Chapter 9
Aid in Dying: United States and Around the World

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9.1 Introduction

The ability to take one's own life was seemingly acceptable until approximately 400 BCE when it is reported that Greek philosopher Socrates condemned the practice. Plato recorded that Socrates believed that individuals were the property of the gods and their individual lives did not belong to them.[1] Plato declared the practice of suicide "disgraceful" and recommended the "perpetrators" be buried in unmarked graves. This practice was followed by Jewish leaders, who refused to allow suicide victims to be buried in "hallowed ground." The refusal of a "proper burial" was followed by Christians until as recently as 1983. Aristotle, in the 300s BCE believed suicide was harm to the state, as the state was denied the labor and productivity of the individual.

In the 1200s CE, priest and philosopher Thomas Aquinas indicated that suicide was a sin against god. In the Middle Ages, not only was the individual refused a proper burial, his or her property was confiscated. Additionally, his or her body may have been dragged through the streets and the corpse otherwise abused.[2] In the 1600s English poet, priest and lawyer John Donne was one of the first persons to defend the act of suicide. He was followed in this conviction in the 1700s by two Frenchmen, philosopher Charles Montesquieu and writer and philosopher Francois Voltaire.

[1] See *Suicide*, Stanford Encyclopedia of Philosophy; and Baton Rouge Crisis Intervention Center, *The History of Suicide*, Jacob Crouch Foundation. See also: Brody (1989), p. 15.

[2] Id.

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The Hippocratic Oath, taken by physicians and reportedly created by Greek philosopher Hippocrates in approximately the 400s BCE contains the following language: "I will not give a lethal drug to anyone if I am asked, nor will I advise such a plan."

In the United States and parts of Europe, suicide was a crime, punishable by imprisonment and oddly enough, death. It was not until the "Suicide Act of 1961" that the act of suicide was decriminalized in the U.K.[3] There continues to be "criminal liability for complicity in another's suicide" in the UK, however. This is true of most of the states in the United States as well.

In the United States, suicide was a criminal offense in many states until very recently. It is no longer a crime in the United States, but assisting the suicide of another is illegal in most U.S. states and in at least one state, even "encouraging" suicide is a criminal offense.[4] Note that the states individually control the laws on suicide, assisted suicide and aid in dying. In *Washington v. Glucksberg*, 521 U.S. 702 (1997), the U.S. Supreme Court recognized that each individual state legislature had the duty and opportunity to determine its particular state's rules on aid in dying.

Most organized religions oppose suicide and aid in dying. Suicide is forbidden under Judaism, Christianity, Islam, and Hinduism (although one may fast to death in the Hindu faith).[5] Buddhism does not condemn suicide.

The United States Supreme Court did however recognize the right to die in *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990) and Americans are now allowed to choose whether they would like to be free of feeding tubes and breathing apparatus when there is no hope of recovery. By executing an "Advance Health Care Directive," individuals may designate a person to make health care decisions for them should they be unable to do so, and/or the individual may make his or her wishes known with respect to artificial hydration and respiration. This is a refusal of life-sustaining treatment rather than any type of aid in dying.

The Catholic Church opposes aid in dying and on June 16, 2011 the United States Conference of Catholic Bishops issued a statement on physician-assisted suicide titled "To Live Each Day With Dignity: A Statement on Physician-Assisted Suicide."[6]

[3] 1961 CHAPTER 60 9 and 10 Eliz 2, see http://www.legislation.gov.uk/ukpga/Eliz2/9-10/60.

[4] See *State Laws on Assisted Suicide*, at: http://euthanasia.procon.org/view.resource.php?resourceID=000132; and the California law at: California Penal Code, Section 401. See also Hall (1996), footnote 23.

[5] See BBC, Euthanasia and Suicide—Judaism, Buddhism, Hinduism; and Salahi (2004) and Kennedy (2000).

[6] http://www.usccb.org/toliveeachday/bishops-statement-physician-assisted-suicide.pdf; and see Neumann (2011).

9.2 Aid in Dying in the United States

Undoubtedly most Americans became familiar with aid in dying, particularly physician aid in dying through Jacob (Jack) Kevorkian who was nicknamed by some as "Dr. Death."[7] He advocated for physician-assisted suicide[8] and by his own count, assisted 130 individuals to end their lives. Dr. Kevorkian, a pathologist practicing in Michigan, created what he called a "suicide machine or the Mercitron." He was charged with murder and subsequently acquitted numerous times, and had his license to practice revoked by both the states of Michigan and California.[9] Approximately two weeks after Michigan voters rejected a provision to legalize physician assisted death, on November 22, 1998 Dr. Kevorkian appeared on the popular television show "60 Minutes," watched by approximately 22 million viewers.[10] He had earlier provided a videotape of himself administering a lethal dose of Secobarbital Sodium (marketed as Seconal), potassium chloride, and a muscle relaxant to Thomas Youk, who suffered from Amyotrophic Lateral Sclerosis (ALS, commonly known as "Lou Gehrig's Disease"). He was charged with the murder of Mr. Youk and was convicted by a Michigan jury in 1999 of second-degree murder and the delivery of a controlled substance. He received a sentence of 10–25 years in prison, but was released in 2007 after serving over 8 years. He agreed as a condition of his release not to offer advice to any other person about aid in dying.[11] Dr. Kevorkian died on June 3, 2011 at the age of 83 of natural causes (thrombosis caused by liver cancer).

