April and the end of October.<sup>440</sup> During that reporting period, 2,614 assisted deaths took place (not including numbers from Quebec, the Northwest Territories, the Yukon, or Nunavut, also territories).<sup>441</sup> This is an increase of 653 over the previous year.<sup>442</sup> Quebec registered 1,664 deaths between December 10, 2015 and March 31, 2018.<sup>443</sup> Since legalization, 6,749 deaths have taken place.<sup>444</sup> Although information is incomplete, Health Canada estimates that approximately 1.12% of all deaths during the reporting period (January 1 through October 31, 2018) were medically assisted suicides or euthanasia.<sup>445</sup>

The vast majority of deaths are by euthanasia, with only one assisted suicide during the 2019 reporting period, and only six since legalization.<sup>446</sup> Roughly equal numbers took place in homes and hospitals (86% combined), and nearly a tenth at some sort of care facility, including hospices.<sup>447</sup> Men and women requested and received hastened death at about equal rates.<sup>448</sup> More than nine out of ten were over the age of 56, with an average age of 72 years.<sup>449</sup> Nearly two-thirds

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suicide or assisted suicide generally, to obstruct its use than to maintain records for their own sake. Nevertheless, the bill does require some filings by medical personnel involved in the process.

<sup>436</sup> *Id.* § 4 (241.31)(3)-(3.1).

<sup>437</sup> Health Canada, *Reporting requirements for medical assistance in dying*, GOVERNMENT OF CANADA, available at <https://www.canada.ca/en/health-canada/services/medical-assistance-dying/reporting-requirements.html>.

<sup>438</sup> *Guidelines for death certificates*, HEALTH CANADA, <https://www.canada.ca/en/health-canada/services/publications/health-system-services/guidelines-death-certificates.html>.

<sup>439</sup> HEALTH CANADA, 2ND INTERIM REPORT ON MEDICAL ASSISTANCE IN DYING 5 (2017), available at <https://www.canada.ca/content/dam/hc-sc/documents/services/publications/health-system-services/medical-assistance-dying-interim-report-sep-2017/medical-assistance-dying-interim-report-sep-2017-eng.pdf> (hereinafter 2ND INTERIM REPORT). Some figures in this report exclude Quebec and some territories.

<sup>440</sup> HEALTH CANADA, FOURTH INTERIM REPORT ON MEDICAL ASSISTANCE IN DYING 3-4 (2019), available at <https://www.canada.ca/en/health-canada/services/publications/health-system-services/medical-assistance-dying-interim-report-april-2019.html> [hereinafter CANADA FOURTH INTERIM REPORT].

<sup>441</sup> *Id.* at 4.

<sup>442</sup> *Id.* at 5 (totaling the two previous reporting periods for a total of 1,961 deaths in 2017). Unless otherwise noted, the information in this section does not include Quebec, the Northwest Territories, Yukon, or Nunavut.

<sup>443</sup> *Id.* at 4 (noting that this number is likely low due to seven months of missing data).

<sup>444</sup> *Id.* This number includes Quebec, but does not include the territories.

<sup>445</sup> *Id.* at 7.

<sup>446</sup> *Id.* at 5, 7 (noting 93% performed by physicians and 7% performed by nurse practitioners).

<sup>447</sup> *Id.* at 5.

<sup>448</sup> *Id.*

<sup>449</sup> *Id.*

had cancer, 16% had circulatory or respiratory conditions, and about one in ten had neurodegenerative disorders.<sup>450</sup>

The report also includes data from some provinces on requests and outcomes during the reporting period. In Alberta, Saskatchewan, Manitoba, and the Atlantic Region,<sup>451</sup> 554 out of 1,000 requesters died by assisted suicide or euthanasia, a fifth died before their assessment was complete, about 6% were found ineligible, and another 6% withdrew their requests.<sup>452</sup> The most common reasons for ineligibility were lack of competence and the patient's death not being reasonably foreseeable.<sup>453</sup> The reports published thus far do not include information about any motivation beyond medical condition.

