CHAPTER 5
EUTHANASIA AND INTERNATIONAL PERSPECTIVE

5.1 Introduction

In truth, the question of euthanasia is not a matter of great concern or controversy throughout the world. The reason for this is not, as one might suspect, the overarching influence of a culturally preeminent religion; neither is it the secularization of the political state. To the contrary, the issue of euthanasia and the controversies surrounding it are inextricably linked with the development of technology. Without both the sufficient development of a nation's technological base and a high economic standard for its citizenry, the issue of euthanasia simply never arises. Within technologically underdeveloped countries, opportunity for artificially prolonging life rarely presents itself. Without the prerequisite technology, the controversy over artificially prolonging the existence of a dying patient is eliminated. Additionally, in countries with a poor economic base, the option of extensive medical care is beyond the means of the vast majority of its citizens. Consequently, the issue of artificially prolonged life never becomes a rallying point for public support, and the cause is subordinated to more immediate matters of survival. Thus, the struggle over the legal status of euthanasia is restricted mainly to economically developed nations.¹

The Universal Declaration on Human Rights (UDHR), 1948 among other significant international documents, consists of five core notions. These are: Human Dignity, Non-Discrimination, Civil and Political Rights, Economic, Social and Cultural Rights and Solidarity Rights.²

The first notion is Human Dignity.³ Article 1 of the Declaration states in part that,

All human are born free and equal in dignity and rights.⁴

This notion appears to emanate from the Judeo-Christian-Islamic tradition, indicative of the preponderance of western and a few Islamic nations involved in drafting the declaration.⁵ Genesis 1.27 states,

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¹ Raymond Whiting, A Natural Right to Die: Twenty Three Centuries of Debate, 37 (2002).
³ Id., at 16.
⁴ Ibid.
⁵ Genesis 1.27 states,
God created man in His image.⁶

This embodies the ultimate and supreme worth of the individual. Christians also accept the sanctity and dignity of the human person proclaimed in Genesis. Similarly, Holy Koran asserts in Sura, ‘Verily, we have honoured every human being’. Likewise, almost all religions of the world uphold the sanctity and absolute value of human life.⁷

5.2 Legal Position of the Right to Die and Euthanasia in various Countries

5.2.1 The Netherlands

Although most Western countries have been as conservative about accepting physician-assisted suicide and euthanasia, there was one notable exception: the Netherlands. As medical ethicist Edmund Pellegrino says, that country is “a living laboratory of what happens when a society accepts the legitimacy of [physician-assisted suicide and euthanasia]. You’ve got direct, empirical evidence” of the consequences.⁸

Throughout history, suicide has been both condemned and commended by various societies. Since the Middle Ages, society has used first the canonic and later the criminal law to combat suicide. In some jurisdictions, an act or incomplete act of suicide is considered to be a crime. However, following the French Revolution of 1789 criminal penalties for attempting to commit suicide were abolished in European countries.⁹ In the Netherlands, euthanasia and assisted suicide have been practiced for a long time. However, on April 1, 2002, a law regarding the practice of euthanasia and assisted suicide was passed in the Netherlands and it became the first nation in the world to legalize euthanasia. The topic of euthanasia is not new to Dutch law and society. For well over one hundred years the Netherlands has had legislation outlawing the practice. However, the post-war experience has been one in which euthanasia and assisted suicide came to be re-examined in the courts of law and public opinion.¹⁰

The Criminal Code of 1886 replaced an older Napoleonic code of 1881. The Code provided two sections which explicitly made both euthanasia and assisted suicide

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⁵ Id., at 16-17.
⁶ Id., at 17.
⁷ Ibid
⁸ Lisa Yount, Right to Die and Euthanasia, 44 (2007).
⁹ The Law commission of India, 210th Report on Humanization and Decriminalization of Attempt to Suicide, 6 (2008).
Besides making euthanasia illegal, the 1886 Code also created criminal liability in cases of assisted suicide. It is important to refer to Article 40 at this juncture. It provides that:

A person who commits an offense as a result of a force he could not be expected to resist is not criminally liable.