It should be noted that in 1990, the United States Congress enacted the "Patient Self-Determination Act," effective on December 1, 1991. The law requires institutions that receive Federal funds to inform patients about Advance Health Care Directives, which then allow patients to refuse certain medical treatments. Additionally, palliative care is often used for individuals who are suffering from pain in their last days of life. The National Hospice and Palliative Care Organization defines palliative care as "treatment that enhances comfort and improves the quality of an individual's life during the last phase of life." The Catholic Church does not

[7] Interestingly, Dr. Kevorkian received the nickname "Doctor Death" in 1956, long before he assisted any patients with death. It was his article entitled "The Fundus Oculi and the Determination of Death" that earned him the name. The article was published in the American Journal of Pathology in December 1956.

[8] Though originally known by the terminology "physician-assisted suicide" advocates now use the term "aid in dying," while opponents generally use the term "euthanasia."

[9] For a brief history of Dr. Jack Kevorkian's life, see http://www.pbs.org/wgbh/pages/frontline/kevorkian/chronology.html. For a "Kevorkian Chronology," see Nightingale Alliance Euthanasia Opposition, at http://www.nightingalealliance.org/cgi-bin/home.pl?article=120.

[10] See Fields-Meyer (1998). Mr. Youk had earlier died on September 17, 1998.

[11] In 2010, HBO aired a film by Barry Levinson entitled "You Don't Know Jack" about Dr. Kevorkian. Al Pacino, who played him, received both a Golden Globe award and an Emmy award for his portrayal.

oppose (and in fact even encourages) palliative care.[12] In fact, the Church even sanctions the use of palliative sedation to relieve pain, and explains the "doctrine of double effect" as the following:

> In palliative sedation, the act itself must be good or at least neutral (administering pain medications or sedation); the intention of the act is to produce a good effect (relief of pain or suffering), although a harmful effect (death) is foreseeable in some cases; the harmful effect of the act must not be the means to the good effect (death is not the means to relieve suffering); and the good effect must outweigh or balance the harmful effect (principle of proportionality).[13]

Some supporters of aid in death have argued that there is no real distinction between palliative sedation and physician-aided death. Those opposed argue that the "desired outcome of physician-assisted suicide and euthanasia is patient death. In contrast, the desired outcome of PS [palliative sedation] is relief of patient suffering through sedation, with the possible risk of hastening death."[14]

One other option is the "voluntary cessation of eating and drinking."[15] Under this approach, death will generally occur within one to three weeks. Under terminal sedation, the median time until death is one to five days. According to the statistics gathered under the Oregon law (see below—Oregon Public Health Division statistics), the median time between the ingestion of medication and unconsciousness was five minutes, and the median time between the ingestion of medication and death was 25 minutes.

9.2.1 Oregon Law

Oregon was the first state in the United States to enact an aid in dying law.[16] On November 8, 1994, the citizens of the state of Oregon approved Ballot Measure 16. The measure was titled "Oregon Death with Dignity Act." Under the Oregon Constitution, laws may be passed and the constitution may be amended by initiative of the people of the state, independent of legislative action.[17] According to the Oregon State Bar Association, the initiative process was a "direct democracy" idea developed in Switzerland. The vote on the death with dignity measure was extremely close—627,980 votes in favor (51.3%) and 596,018 votes in opposition (48.7%).

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[12] See, for example, http://www.usccb.org/prolife/programs/rlp/03rlgloth.shtml.

[13] Bruce et al. (2006).

[14] Olsen et al. (2010).

[15] Kahn et al. (2003).

[16] Prior to passage, both the states of Washington (Ballot Initiative 119—defeated by a vote of 54% to 46%) and California (Proposition 161—defeated by a vote of 54% to 46%) voted on but did not pass aid in dying laws.

[17] Oregon Constitution, Article IV, Section 1 (2).

How did this measure appear on the ballot? According to Professor Valerie J. Vollmar of Willamette University College of Law in Oregon, the measure was a "grass-roots effort" of interested individuals, physicians, and lawyers.[18] It was opposed by the American Medical Association, Right to Life groups, most religious groups (in particular the United States Council of Catholic Bishops), certain disability groups, and general opponents of euthanasia. The American Medical Association's Code of Medical Ethics, Section 2.211, adopted by the House of Delegates in 1994 states the following:

> Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.