## **Victoria, Australia (2017)**

The state of Victoria, Australia, passed the Voluntary Assisted Dying Act 2017, which came into effect in late June of 2019, making it the only Australian jurisdiction to allow the practice at time of writing.<sup>454</sup> The law allows both assisted suicide through self-administration and euthanasia through practitioner administration.<sup>455</sup> Like other jurisdictions, the Victorian law requires that a patient be a competent adult resident of Victoria diagnosed with a terminal illness likely to cause death within six months (or twelve for those with neurodegenerative disorders).<sup>456</sup> Mental illness and disability are not on their own qualifying conditions.<sup>457</sup>

The patient must make an initial request, a written request, and a final request.<sup>458</sup> The written request be witnessed by two people, at least one of whom must be disinterested.<sup>459</sup> Patients must raise the topic; physicians are not allowed to bring up assisted suicide, and must advise the patient of other options for their care.<sup>460</sup> The patient can change his or her mind at any time.<sup>461</sup> The law also requires, as is practice or required in other jurisdictions, that death certificates list the cause of death as the qualifying illness.<sup>462</sup>

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<sup>450</sup> *Id.* at 6.

<sup>451</sup> The data from Newfoundland, Prince Edward Island, Nova Scotia, and New Brunswick are grouped together in the report. *Id.* at 10.

<sup>452</sup> *Id.* at 9-10 (noting that Manitoba's practices include an earlier review process that may filter out more ineligible requesters before their formal written request).

<sup>453</sup> *Id.* at 6.

<sup>454</sup> Ben White & Lindy Willmott, *Now that VAD is legal in Victoria, what is the future of assisted dying reform in Australia?*, ABC RELIGION & ETHICS (Jun. 24, 2019), <https://www.abc.net.au/religion/the-future-of-assisted-dying-reform-in-australia/11242116>. The Australian Northern Territory briefly legalized the practice in 1996 before it was repealed by the national parliament in 1997 due to its deleterious impact on Aborigines' attitudes towards and trust in healthcare services. David W. Kissane, *Deadly Days in Darwin*, in *THE CASE AGAINST ASSISTED SUICIDE* 205-06 (Kathleen Foley & Herbert Hendin, eds., 2002).

<sup>455</sup> Voluntary Assisted Dying Act 2017 (Vic) ss 45-46 (Austl.).

<sup>456</sup> *Id.* s 9(1).

<sup>457</sup> *Id.* s. 9(2)-(3).

<sup>458</sup> *Id.* ss 11, 34, 38.

<sup>459</sup> *Id.* ss 35-36.

<sup>460</sup> *Id.* ss 8 and 19.

<sup>461</sup> *Id.* s 12(1).

<sup>462</sup> *Id.* s 119.

In addition to the provisions common to most assisted suicide and euthanasia laws, the Act features stricter documentation requirements. Every patient requesting assisted suicide must have both a “coordinating practitioner” and a “consulting practitioner” assess their health and eligibility.<sup>463</sup> At least one of the practitioners must have at least five years of experience and both must have completed a training program designed by the Voluntary Aid in Dying Review Board (also created in the law).<sup>464</sup> The coordinating practitioner takes on significant administrative responsibilities and serves as a point person for ensuring eligibility and that forms are submitted properly.<sup>465</sup> They must also explain risks in greater detail, including the potential risks of taking the drug (including death), counsel the patient on how to store and take the drug, return an unfilled prescription, and ensure the return of any unused assisted dying substance.<sup>466</sup>

The consulting practitioner also makes an eligibility determination, and both doctors must agree that the requester is eligible for the process to proceed.<sup>467</sup> Doctors can refuse either role based on conscientious objection or the inability to carry out all the duties based on their other work, and must notify patients within seven days of doing so.<sup>468</sup> The law does not specify that a conscientious objector must provide a referral.

There must be at least nine days between the first (oral) request and the final (written) request following the eligibility assessments unless the patient is likely to die within that time.<sup>469</sup> The coordinating practitioner must then identify a contact person to ensure the medication’s security after use and submit all the required paperwork certifying eligibility following the final request to the Review Board, which will respond by issuing or denying a permit within three business days.<sup>470</sup> There are separate permits for self-administration and practitioner administration of the life-ending medication.<sup>471</sup> A patient who can no longer self-administer can request a practitioner administration permit without restarting the process.<sup>472</sup> However, the patient must retain mental competence throughout the process;<sup>473</sup> the law does not contemplate advance directives.

The medication is subject to more control in Victoria than elsewhere. Pharmacists must inspect permits and complete their own forms before dispensing it.<sup>474</sup> It must be kept in a locked box outside of use.<sup>475</sup> The contact person for someone with a self-administration permit must

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<sup>463</sup> *Id.* ss 10, 15, 24.