This superior force is a defense of necessity. It was this defense of necessity found in Article 40 that courts would use to relieve physicians in violation of Articles 293 and 294 from criminal liability. These provisions of the 1886 Criminal Code relating to euthanasia and assisted suicide were little applied in the pre-war period. The rise of the Nazi Party in Germany and the eventual brutal occupation of the Netherlands from 1940 to 1945 might explain some reluctance amongst the Dutch in this period to show any interest in euthanasia. However the Nazis carried out an involuntary euthanasia program, largely in secret. Whatever the reason, there was relatively little concern in the Netherlands on the issue of euthanasia and assisted suicide until the close of the Second World War. Due to outrage over Nazi euthanasia, in the 1940s and 1950s there was very little public support for euthanasia, especially for any involuntary, eugenics-based proposals. Catholic Church leaders, among others, continued speaking against euthanasia as a violation of the sanctity of life. Nevertheless, owing to its principle of double effect, Roman Catholic moral theology did leave room for shortening life with pain-killers and what could be characterized as passive euthanasia. However, by the 1960s, advocacy for voluntary euthanasia increased.

In 1952, a doctor from Eindhoven was tried for killing on request. The doctor had acceded to the request of his brother, who was suffering from advanced tuberculosis. In his defense the doctor told the district court that his conscience had compelled him to act in accordance with his brother’s wish to die. Although he was found guilty of killing on...
request under Article 293, the court’s sentencing was drastically more lenient than the maximum of twelve years imprisonment contemplated by the Code. The doctor was only given one year of probation. This sentencing generated very little commentary or controversy.\textsuperscript{17} There was a much more pronounced reaction to a 1969 decision of the Court of Appeals, Amsterdam, which held that before terminating life-support the physician must consult with other colleagues and discuss the situation with the family of the patient.\textsuperscript{18}

The next significant case to appear on the jurisprudential landscape was the 1973 decision in \textit{Postma}. Ms. Postma was a doctor who terminated the life of her 78 year-old mother, who had been living in a nursing home and recovering from a cerebral hemorrhage. The deceased had made her desire to die known to both her daughter and the nursing facility staff. It was the first decision that, although not speaking directly to euthanasia per se, hinted that doctors who administer pain relievers in quantities likely to lead to death might escape criminal liability if they adhere to certain conditions i.e. the patient must be incurably ill; the suffering must be mentally or physically unbearable; there is an expressed wish to die; the patient is in the terminal phase of illness; and the person who accedes to the request is a doctor (preferably the doctor responsible for treatment).\textsuperscript{19}

In 1981 charges were brought against Ms. Wertheim, a euthanasia activist accused of assisting in the death of a 67 year-old woman suffering from various maladies.\textsuperscript{20} The Rotterdam District Court dispatched with the fact that assisted suicide is explicitly criminalized in Article 294 of the Criminal Code by creating a set of requirements, which if followed, might justify assisted suicide. These requirements are divisible into conditions on the patient and those assisting him. The Wertheim Court required the following relating to the patient: the presence of unbearable physical or mental suffering; that this suffering and the desire to die were enduring; that the decision to die was made voluntarily; that the patient was well informed of his situation and alternatives, was capable of and actually did weigh the various considerations; that there were no