Supporters of the measure were "socially liberal Christian and Jewish religious denominations," civil rights groups and some organizations representing the rights of the terminally ill.[19]

Arguments in favor of aid in dying include the following: personal autonomy, medical science advances that have outpaced pain relief and quality of life care, equitable treatment for all of those near death, honesty (aid in dying was in fact occurring but was not reported), the rights of individuals versus the state, and compassion in end of life care. Arguments against are the following, among others: the sanctity of life, religious beliefs that only a higher power should decide when the end comes, the fallibility of the medical profession (the person may in fact not be near death), individuals will not necessarily wish for death but will be encouraged (by family and by the state) to request death, the effect of depression on any decision, the disabled and aged will be targeted, physicians "must do no harm," and aid in dying is an act of murder.[20]

The first actual legal death under the Death with Dignity Act did not occur until March 24, 1998, due to a number of legal measures pursued after the vote. The original measure was designed to take effect 30 days after the election, or December 8, 1994. Instead, the United States District Court for the District of Oregon issued a temporary restraining order on December 7, 1994 against the measure (*Lee v. Oregon*, 869F. Supp. 1491 (D. Or. 1994)). The injunction was made permanent by the District Court (Chief Judge Hogan) on August 3, 1995 (*Lee v. State of Oregon*, 891F. Supp. 1439 (D. Or. 1995)). The plaintiffs in *Lee* were specific physicians, a number of terminally ill patients, and two residential care facilities, all located in Oregon. The plaintiffs alleged that the measure violated the equal protection clause and their due process rights under the Fourteenth Amendment to the United States Constitution, their free exercise of religion and freedom of association rights under the First Amendment to the United States Constitution,

[18] Professor Vollmar has a website entitled "Physician-Assisted Death," located at: http://www.willamette.edu/wucl/faculty/profiles/vollmar_pad/index.php.

[19] Masci (2007).

[20] For an excellent resource, see *Ethics in Medicine, Physician-Aid-in-Dying*, the University of Washington School of Medicine, at http://depts.washington.edu/bioethx/topics/pad.html#ques5.

and their statutory rights under the Americans with Disabilities Act of 1990 and the Religious Freedom Restoration Act of 1993.[21]

The United States Court of Appeals for the Ninth Circuit issued its opinion in *Lee v. State of Oregon* on February 27, 1997. The Court found that the federal courts did not have jurisdiction to "entertain Plaintiffs' claims" and the case was vacated and remanded with instructions to dismiss the case. In particular, the Court found that the plaintiffs lacked standing to bring the claims. The United States Supreme Court denied certiorari in *Lee v. Harcleroad*, 522 U.S. 927 (1997) on October 14, 1997.

There were two significant developments during the pendency of the *Lee* case. First, the United States Supreme Court decided two cases, *Washington v. Glucksberg*, 521 U.S. 702 (June 26, 1997), and *Vacco v. Quill*, 521 U.S. 793 (June 26, 1997). Both cases concerned state criminal statutes which made it a crime to assist another to commit suicide (a New York law and a Washington law). Second, the Oregon legislature passed HB 2954—a bill to send Measure 51 to the voters of the state of Oregon to repeal the Death with Dignity Act (DWDA).

Both the *Glucksberg* and *Quill* cases involved constitutional challenges to the particular states' criminal bans on physician-assisted suicide. In *Glucksberg*, the issue was whether a Washington ban violated the Fourteenth Amendment's *Due Process Clause*, and in *Quill* the issue was whether the New York ban violated the Fourteenth Amendment's *Equal Protection Clause*. The U.S. Supreme Court issued unanimous opinions in both cases and found that neither the Due Process Clause nor the Equal Protection Clause was violated. It upheld the constitutionality of the bans. There were 41 amicus curiae (Friend of the Court) briefs filed supporting the New York and Washington laws, and 19 amicus briefs in opposition to the ban (supporting the decriminalization of assisted suicide).[22]

In his majority opinion, Justice Rehnquist relied heavily on the American Bar Association (AMA) brief.[23] He rejected Harvard law professor Lawrence Tribe's argument that essentially there was no distinction between removing life support (found constitutional in *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1990)) and physician-assisted death. Professor Tribe was one of the attorneys for Timothy Quill and the other physicians who challenged the law.

There was a bit of a bright spot for supporters of physician-assisted suicide—in the language of the majority opinion (Rehnquist) and the concurring opinions of Justices O'Connor, Souter and Breyer. The opinions cited the "deeply rooted" ban on assisted suicide, but the holding permitted the "debate to continue, as it should in a democratic society." In the majority opinion, Justice Rehnquist stated, "Americans are engaged in an earnest and profound debate about the morality,

[21] *Lee v. State of Oregon*, 107F. 3d 1382 (9th Cir. 1997), vacating and remanding *Lee v. State of Oregon*, 891F. Supp. 1429 (D. Or. 1995), cert. den. *Lee v. Harcleroad*, 522 U.S. 927 (Oct. 14, 1997).