<sup>464</sup> *Id.* ss 10(2), 17, 26, 114, 92-93.

<sup>465</sup> *Id.* ss 15-22, 37-38, 41, 43, 47, 54, 56-57. See also *id.* Schedule 1 Forms.

<sup>466</sup> *Id.* ss. 19(1)(d)-(e), 57(a), (c), (e)-(f).

<sup>467</sup> *Id.* ss 22, 25, 29, 31.

<sup>468</sup> *Id.* s 13(1).

<sup>469</sup> *Id.* s 38.

<sup>470</sup> *Id.* s 43; Bregje Onwuteaka-Philipsen, Lindy Willmott, & Ben P. White, *Regulating voluntary assisted dying in Australia: some insights from the Netherlands*, 211 *MED. J. AUSTRAL.* 438, 438 (2019) (citing Voluntary Assisted Dying Regulations 2018 regulation 7).

<sup>471</sup> Voluntary Assisted Dying Act 2017 (Vic) ss 45-46 (Austl.).

<sup>472</sup> *Id.* s 53.

<sup>473</sup> *Id.* ss 47(3)(1) and 48(3)(b) (requiring the coordinating practitioner to be satisfied that the person has decision-making capacity).

<sup>474</sup> *Id.* ss 60 and Schedule 1 Form 6.

<sup>475</sup> *Id.* s 61.

return unused medication to the pharmacy for destruction within fifteen days of the patient's death or decision to request a practitioner-administration permit; not to do so is a criminal offense.<sup>476</sup>

Although the law limits liability for reasonable but mistaken eligibility assessments,<sup>477</sup> it imposes it in cases where other jurisdictions do not. For example, there are punishments for inducement or pressure to make a request for assisted death, for falsifying records, and for making false statements in a report or form.<sup>478</sup> A contact person may face criminal penalties for failing to return unused medication. Unusually, the bill also extends criminal liability to corporate officers for healthcare facilities if the entity commits a criminal offense and the officer is found to have failed to exercise due diligence to prevent it.<sup>479</sup>

Victoria's Voluntary Assisted Dying Review Board has published its first report to include data on access to assisted suicide and euthanasia under the law's provisions for the latter half of 2019, after the law came into effect. The vast majority of the report's contents are qualitative rather than quantitative; only one page includes any data about assisted suicide requests under the law's provisions. None of that includes information about the demographic breakdown of those seeking assisted suicide, their major concerns, or illnesses, ostensibly for privacy purposes but far less substantive than similar reports from other jurisdictions.

Of 136 initial requesting patients, 135 were found eligible by their coordinating practitioner, and 100 out of 102 were found eligible by the consulting practitioner.<sup>480</sup> One hundred patients applied for assisted dying permits, with 70 requesting and being approved for self-administration permits and 11 requesting and being approved for practitioner administration permits.<sup>481</sup> A further nineteen applications were withdrawn, for reasons which "may include administrative error or confirmation of death by means other than voluntary assisted dying."<sup>482</sup> Sixty-six prescriptions were dispensed, mostly for self-administration but including nine for practitioner administration.<sup>483</sup> There were 52 confirmed deaths under the law's provisions, including all nine patients whose lethal prescriptions were filled under a practitioner administration license.<sup>484</sup>

The Voluntary Assisted Dying Review Board also provides online training which medical practitioners must complete in order to qualify to serve as a coordinating or consulting practitioner under the act.<sup>485</sup> The report notes that 365 practitioners registered for the training, and that it required an average of four hours to complete, but does not state how many actually completed the training.<sup>486</sup> One hundred thirty-four practitioners registered in the online Voluntary Assisted Dying Portal, most located in the metro Melbourne area, and submitted 649 forms.<sup>487</sup> The report

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<sup>476</sup> *Id.* ss 45(c), 89.

<sup>477</sup> *Id.* s 80.

<sup>478</sup> *Id.* ss 86-88.

<sup>479</sup> *Id.* s 91.

<sup>480</sup> VOLUNTARY ASSISTED DYING REV. BOARD, REPORT OF OPERATIONS JUNE TO DECEMBER 2019 3 (2020), available at [https://www.bettersafecare.vic.gov.au/sites/default/files/2020-02/VADRB\\_Report%20of%20operations%202019-2020.pdf](https://www.bettersafecare.vic.gov.au/sites/default/files/2020-02/VADRB_Report%20of%20operations%202019-2020.pdf).