\textsuperscript{17} Nederlandse Jurisprudentie 1952, no. 275. Cited in \textit{Ibid.}  
\textsuperscript{18} Nederlandse Staatscourant 1969, no. 55:3-8. Cited in \textit{Ibid.}  
\textsuperscript{20} Nederlandse Jurisprudentie 1982, no. 63: 223. Cited in \textit{Ibid.}
alternative means to improve the situation; and that the person’s death did not inflict any unnecessary suffering on any third party. The requirements as to the assistance itself were as follows: the decision to assist must not be made by one person alone; a doctor must be involved; and both the decision and the assistance itself must be in accordance with utmost care. Applying these newly adopted requirements to the actions of Wertheim, the Court ruled that the defendant failed to conform to them, and found her guilty of assisted suicide under Article 294. The prosecution in Wertheim had been seeking a conviction for murder, and not being satisfied with the conviction or the sentence imposed, initially filed an appeal. The appeal was later dropped. With a confusion exposed as to how exactly prosecutions in such cases would advance, the national College of Procurators-General decided that uniformity was in order. This intervention of the College of Procurators-General was a significant move in settling the matter of when an individual otherwise in violation of the Criminal Code’s prohibitions on euthanasia and assisted suicide might be justified in his action and not subject to prosecution. The aftermath of the Wertheim decision created a type of informal legalization of euthanasia and assisted suicide by means of prosecutorial policy. However, this was a policy without any discernable substantive legal grounding. This would change in the period from 1982 onwards, as a form of legal justification for the practices developed.\footnote{Ibid.}

Euthanasia presents a paradox in the code of medical ethics, for it involves a contradiction within the Hippocratic Oath, which is essentially the promise to prolong and protect life even when a patient is in the late and most painful stages of a fatal disease. The paradox lies in the fact that while an attempt to prolong life violates the promise to relieve pain, relief of pain by killing violates the promise to prolong and protect life.\footnote{Rishab Gupta, “Euthanasia: Contemporary Debates”. Available at www.manupatra.co.in/Articles/Artlist.aspx - (Accessed on 12.1.09).} This argument of ‘conflict of duties’ was used by the defense in a crucial case decided by the Dutch Supreme Court in the groundbreaking Schoonheim case.\footnote{Supra note 13 at 62-63, 322-338.} (also called 1984 Alkmaar case). Schoonheim, a general practitioner, performed euthanasia on a 95 year-old patient who had requested such treatment. At trial in the
Alkmaar District Court, the defendant offered defenses of “absence of substantial violation of the law” and “necessity”. The “necessity” referred to here is based on the defendant’s argument that he was presented with a conflict of duties. The trial court accepted the first defense, and the prosecution appealed to the Court of Appeals, Amsterdam. The appellate court rejected all of the defenses, and found Schoonheim guilty of a violation of Article 293 but did not impose any punishment. The Supreme Court affirmed the lower court’s rejection of the defense based on “absence of substantial violation,” but held that the Article 40 defense of necessity had been inadequately considered by the lower courts. The verdict was vacated and referred to the Court of Appeals at The Hague. The Hague Court of Appeals, after obtaining more evidence, accepted the defense of necessity and acquitted Schoonheim.25 

Schoonheim was the first case in which no criminal liability was imposed on a physician who had committed euthanasia on the ground of defense of necessity.26

The second occasion on which the Supreme Court addressed euthanasia was the Pols case. The defendant Pols was a psychiatrist who in 1982 killed her 73 year-old friend who had been suffering from multiple sclerosis and expressed a wish to die. Pols offered two defenses: “absence of substantial violation of the law” and “necessity”. The Supreme Court held that there was no “medical exception” defense available in euthanasia prosecutions and rejected both the defenses. Thus it was made clear that there was no social consensus that euthanasia is a form of “normal medical practice” capable of being understood within the “medical exception.”27

In 1984, the Executive Board of the Royal Dutch Medical Society issued a report in which the permissibility of euthanasia itself was not addressed, but rather under what conditions it would be acceptable. The report claimed that euthanasia performed by a

24 The Criminal Code of 1886, art. 40. Article 40 provides for a defense in cases of “irresistible compulsion or necessity.” “The defence takes two forms: first, ‘psychological compulsion’ and secondly ‘emergency’ or choosing to break the law in order to promote a higher good.

25 Nederlandse Jurisprudentie, 1987 no. 608. Cited in supra note 10. In the same year, the Royal Dutch Medical Association issued guidelines on euthanasia, which were later put into law by the Dutch Parliament in 1993. Under these guidelines, Dutch doctors could provide help to patients who were suffering unbearably without any hope of improvement and who also asked to be helped to die. Ibid.