[22] Coleson (1997), pp. 3–99.

[23] See Palmer (1998).

legality, and practicality of physician-assisted suicide." In his concurring opinion, Justice Breyer stated the following:

> But I would not reject the respondents' claim without considering a different formulation, for which our legal tradition may provide greater support. That formulation would use words roughly like a "right to die with dignity."

Most notably, in Justice O'Connor's concurring opinion, she stated the following: "There is no dispute that dying patients in . . .New York can obtain palliative care, even when doing so would hasten their deaths."

The second development that occurred during the pendency of the *Lee* case was a movement by the Oregon legislature to prevent the Oregon law from taking effect. The legislature was motivated, it said, by what it saw as fatal flaws of the Act as passed by the people, including the allegation that oral suicide attempts fail and patients suffer immeasurably. Measure 51 was sent to the voters on October 15, 1997 and a special election was held on November 4, 1997. Supporters of the repeal, including Physicians for Compassionate Care, the U.S. Conference of Catholic Bishops,[24] the Oregon Medical Association, and Oregon Right to Life cited a study done in the Netherlands which showed that complications arose in 20% of the oral barbiturate cases.[25] Opponents of the repeal, including Oregon Governor Kitzhaber (himself a former emergency room physician), Physicians for Death with Dignity, a local millionaire, and George Soros (a Hungarian-American businessman), countered that there was no credible evidence that patients would suffer from vomiting, convulsions, or other symptoms when the correct dose of oral medication was taken. They also cited reports that indicated that individual physicians and psychiatrists, when surveyed individually, supported aid in dying. Final spending reports on the Measure indicated that the Yes on 51 Campaign (repeal of DWDA) spent $4,077,882 and the opponents of repeal (Oregon Right to Die) spent $966,000. The election was the third most expensive ballot measure in Oregon history, according to Professor Vollmar.

Measure 51 was defeated by a 60% to 40% margin and the DWDA went into effect. The current law is Oregon Revised Statutes, Sections 127.800 through 127.995.[26] The "Safeguards" provisions of the law are at ORS 127.815 through 127.880 and include (among other things) a requirement that the patient have a life expectancy of less than six months, must be 18 or older, an Oregon resident, evaluated by at least two physicians, be free of psychiatric or psychological disorders or depression that impairs judgment, make a written request, wait for the prescription, and wait for a specific amount of time between the request and the ingesting of the medication to end his or her life. There is a "Guidebook for Health

[24] The U.S. Conference of Catholic Bishops have issued a report by F. Michael Gloth, III, M.D., entitled *Physician-assisted Suicide: the Wrong Approach to End of Life Care*.

[25] An excellent history of the Measure as well as arguments both in favor and in opposition is available at: http://www.leg.state.or.us/comm/commsrvs/51final.pdf.

[26] Available at: http://www.leg.state.or.us/ors/127.html.

Care Professionals" available through the Oregon Health Sciences University website.

The challenges to the law were not yet finished. Two Republican congressmen, neither from the state of Oregon reported the Oregon law to the U.S. Drug Enforcement Administration (the DEA, part of the U.S. Department of Justice) and they asked the DEA to investigate whether doctors who prescribed the medication would face penalties under the Controlled Substances Act (CSA).[27] In December of 1997, the answer came back "yes" in the view of DEA Chief Constantine. The U.S. Attorney General at the time, Janet Reno agreed to review the opinion. Attorney General Reno had earlier determined (in 1994) that the law did not violate the CSA. On June 5, 1998, she sent a letter to Representative Henry Hyde of Illinois and stated the following: "The Department has reviewed the issue thoroughly and has concluded that adverse action against a physician who has assisted in a suicide in full compliance with the Oregon Act would not be authorized by the CSA." She was quick to specify however that the President did not support the Act and that no federal funds could be used in connection with the Act.

On November 7, 2000, George Bush was elected President of the United States. Attorney General Janet Reno's last day in office was January 20, 2001, the date Bush was sworn in as President. President Bush appointed John Ashcroft as Attorney General and he took office on February 2, 2001. On November 9, 2001, Attorney General Ashcroft issued a directive (the "Ashcroft Directive") by which he determined that dispensing medicine under the Oregon DWDA was not a "legitimate medical purpose" under the Controlled Substances Act (CSA).[28] Incidentally, Ashcroft was formerly a Senator who while in office introduced legislation to amend the CSA to prohibit physicians from prescribing medication for assisted death.[29] According to Ashcroft, any physician who wrote a prescription for the medication under the DWDA could be held liable for civil and criminal penalties.