<sup>481</sup> *Id.*

<sup>482</sup> *Id.*

<sup>483</sup> *Id.*

<sup>484</sup> *Id.*

<sup>485</sup> *Id.* at 6.

<sup>486</sup> *Id.*

<sup>487</sup> *Id.*

noted that forms were returned for corrections or completion in 83% of cases.<sup>488</sup> Nevertheless, the Board found 100% compliance through retroactive review.<sup>489</sup> The report also expressed concern that criminal provisions forbidding the use of telecommunications to provide suicide-related material have “potential for significant impact [on] rural and remote Victorians unable to use telehealth technology to complete appointments.”<sup>490</sup>

## **Italy (2019)**

In 2019, the Constitutional Court of Italy, the nation’s highest court, found a criminal prohibition on assisting suicide unconstitutional under specific conditions.<sup>491</sup> This followed from a 2017 case brought against an Italian political activist who drove his friend to Switzerland to end his life under its laws.<sup>492</sup> The man who sought assistance in ending his life had been tetraplegic and blind following an accident five years earlier.<sup>493</sup> When the assisting friend returned to Italy, he turned himself into the police with the intention of challenging the law forbidding suicide assistance.<sup>494</sup> At the time, Article 580 of the Criminal Code stated that “[a]nyone who determines someone else’s suicide or reinforces another’s suicide intention, or facilitates its execution in any way, is punished, if suicide occurs, with imprisonment for five to twelve years.”

A court in Milan referred the case to the Constitutional Court suggesting that the ban might be unconstitutional on various bases, such as a right to suicide under Italian and European law or the law’s indiscriminate treatment of different levels of influence and assistance.<sup>495</sup> The Constitutional Court disagreed with much of the lower court’s theory, rejecting a broad reading of European Court of Human Rights case law related to articles 2 (right to life) and 8 (right to respect for private and family life) of the European Convention on Human Rights and related Italian Constitutional provisions.<sup>496</sup>

However, the Court did find that banning suicide assistance did violate provisions of the Italian constitution.<sup>497</sup> It issued an order which invalidated the provision in limited circumstances, citing the technological advances which prolong the dying process beyond what was envisioned

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<sup>488</sup> *Id.* at 8.

<sup>489</sup> *Id.* at 9.

<sup>490</sup> *Id.* at 10.

<sup>491</sup> *Italy’s top court rules assisted suicide not always a crime in landmark case*, EURONEWS (Sept. 26, 2019), <https://www.euronews.com/2019/09/25/italy-s-constitutional-court-to-clarify-law-on-assisted-suicide>.

<sup>492</sup> *Id.*

<sup>493</sup> *Id.*

<sup>494</sup> *Id.*

<sup>495</sup> Corte Const., 24 ottobre 2018, Ordinanza no. 207, Considerato in diritto § 1, in G.U. 1a serie speciale, 21 novembre 2018, n. 46 at 120-21 (It.). Due to challenges in locating a copy of the Raccolta Ufficiale delle Sentenze e Ordinanze delle Corte Costituzionale (Official Records of the Judgments and Ordinances of the Constitutional Court), citation has been provided to the Gazzetta Ufficiale Della Repubblica Italiana (Official Gazette of the Republic of Italy) 1a special series, which publishes Constitutional Court decisions, for both this order and the subsequent final judgment in the same case. The court also provides sections of its decisions and orders in the English language, which are available via its website. A case summary and the court’s translation of its conclusions on points of law may be found by visiting [www.cortecostituzionale.it](http://www.cortecostituzionale.it), clicking on the “EN” (English language) button, clicking “Judgments”, and then selecting the year 2018. This decision is labeled Judgment No. 207 of 2018.

<sup>496</sup> *Id.* §§ 4-5, 7-8, in G.U. 1a serie speciale, 21 novembre 2018, n. 46 at 121-23.