26 Ibid.


190
A year after these requirements were promulgated, the case of Admiraal was occasion for judicial adoption of the “requirements of careful practice.” The case set the precedent that doctors in compliance with the “requirements of careful practice” will not be convicted for performing euthanasia. In addition, subsequent case law answered the question of whether all of the requirements always had to be fulfilled in order to prevent prosecution. In 1988 the Supreme Court upheld a decision of the Arnhem Court of Appeals that held that failure to consult another doctor alone is insufficient grounds for prosecution. One of the requirements of careful practice, under which physicians performing euthanasia and assisting with suicide were assured freedom from prosecution, required that the patient be suffering. Doctors with patients who were suffering physically were not subject to prosecution, but it was not yet clear whether they would be treated the same in cases involving patients with non-somatic suffering.

The Supreme Court addressed the issue of non-somatic suffering in the landmark 1994 case of Chabot. Dr. Boudewijn Chabot was a psychiatrist who supplied lethal drugs to a patient who had recently experienced a series of traumatic events that had left her with no desire to live. Although offered treatment for her condition, the patient

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28 Ibid.
29 Nederlandse Jurisprudentie, 1985 no. 709. Cited in Ibid.
30 Ibid.
31 Ibid.
32 Ibid.
33 Supra note 13 at 329-340.
refused. The prosecution argued that the defense of justification should not be available to doctors who assist with suicides in cases where the suffering is non-somatic and the patient is not in the “terminal phase.” The Supreme Court rejected this contention, and held that in such cases the justification can be rooted in the autonomy of the patient herself. The Court noted that, “the wish to die of a person whose suffering is psychic can be based on an autonomous judgment.” However, since Chabot did not consult an independent medical expert, who had himself examined the patient, and such evidence of consultation is essential in cases of non-somatic suffering, the Court found him guilty of assistance with suicide. However no punishment was imposed. Thus, Chabot represents a significant extension of the Dutch Supreme Court’s willingness to rely upon the norm of individual autonomy.\textsuperscript{31}

The jurisprudence addressing this category has been primarily concerned with cases of infants with birth defects. \textit{Prins} was a 1995 case in which a gynecologist stood trial for the murder of a three day-old baby girl with spina bifida. Surgery on the baby’s condition was deemed futile, and since the infant was suffering greatly, and it was believed that nothing could be done to relieve the pain, the doctors and parents decided to administer a lethal injection. The defendant offered three defenses: a) current understanding of the phrase “take a person’s life” used in Article 289 of the Criminal Code does not apply to a life-terminating action by a physician in the context of careful medical practice; b) the action was done in accordance with medical-professional standards (the medical exception); and c) necessity. The Alkmaar District Court rejected the first two defenses, but held that the defense of necessity could be accepted in cases of active termination of life without an explicit request, as long as a series of requirements were met. Prins was acquitted and the Amsterdam Court of Appeal upheld the acquittal.\textsuperscript{34}

\textit{Prins} signaled a change in Dutch law, as the normal requirement that euthanasia be voluntary and at the request of the patient was not followed, resulting in the acceptance of non-voluntary euthanasia.\textsuperscript{35} The question of whether patient suffering is actually a necessary requirement to protect the physician assisting in suicide or performing euthanasia was addressed in the case of Dr. Philip Sutorius. In 1998 the general

\begin{thebibliography}{1}
\bibitem{33} \textit{Supra} note 10.
\bibitem{34} \textit{Supra} note 13 at 341.
\bibitem{35} \textit{Supra} note 10.
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practitioner Sutorius assisted Edward Brongersma, an 86 year-old former senator of the Labor Party, with his suicide. Brongersma suffered from no physical or mental ailment, but felt “sad and lonely” when he asked Sutorius to end his life. His reason for desiring death was concern about physical decline, a feeling that his existence was hopeless, and a general “tiredness of life”. The deceased claimed that death had “forgotten” him. Sutorius presented the opportunity to eliminate the suffering requirement from the list of conditions physicians must keep to avoid prosecution in cases of euthanasia or assisted suicide. The Amsterdam Court of Appeals declined to so rule, preserving the original suffering requirement. This decision is plainly at odds with one of the norms often cited as underlying the Dutch euthanasia jurisprudence, individual autonomy. If individuals are truly autonomous, the presence of suffering should not be a pre-condition for allowing them to terminate their lives.