The State of Oregon challenged the Ashcroft Directive and successfully obtained a permanent injunction against the enforcement of it. A lawsuit began (filed by a doctor, pharmacist, terminally ill patients and the State of Oregon itself) and ultimately the issue was heard before the United States Supreme Court in *Gonzales v. Oregon*, 546 U.S. 243 (2006). The name of the case was *Gonzales* because Alberto Gonzales succeeded Ashcroft on February 3, 2005 as Attorney General of the United States.

The Supreme Court analyzed the case as an administrative law case, despite the invitation to decide the case based only upon a state's rights versus the federal government's rights. The majority considered the three levels of deference to the

[27] See Gonzales v. Oregon, 546 U.S. 243 (2006), p. 253.

[28] See Goodman (2007).

[29] For an excellent discussion of this issue, see The Pew Forum on Religion and Public Life, *Supreme Court's Decision in Gonzales v. Oregon: High Court Rejects Federal Regulation of Physician-Assisted Suicide*, January 2006.

administrative rule, *Auer* deference, *Chevron* deference, and *Skidmore* deference. It determined, in a 6 to 3 decision that *Skidmore* deference applied, and the government failed to show the necessary "persuasive" standard. The Court noted that the purpose of the Controlled Substances Act was to regulate illicit drugs, addiction and drug abuse. The Court concluded that the Attorney General exceeded his authority. The Oregon law remained in effect.

There was, however, one more challenge to the DWDA. In March 2011, nine Republican Oregon House of Representatives members introduced House Bill 2016 before the Oregon legislature. The bill never received a hearing due to lack of support, but it would have required any terminally ill individual to undergo counseling and have a psychiatrist or psychologist determine that the person did not suffer from depression or a psychological disorder in order to use the Act.

In March 2011, the Oregon Public Health Division released a Summary of the DWDA's results over the earlier 13 years.[30] As of the end of 2010, a total of 821 prescriptions were written under the DWDA and 525 (64%) of those patients died from ingesting the medication. Most of the individuals were over the age of 65, the vast majority were white (Caucasian) and well-educated. The majority of those who used the DWDA had cancer or amyotrophic lateral sclerosis (ALS, commonly known as "Lou Gehrig's Disease"). During the previous 13 years, there were three "failed ingestions"—two of those in the year 2010, both of which involved regurgitation. Ninety-six percent of the cases reported no complications. Most of the individuals had some form of health insurance. In most cases, the prescribing physician was not present at the time of death. The most common reasons given for ingesting the medication were loss of autonomy, the decreasing ability to participate in activities and the loss of dignity. Slightly more males used the DWDA than females, and most of the individuals were married. A great majority were in hospice care at the time of death. Interestingly, 94% had informed their families of their decision.[31]

It is undoubtedly obvious from the above discussion that individuals and groups both within Oregon and within the entire United States hold very strong and differing opinions on the issue of aid in dying. Thus far, no state has had as tortuous a path to aid in dying as the State of Oregon has had. A film on the Oregon DWDA titled "How to Die in Oregon" by Peter D. Richardson won the 2011 Sundance Film Festival Grand Jury Prize: Documentary. Only two other states have legalized aid in dying—the States of Washington and Montana.

9.2.2 Washington Law

On November 4, 2008, the citizens of Washington approved Initiative 1000 by nearly a 20% margin. The Washington DWDA went into effect on March 5, 2009 (RCW 70.245) and is modeled on the Oregon DWDA, again with significant safeguards.

[30] See: CD Summary, Oregon Public Health Division, Oregon Health Authority (2011).

[31] For all of these data, see: Oregon Public Health Division (1998–2010).

The former governor of Washington, Booth Gardner (who has Parkinson's disease) filed the Initiative. The Seattle Times newspaper reported that the supporters of the Initiative raised $4.9 million (with the largest contributor being former governor Gardner) and the opposition groups raised $1.6 million (most of that from Catholic groups). The Washington State Medical Association opposed the Initiative. Interestingly, former governor Gardner's condition would not qualify under the Initiative as his condition does not meet the requirements for the statute.

A woman with pancreatic cancer became the first person to use the DWDA and according to data collected for 2009, medication was dispensed to 63 individuals and 36 died after ingestion.[32] In 2010, medicine was dispensed to 87 individuals and 51 died after ingestion. Groups against the initiative were the "Coalition Against Assisted Suicide," formed by Democratic State Senator Prentice, a former nurse; the disability-rights group "Not Dead Yet;" and the "Christian Medical Association." The Christian Medical Association cited a "Dutch medical study" which indicated that Dutch doctors administered lethal injections to approximately 1000 patients who never consented to the medication.[33] This is dubious at best, as this action if taken would have been murder under the laws of the Netherlands. There was no constitutional challenge to the Washington law, although it has not been without criticism.[34]

9.2.3 Montana Law

On the last day of the year 2009, the Montana Supreme Court decided *Baxter v. State of Montana*, 2009 MT 449, 224 P. 3d 1211 (2009), and the Court determined that if a terminally ill patient consents, a physician who prescribes medication to end the patient's life is immune from prosecution for homicide. The Montana Supreme Court rephrased part of the issue on appeal as do "competent, terminally ill patients have a constitutional right to die with dignity?" The Montana Supreme Court specifically stated the following:

> The Montana Rights of the Terminally Ill Act indicates legislative respect for a patient's autonomous right to decide if and how he will receive medical treatment at the end of his life. The Terminally Ill Act explicitly shields physicians from liability for acting in accordance with a patient's end-of-life wishes, even if the physician must actively pull the plug on a patient's ventilator or withhold treatment that will keep him alive.