<sup>497</sup> *Id.* § 9, in G.U. 1a serie speciale, 21 novembre 2018, n. 46 at 124-25.

at the law’s adoption, that some may find dying under heavy sedation unacceptably undignified, and that death is the outcome both of refusing unwanted treatments and ending one’s life.<sup>498</sup> The law banning assisted suicide, in the court’s view, amounted to “imposing one single way to take their leave of life” contrary to the patient’s autonomy and possible his or her own understanding of a dignified way to die.<sup>499</sup> Nevertheless, the court’s order also stated that setting regulations for the practice was the work of the legislature, and delayed final judgment to give the legislature an opportunity to pass a law under which suicide assistance could take place.<sup>500</sup>

The Italian Parliament discussed but ultimately did not pass a law setting out conditions under which suicide assistance could take place.<sup>501</sup> The court stated that in some cases it may simply have left the situation, but that in light of the provisional being rendered unconstitutional, some guidance was necessary.<sup>502</sup> After reiterating its reasoning from the 2018 order, it highlighted the state interest in protecting life and the risks to the vulnerable,<sup>503</sup> as well as the importance of ensuring the right to palliative care is met to ensure a free choice.<sup>504</sup> It also stated that there is a right of conscientious objection.<sup>505</sup> Although the court’s constitutional findings could allow non-doctors to assist suicide, the decision constrains the practice to medical personnel.<sup>506</sup>

The decision lays out several criteria it considers part of the right it has scoped out, but notes that absent legislation, public healthcare facilities will be responsible for implementing practices in line with the court’s decision.<sup>507</sup> Criminal courts will also have to assess each case before them to determine whether the “assistance was provided in ways that, albeit differing from those mentioned, offered substantially equivalent guarantees.”<sup>508</sup> Those requirements are: “incurable illness, serious physical or psychological suffering, dependence on life-support treatment, and the ability to make free and informed decisions,” as assessed by doctors.<sup>509</sup> The patient’s request must be “clearly and unambiguously expressed in a manner compatible with his or her condition” and have been informed about that condition, other options for treatment, palliative care, and constant sedation.<sup>510</sup> The court also states that, absent legislation, regional ethics boards must assist in evaluating complex eligibility questions.<sup>511</sup>

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<sup>498</sup> *Id.* §§ 8-9, in G.U. 1a serie speciale, 21 novembre 2018, n. 46 at 123-25.

<sup>499</sup> *Id.* § 9, in G.U. 1a serie speciale, 21 novembre 2018, n. 46 at 12 5.

<sup>500</sup> *Id.* § 11, in G.U. 1a serie speciale, 21 novembre 2018, n. 46 at 126.

<sup>501</sup> Corte Const., 25 settembre 2019, Sentenze no. 242, Considerato in diritto § 3, in G.U. 1a serie speciale, 27 novembre 2019, n. 48 at 42 (It.). The court English language summary and translation of the conclusions on points of law section of its decision is available via its website. Visit [www.cortecostituzionale.it](http://www.cortecostituzionale.it), click on the “EN” (English language) button, click “Judgments”, and then selecting the year 2019. This decision is labeled Judgment No. 242 of 2019.

<sup>502</sup> *Id.* § 4, in G.U. 1a serie speciale, 27 novembre 2019, n. 48 at 42-43.

<sup>503</sup> *Id.* § 5, in G.U. 1a serie speciale, 27 novembre 2019, n. 48 at 43.

<sup>504</sup> *Id.* § 5, in G.U. 1a serie speciale, 27 novembre 2019, n. 48 at 44.

<sup>505</sup> *Id.* § 6, in G.U. 1a serie speciale, 27 novembre 2019, n. 48 at 44.

<sup>506</sup> *Id.* § 5, in G.U. 1a serie speciale, 27 novembre 2019, n. 48 at 43.

<sup>507</sup> *Id.* § 5, in G.U. 1a serie speciale, 27 novembre 2019, n. 48 at 44.

<sup>508</sup> *Id.* § 7, in G.U. 1a serie speciale, 27 novembre 2019, n. 48 at 44.

<sup>509</sup> *Id.* § 7, in G.U. 1a serie speciale, 27 novembre 2019, n. 48 at 45.

<sup>510</sup> *Id.*

<sup>511</sup> *Id.* § 5, in G.U. 1a serie speciale, 27 novembre 2019, n. 48 at 44.

Despite the court “strenuously reiterat[ing] its wish that the matter be subjected to prompt and complete regulation” by the legislature in line with the principles it laid out,<sup>512</sup> as of writing the Italian parliament has not passed a law on the matter.