For some years after euthanasia and assisted suicide had achieved the status of de facto legality in the Netherlands, little was known of the actual frequency of such medical behavior. In 1990 and 1995 national studies were undertaken to provide statistical data to address the question. What follows now is a discussion of the studies. In 1990 there were an estimated 25,100 requests made by patients for euthanasia or assisted suicide at a later time in the course of a disease. The results of the 1995 study estimate the number at 34,500, a 37% increase in requests from the 1990 estimate. In 1990 there were an estimated 8,900 explicit requests for euthanasia or assisted suicide at a particular time. The 1995 study estimated 9,700 such requests, a 9% increase from the 1990 figure. There was a clear increase in both generalized and concrete requests for euthanasia and assisted suicide from 1990 to 1995. The interview study revealed that 2,447 deaths, 1.9% of all deaths in the Netherlands in 1990, were attributable to euthanasia. The same method used in the 1995 study produced a number of 3,118 deaths via euthanasia, 2.3% of total deaths. The questionnaire method produced only slightly differing results: for 1990, 2,189 (1.7%) and for 1995, 3,253 (2.4%). Both methods in the two studies indicate that there was a steady growth in the number of deaths by euthanasia in the Netherlands.

36 Supra note 13 at 323.
from 1990 to 1995. The raw number of estimated euthanasia deaths increased 21.5% from 1990 to 1995. Assisted suicide in both 1990 and 1995 was much less common than euthanasia. The interviews yielded the following estimates for assisted suicide: 386, .3% of all deaths, in 1990; and 515, .4%, in 1995. The questionnaire method produced slightly lower estimates of .2% of total deaths for both years (with 258 in 1990, and 271 in 1995). There was little real increase in assisted suicides over the period covered in the studies. The most controversial activity studied was the ending of life without the patient’s explicit request. There is no data available for this in the 1990 interview study. The 1995 interview study estimated that 949, .7% of all deaths for that year, were a result of patients being killed without their request. The questionnaire study of the same year produced identical results, and the 1990 questionnaire study yielded that 1030, .8% of all deaths for that year, were of this category. This category, which is euthanasia without the voluntariness component, is roughly a third as more frequent as euthanasia i.e. the definition of euthanasia meeting the Dutch voluntary request condition (which includes assisted suicide). It is about twice as common as the category of assisted suicide. A category dwarfing all of the three mentioned above is death by the administration of a large dose of a palliative drug. The interview study of 1990 indicated that 20,992, 16.3% of all deaths, patients died in this fashion that year. The same method in 1995 produced an estimated 19,925, 14.7% of the 135,546 Dutch deaths that year. The questionnaire studies resulted in higher numbers for both 1990 and 1995. These figures were 24,212 (18.1% of all deaths), and 25,889 (19.1% of all deaths), respectively.38

The case law established the criteria by which physicians might be justified before the law in the performance of euthanasia and assisted suicide. The judicial acceptance of such practices caused difficulties in the way death is reported and non-natural death investigated. “The Law on the Disposal of Corpses requires that prior to burial or cremation . . . a doctor must attest that the death was attributable to a natural cause.” Normally, in cases where the death is clearly a result of a natural cause, the attending physician simply certifies it as such. If the deceased’s own physician cannot certify the death, he is obligated to report it to the municipal coroner, who in turn examines the

38 Ibid.
body. If the coroner also cannot certify the death as natural, he is required to refer the case to the prosecutor. This obviously puts the euthanasia-performing physician in an imposition, as he is not able to claim that the death is natural, thereby opening his actions to criminal investigation. The old system of reporting death presented a strong built-in incentive for physicians assisting in death to simply falsify death certificates and record euthanasia deaths as “natural.”