This was undoubtedly the most far-reaching and dramatic language issued to date on aid in dying. In 2011, there were two bills that were "tabled" (failed to move

[32] See statistics reported by the Washington State Department of Health, available at: http://www.doh.wa.gov/dwda/.

[33] Jones (2008).

[34] See, for example, Dore (2010).

past the Committee and to a vote) that would have legislatively reversed the decision of the Montana Supreme Court.[35] Interestingly, the legislature also tabled Senator Blewett's bill (SB 167) that would have provided for certain procedural safeguards similar to those that appear in the Oregon and the Washington laws.[36]

9.3 Aid in Dying in Countries Other Than the United States

Relatively few countries have legalized aid in dying, physician-assisted suicide or euthanasia for terminally ill adults. Each jurisdiction that does allow the practice has its own precise guidelines and procedures. Switzerland has allowed aid in dying since 1937, although there is no specific statute allowing the practice.[37] It is the only jurisdiction to date that allows foreigners to avail themselves of their law. This practice has been criticized, most recently when renowned British conductor Sir Edward Downes and his wife ended their lives at a suicide clinic outside of Zurich. Sir Edward himself was in relatively good health at age 85, but his wife was facing terminal cancer. Several articles appeared in London papers comparing the couple to a modern day *Romeo & Juliet*.[38] This and the case of British citizen Craig Ewert, who had ALS and traveled to Switzerland to end his life, sparked international debate over residency requirements. The documentary "The Suicide Tourist" tells the story of Mr. Ewert.[39] All other nations have strict residency requirements which forbid foreigners from entering their borders to use their aid in dying laws.

Approximately 60 years after Switzerland first allowed aid in dying, another jurisdiction followed suit. It was then that the State of Oregon passed its Death with Dignity Act, That same year, the Constitutional Court of Colombia allowed "mercy killing."[40] In 1999, Albania had also legalized assisted suicide, but only if three or more family members consent.

The Netherlands and Belgium both legalized assisted suicide in 2002. In actuality, beginning in 1990 in the Netherlands, prosecution of a physician assisting in a suicide was "unlikely if a doctor complies with the Guidelines on euthanasia and physician assisted suicide set out in the non-prosecution agreement between the Dutch Ministry of Justice and the Royal Dutch Medical Association."[41] Certain procedural requirements were agreed to by the Ministry of Justice and the Medical

[35] See Blewett and Barrett (2011).

[36] See http://data.opi.mt.gov/bills/2011/billhtml/SB0167.htm. This was tabled by Committee on February 10, 2011.

[37] Ebbott (2010).

[38] *See* Mendick and Randhawa (2009).

[39] See PBS, Frontline, *The Suicide Tourist*, available at: http://www.pbs.org/wgbh/pages/frontline/suicidetourist/.

[40] See http://medlaw.oxfordjournals.org/content/17/2/183.short?rss=1.

[41] Cohen-Almagor (2001–2002).

Association, including that "euthanasia must be a last resort," and the patient request had to be free and voluntary, and the patient was suffering unbearably and there was no prospect of improvement. In 2002, the Netherlands enacted the "Termination of Life on Request and Assisted Suicide (Review Procedures) Act." Under the Act, physicians who assist a patient in dying are required to report their action to a review board to ensure that all the legal requirements (patient is terminally ill, has repeatedly requested euthanasia, is fully aware of their condition, and has consulted with at least two physicians) have been met. The law prohibits physicians from assisting anyone under the age of twelve in ending their lives, and those between twelve and sixteen must have parental consent. Patients are allowed to administer the lethal dose of medication themselves, but must have a doctor in attendance, both to ensure that the medicine is taken by the person for whom it is intended and to ensure no errors are made.

Belgium does not use the term "assisted suicide," instead preferring the term "euthanasia," which is defined as intentionally ending the life of someone at that person's request. Belgium has fewer regulations than the Netherlands, but physicians are still required to report after assisting a patient to die. These reports are reviewed by a committee to determine whether the death complied with the procedures required by law. If two-thirds of the committee members believe the laws have not been complied with, the case will be referred for criminal prosecution. A report published in *Medical Care* analyzing Belgium's euthanasia statistics since 2002 concluded that "patients who died by euthanasia were more often younger, men, had cancer, and died at home, compared with all deaths in the population."[42]

Luxembourg also legalized assisted suicide in 2008, after earlier initiatives failed due to monarchy opposition. In 2008, Luxembourg's constitution was amended to alter the powers that the royals had in lawmaking, and assisted suicide was legalized several months later.