## **Germany (2020)**

In February 2020, the German Constitutional Court struck down a 2015 law in Germany which banned assisting suicide in a “businesslike manner.” In its decision on six constitutional complaints by different individuals and organisations, namely advocates of the practice, organizations representing patients wanting to undergo assisted suicide, as well as medical doctors, the Court concluded that the provision is unconstitutional and therefore null and void.<sup>513</sup>

The act of assisting in suicide in a “businesslike” manner was criminalised in 2015, with the intention of excluding undue pressure and complying with the duty of protecting the right to life, as defined in the German Basic Law. Section 217 of the German Criminal Code stated:

Businesslike support of suicide

(1) Whoever, with the intention of supporting the suicide of another person, provides, procures or arranges the opportunity for such person in a businesslike manner shall be punished by a penalty of imprisonment for a term not exceeding three years or a fine.

(2) A participant shall be exempt from punishment, if he/she does not act in a businesslike manner and is either a relative of or is close to the person referred to in subsection (1).<sup>514</sup>

The “businesslike” manner of supporting the suicide of another person meant an intention to act repeatedly and it would be determined based on the number of such actions, not whether the service served a commercial purpose.<sup>515</sup> The Court took the position that the aim of Sect. 217 was legitimate, but that it exceeded the principle of proportionality. It also recognized for the first time a “right to self-determined dying” as part of the right to development of one’s personality, which is guaranteed under German Basic Law.<sup>516</sup> As the criminal punishment of businesslike services made the exercising the “right to self-determined dying” not practical, the Court found the law unconstitutional.<sup>517</sup>

Human dignity is a central concept of the German Basic Law, enshrined in its Article 1 as inviolable. There are three specific freedoms defined in Article 2 of the Basic Law, first of which is the right to free development of personality: “Everyone shall have the right to the free development of his personality insofar as he does not violate the rights of others or offend against

<sup>512</sup> *Id.* § 9, in G.U. 1a serie speciale, 27 novembre 2019, n. 48 at 45.

<sup>513</sup> Bundesverfassungsgericht [BVerfG] [Federal Constitutional Court], Feb. 26, 2020 - 2BvR2347/15, 2BvR2527/16, 2BvR2354/16, 2BvR1593/16, 2BvR1261/16, 2BvR651/16 - Rn.(1-343) § 337, available at [http://www.bverfg.de/e/rs20200226\\_2bvr234715.html](http://www.bverfg.de/e/rs20200226_2bvr234715.html). See section on Switzerland, *infra*, for information about involvement by Dignitas organizations.

<sup>514</sup> Strafgesetzbuch [StGB] [Penal Code], Dec. 3 2015, Bundesgesetzblatt [BGBl] § 217 (Ger.).

<sup>515</sup> BVerfG 2BvR2347/15, 2BvR2527/16, 2BvR2354/16, 2BvR1593/16, 2BvR1261/16, 2BvR651/16 - Rn.(1-343), § 74.

<sup>516</sup> *Id.* § 208-211.

<sup>517</sup> *Id.* § 216.

the constitutional order or against morality.”<sup>518</sup> Personality not being an objective value (in contrast to human dignity), it does not generally impose affirmative obligations on the state, but personality rights come into play, potentially, whenever an action is not protected by a more specific right.<sup>519</sup> In this case, the Court understood the decision of the person to end their own life as existentially meaningful for their personality and the expression of their self-determination.<sup>520</sup> The Court recognizes that life is the “vital basis of the value of human dignity” and that suicide sets an end to the preconditions of self-determination. However, in spite of this it found that the decision to commit suicide is not opposed to dignity, but rather that this decision is an expression of their dignity.<sup>521</sup>

The intentional killing of another human being, even at their explicit request (euthanasia) remains illegal in Germany.<sup>522</sup>

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<sup>518</sup> StGB BGBI Art. 2(1) GG.

<sup>519</sup> Edward J. Eberle, *Human Dignity, Privacy, and Personality in German and American Constitutional Law*, UTAH L. REV. 963, 979 (1997).

<sup>520</sup> BVerfG 2BvR2347/15, 2BvR2527/16, 2BvR2354/16, 2BvR1593/16, 2BvR1261/16, 2BvR651/16 - Rn.(1-343), § 208.

<sup>521</sup> *Id.* § 211.

<sup>522</sup> *Id.* § 17, 23.