The Minister of Justice and the Royal Dutch Medical Association came to an agreement in 1990 which established a procedure for reporting in cases of euthanasia, assisted suicide, and termination of life without explicit request. The agreement, which created a new procedure that came into force in 1991, allayed some of the fears of prosecution for physicians engaging in life-terminating behavior. In return for this concession to the medical community, the government hoped to increase disclosure rates of euthanasia deaths, promote the adherence to “the requirements of careful practice,” and national uniformity in reporting. Under the agreed-upon procedure, the physician does not immediately issue a certificate of natural death in the case of assisted-death, but informs the coroner. The physician then completes a checklist mirroring the requirements of careful practice, and the coroner conducts a postmortem investigation and contacts the public prosecutor. “The public prosecutor makes the decision whether to permit burial or cremation... and presents an opinion to the prosecutor general.” The prosecutor general then has the option to present the case and his opinion of it to the College of Procurators General, which decides (subject to veto by the Minister of Justice) whether to prosecute the physician.

The Dutch Parliament simply adopted this procedure in the 1993 amendment to the Law on the Disposal of Corpses. The essential change offered in this legislation was in the amendment of Article 10, which previously had required a coroner unable to issue a death certificate to make a report to the prosecutor according to a form prescribed by the Minister of Justice. The amended Article 10 required that the form be prescribed by

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39 Supra note 13 at 39.
40 Supra note 10.
42 Ibid.
43 Supra note 13 at 309.
Order in Council which is submitted by a Minister and approved by the Government (Queen and Council of Ministers) upon consultation from the Council of State. A little over two weeks after the passage of the amended Article 10, an Order in Council was issued. The Order required the municipal coroner to issue a report to the prosecutor in cases of “suspected” euthanasia, assisted suicide or termination of life without explicit request. The reporting coroner must certify that he has received a written report from the responsible doctor which addresses all of the questions on the list of points requiring attention.44

The 1993 legislation and order set a common standard procedure for reporting of physician-assisted deaths; it did not have any effect on the explicit prohibition of euthanasia and assisted suicide contained in the Criminal Code. This claim that the Criminal Code was unaffected notwithstanding, Parliament’s codification of a reporting procedure for acts in violation of the Code demonstrates the extent to which the relevant Code articles were mere paper tigers.45 The law passed by the Dutch Parliament in 2002 that legalizes euthanasia and assisted suicide did not develop in a vacuum. As noted above, it was largely legislative adoption of judicially created exceptions to the Criminal Code. Although the courts provided the substance, there were several legislative proposals made in the last two decades.46 On March 15, 2002, the Termination of Life on Request and Assisted Suicide (Review Procedures) Act was made law. The law became effective as on April 1, 2002. It made significant amendments to the sections of the Criminal Code proscribing Euthanasia and assisted suicide.47 Article 293 now reads:

1. A person who terminates the life of another person at that other person’s express and earnest request is liable to a

44 Supra note 10.
45 Ibid.
46 The first such draft was the 1985 proposal of the State Commission on Euthanasia. It presented a new Article 292b, which provided that doctors who intentionally terminate the life of someone not able to express their will are not punishable if “the termination of life was performed by a doctor in the context of careful medical practice on a patient who, according to prevailing medical opinion, has permanently lost consciousness, and after treatment has been stopped because it was futile.” The Commission also proposed an amendment to Article 293 that would have prevented the punishment of doctors for euthanasia or assisted suicide that acted within the context of “careful medical practice” in the termination of the life of a patient in a situation of “hopeless necessity.” The proposal also detailed the conditions of “careful medical practice.” There were no substantive changes made to Article 294 and its prohibition on assistance with suicide. Supra note 13 at 314-316.
47 Supra note 10.
term of imprisonment of not more than twelve years or a fine of the fifth category.