9.3.1 Countries Where Aid in Dying Is Criminalized Behavior

There are also a number of nations where physician assisted suicide is not only disapproved of, but the act results in serious criminal sanctions. Norway, for example, authorizes murder charges or accessory to murder charges for those who assist someone in ending their life. In 2000, a prominent Norwegian physician was found guilty of "willful murder" after assisting a patient suffering from multiple sclerosis to end her life. Recently a commission voted against de-criminalizing assisted suicide by a vote of 5-2.

Italy also penalizes assisting someone in ending his or her life. Several high-profile right-to-die cases in recent years have led to intense debate over the legalization of assisted suicide, as well as the role of autonomous decision-making in

[42] Smets et al. (2009).

end-of-life care. The 2009 case of Eluana Englaro, a young woman who was in a persistent vegetative state for 17 years following a car accident, spurred Prime Minister Silvio Berlusconi to propose emergency legislation that would have made it illegal for caregivers to remove feeding tubes and hydration from patients in vegetative states. Eulana's father had fought for years in Italy's courts for a dignified end to his daughter's life, and she passed away several days after her feeding tube was finally removed. The case brings to mind the United States cases of Karen Ann Quinlan and Terri Schiavo both of which caused intense debate and significant and lengthy litigation. Prime Minister Berlusconi's legislation was never passed, as it was deemed to be unconstitutional and in contradiction to an earlier Italian Court ruling that gave Mr. Englaro permission to remove his daughter's feeding tube. Mr. Englaro had convinced the Court that his daughter would not want to live her life attached to machines. The Vatican decried her death, stating that it would "still be regarded as a crime."[43] Mr. Englaro, along with thirteen other people accused of assisting in Eulana's death (primarily doctors and nurses at the nursing home in which she died) faced a murder investigation. The investigation was terminated in 2010 without the filing of formal charges. Italy does not have legislation governing living wills, and Prime Minister Berlusconi has been vocal in his promises that, if any such legislation were to pass, it would have to be very restrictive and not allow the removal of hydration or nutrition assistance, nor any type of euthanasia. The debate was re-ignited in November 2010, when famed 95-year-old film director Mario Monicelli committed suicide by jumping from his fifth floor hospital window in Rome. Reports stated that Mr. Monicelli was fighting terminal prostate and pancreatic cancer.[44] Known as "the father of Italian comedy," Mr. Monicelli's suicide immediately following the Englaro case has reignited the debate over assisted suicide in Italy.

Physician assisted suicide is also illegal in Australia and New Zealand. Australia's Northern Territory at one point legalized aid in dying by its Rights of the Terminally Ill Act of 1995; however, only four people used the law before it was repealed in 1997. Dr. Philip Nitschke, an Australian physician and the founder of Exit International (an international euthanasia advocacy group) assisted in these deaths. While the Rights of the Terminally Ill Act was repealed, it appears that decriminalization of assisted suicide may soon happen in Australia. In 2005, a nurse who helped her ailing parents die was sentenced to several years in prison, but the judge suspended the sentence because he found that imprisoning her would violate public policy. In July 2010, Tasmania's Attorney General Lara Giddings spoke optimistically about legal reform under the next 4 years of the Labour-Green Party's government, which would include a privately-backed bill that aimed to legalize euthanasia. This bill is not expected to be presented to Parliament until

[43] Owen (2009).

[44] *See Italian Cinema Great Mario Monicelli Kills* Himself, BBC NEWS, Nov. 30, 2010. Available at: http://www.bbc.co.uk/news/world-europe-11873511.

late 2011, but its existence suggests that Australian attitudes toward so-called euthanasia are shifting.

In England and Wales, the Suicide Act of 1961 criminalizes assisting someone to end his or her life, and authorizes a prison term of up to 14 years. However, more recently a number of Britons have aided relatives in traveling abroad to take advantage of aid in dying laws in other jurisdictions. Thus far, no arrests have been made. In 2008, noting the inconsistencies between the language of the law and the lack of criminal prosecutions, West Yorkshire political activist Debbie Purdy filed a lawsuit seeking clarification. Specifically, she asked whether her husband Omar would face criminal sanctions if he aided her in traveling to Zurich to end her life. She had experienced a lengthy battle with multiple sclerosis.