2. The offence referred to in the first paragraph shall not be punishable if it has been committed by a physician who has met the requirements of due care as referred to in Article 2 of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act and who informs the municipal autopsist of this in accordance with Article 7 second paragraph of the Burial and Cremation Act. (Article 20-A of the Act).

Article 294 now reads:

1. A person who intentionally incites another to commit suicide, is liable to a term of imprisonment of not more than three years or a fine of the fourth category, where the suicide ensues.

2. A person who intentionally assist [sic] in the suicide of another or procures for that other person the means to commit suicide, is liable to a term of imprisonment of not more than three years or a fine of the fourth category, where the suicide ensues. Article 293 second paragraph applies mutatis mutandis. (Article 20 B of the Act).

In light of these amendments to the Criminal Code, physicians who engage in euthanasia or assisted suicide can avoid criminal sanction if they act in accordance with the requirements of due care and report the death in a proper manner. The requirements of due care are provided in section 1 of Article 2. The requirements of due care, referred to in Article 293 second paragraph Penal Code mean that the physician:

i. holds the conviction that the request by the patient was voluntary and well-considered,

ii. holds the conviction that the patient’s suffering was lasting and unbearable,

iii. has informed the patient about the situation he was in and about his prospects,

ibid.
iv. the patient hold the conviction that there was no other reasonable solution for the situation he was in,

v. has consulted at least one other, independent physician who has seen the patient and has given his written opinion on the requirements of due care, (referred above), and

vi. has terminated a life or assisted in a suicide with due care.49

Section 2 of Article 2 also addresses situations in which consent is problematic due to the incapacity or minority of the patient. Section 2 allows for “advanced directives,” whereby a previously written request for termination of life will be honored in cases where the patient is at least sixteen years of age and not capable of expressing his will on the matter. Somewhat counter-intuitively, the text does not require that the individual be sixteen years of age at the time of making a written request—only that in order to honor a written request the incapacitated patient must be at least sixteen at “the time of termination”. Minority per se will not result in the invalidation of a request; but the request must be made by one with a “reasonable understanding” of his interests.50

Sections 3 and 4 of Article 2 address concerns relating to minors and parental rights. Patients between the ages of sixteen and eighteen with a reasonable understanding of their interests may have a request for euthanasia honored after their parent(s) or guardian(s) have “been involved in the process.” For patients between age twelve and sixteen, the parent(s) or guardian(s) have an absolute right to veto their child’s decision to be euthanized. In order to meet the requirements of due care in such situations, the physician must be sure that the parental guardian(s) “agree” to the termination. An earlier Lower House draft of the bill contained an exception to the absolute parental veto for children between ages twelve and sixteen. This provision, which would allow a twelve-year old to choose euthanasia against the wishes of a parent, proved too controversial and was later removed by the Government.51

In the establishment of the Regional Review Committees52 for Termination of Life on Request and Assisted Suicide, the Act provides a framework for oversight of