Her main argument was that the Director of Public Prosecutions was violating her human rights by failing to clarify ambiguities on how the Suicide Act of 1961 was actually enforced. In September 2009 she prevailed when the Director of Public Prosecutions published new guidelines to clarify when relatives or caregivers are likely to be prosecuted under the law. While assisted suicide still remains illegal, "the general approach we've taken [with the new guidelines] is to try to steer a careful course to protect the vulnerable from those who might gain from hastening their death but also identifying those cases where no one thinks it's in the public interest to prosecute."[45] The new guidelines take into account factors such as whether the terminally ill person requested suicide of their own volition (i.e., instead of being coerced), whether the relatives or caretakers who assisted them stood to benefit financially from their death, and whether the person was fully able to understand their medical diagnosis and had considered alternatives and consequences to their actions.

9.3.2 New Legislation: The "Out of Free Will" Movement

While countries like England and Italy are proposing legislation that narrows or clarifies their laws regarding assisted suicide, at least one country is seeking to broaden its laws. In the Netherlands, a Dutch citizens group is pushing a movement called "Out of Free Will." This movement calls for legislation that would allow those who are over the age of 70 and who believe they have lived a "complete life" to end their lives with medical assistance. As of this date, aid in dying is authorized only under very limited conditions—when death is imminent. This is true of the Netherlands as well. Aid in dying is only allowed by Dutch law when the patient is terminally ill and experiencing "hopeless and unbearable" suffering.

This proposed change (Out of Free Will) would allow any person over 70 years of age, regardless of their health, who has expressed an "explicit, logical and

[45] *New Guidance on Assisted Suicide*, BBC NEWS, Sept. 20, 2009. Available at: http://news.bbc.co.uk/2/hi/uk_news/8265304.stm.

consistent" wish to end his or her life.[46] The rationale behind this movement is that elderly citizens should have the right to end their lives in a dignified manner, especially in the event they feel that the quality of their life is deteriorating. The drawbacks of aging, which include extensive and extended health problems, declining independence, the deaths of friends and family members, leave many seniors feeling helpless and vulnerable. Hédy D'Ancona, a 72-year-old feminist, former Minister, and avid supporter of the initiative stated that worrying about what the future held and feeling powerless over when and how she would die "took some of the enjoyment out of what was otherwise a pleasurable phase of her life." The "Out of Free Will" movement is viewed as creating a new medical niche, where certified caregivers, spiritual advisors, psychologists, nurses, and other specialists will assist patients in gently ending their lives. Many opponents of assisted suicide and euthanasia base their position on a "slippery slope" argument. Under this theory, once aid in dying is approved for terminally ill patients, its scope may spread toward those with disabilities, those who are mentally ill, and those who are viewed as burdens to their families. This will send the message that these people are not valuable members of society. There is also the concern over coercion, that elderly or terminally ill people may be manipulated by family members or caregivers into taking their own lives. Dutch legal scholar Eugéne Sutorius, another avid supporter of the Out of Free Will movement, does not deny the legitimacy of these concerns, but states that a legal and transparent system of aid in death will help determine that deaths are voluntary and consistent with each patient's wishes. Additionally, many elderly people already take their own lives, sometimes by violent means; having a safe method and trained assistant will eliminate a large part of the risk of any error that might occur in taking one's own life. He also points to when the Netherlands first approved physician-assisted suicide for the terminally ill and states "it was thought to be the first step onto a slippery slope that would lead the medical profession to lose its integrity. But I have seen nothing of the kind happen."

9.4 Conclusion

Undoubtedly the debate about aid in dying will continue both in the United States and in other countries. The aging of the population is at an unprecedented level.[47] Additionally, the prevalence of chronic diseases and of individuals surviving many years with these diseases will only intensify the debate.[48] Hopefully this debate will be productive and we will keep uppermost in our mind the value of our aged population. Discussion should continue on this ethical, moral and health issue.

[46] Jensma (2010).

[47] See http://www.un.org/esa/population/publications/worldageing19502050/; and http://www.un.org/esa/population/publications/WPA2009/WPA2009_WorkingPaper.pdf.

[48] See: http://www.cdc.gov/chronicdisease/resources/publications/aag/aging.htm.

The debate seems to center around individual autonomy versus societal religious values. At present there appears to be no objection to procedurally protective aid in dying provisions with the exception of religious objections. Of course it is essential that our societies protect their weakest members—in particular the elderly and those with physical disabilities. Procedural provisions such as those contained in the laws of the Netherlands, Oregon, Washington and other areas protect those who have no interest in aid in dying. Vigilance is absolutely essential to guard against an individual being coaxed into requesting assistance by relatives or by their own belief that they are becoming a burden to society, friends and family. We do not want to push someone to the precipice.

The decrease in those following a particular religion combined with the aging of the population will undoubtedly result in an increase in the demand for aid in dying. The physical capacity of our own bodies has not kept pace with advances in medical technology and individuals should be entitled to choose whether they would like to suffer and let nature take its course, or whether to end their life when there is no hope of healing. Given the worldwide "silver tsunami" difficult decisions need to be made about aid in dying worldwide.[49]

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[49] http://www.seniorsworldchronicle.com/2010/02/world-silver-tsunami.html.

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