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50 Supra note 10.
51 Ibid.
52 The Criminal Code of 1886, Article 3. Also see article 4, 8, 9, 10, 12, 14, 17, 21-A, 21-B and 21-C.
physician decisions to terminate life. If the committee issues an opinion that the requirements of due care were violated, the matter is referred to the College of Procurators General and the regional health care inspector. The ability to pursue criminal prosecution rests with the former, which will also create national uniformity in prosecution standards. With an understanding of the background to and substance of the new Dutch law, consideration of its validity under the Convention for the Protection of Human Rights and Fundamental Freedoms is now appropriate.\(^5\) Under the previous system, doctors had been reluctant to report their death-inducing activities. According to the Dutch government, the primary reason for changing the law was "to bring matters into the open, to apply uniform criteria in assessing every case in which a doctor terminates life, and hence to ensure that maximum care is exercised in such cases." This assumed that legalization would make doctors more forthcoming, more accurate and more careful.\(^4\) But that did not happen. In fact, Dutch doctors felt that the formalities contained in the new law were "too much fuss" and, consequently, fewer, not more, cases of physician-induced death were reported,\(^5\) leading to consideration of possible penalties for non-reporting.\(^6\) The official number of euthanasia cases in the Netherlands is on the rise, but not all cases of killing patients are included. The official report mentions only a few cases involving physicians who didn't follow the proper protocols when killing the patient. In 2003, in the Netherlands, 1626 cases were officially reported of euthanasia in the sense of a physician assisting the death (1.2% of all deaths). The ANP news service indicated the number of euthanasia cases rose to 2,120 in 2007 from 1,923 in 2006.\(^7\) Usually the sedative sodium thiopental is intravenously administered to induce a coma. Once it is certain that the patient is in a deep coma, typically after some minutes, Pancuronium is administered to stop the breathing and cause death. Officially reported were also 148 cases of physician assisted dying (0.14% of all deaths), usually by drinking a strong (10g) barbiturate potion. The doctor is required to be present for two reasons: (a) to make sure the potion is not taken by a different person, by accident (or, theoretically, by choice).\(^5\)

\(^5\) *Supra* note 10.


for "unauthorized" suicide or perhaps even murder) and (b) to monitor the process and be available to apply the combined procedure mentioned below, if necessary. By far, most reported cases concerned cancer patients. Also, in most cases the procedure was applied at home.58

The UN Human Rights Committee in 2001, discussed the issue of euthanasia and assisted suicide in the Netherlands. The Committee acknowledged that the new Act concerning review procedures on the termination of life on request and assisted suicide (which would come into force on 1 January 2002), was the result of extensive public debate addressing a very complex legal and ethical issue. It further recognized that the new law sought to provide legal certainty and clarity in a situation which had evolved from case law and medical practice over a number of years. The Committee was well aware that the new Act did not as such decriminalize euthanasia and assisted suicide. However, where a State party sought to relax legal protection with respect to an act deliberately intended to put an end to human life, the Committee believed that the Covenant obliged it to apply the most rigorous scrutiny to determine whether the State party's obligations to ensure the right to life were being complied with (Articles 2 and 6 of the Covenant).59 The inclusion of "due care" requirements transformed the crimes into medical treatments as physicians had advocated. Under the new law, minors between sixteen and eighteen may request that their lives be terminated and, although parents or guardians must be consulted, but they (parents) have no authority to prevent the requested death. Thus Children between the ages of twelve and sixteen may request euthanasia or assisted suicide but a parent or guardian must agree with the decision.60 In the first week of December 2004, the Netherlands, witnessed a major controversy over the issue of child euthanasia. The Groningen Academic Hospital said that with the permission of parents and independent doctors, it had carried out involuntary euthanasia on four severely disabled and terminally ill babies in 2003. This is known as neo-natal euthanasia

58 Supra note 10.
60 The Termination of Life on Request and Assisted Suicide (Review Procedure) Act, Chapter II. Due Care Criteria, Section 2.
or post-birth abortion. The hospital authorities defended their action pointing out that these babies had been born with such serious and incurable defects that the "most humane" action was to assist or allow them to die. Besides, parents and relatives end up doing this in secret anyway and so why not legalize it, they argued.\textsuperscript{61}

Euthanasia of children under the age of 12 remains technically illegal; however, Dr. Eduard Verhagen has documented several cases and, together with colleagues and prosecutors, has developed a protocol to be followed in those cases. Prosecutors will refrain from pressing charges if this Groningen protocol\textsuperscript{62} is followed.

Dutch death regulations require that euthanasia be strictly limited to the sickest patients, for whom nothing but extermination will alleviate overwhelming suffering — a concept in Dutch law known as force majeur. But once mercy killing was redefined as being good in a few cases rather than being bad in all circumstances, it didn't take long for the protective guidelines to be viewed widely as impediments to be overcome instead of important protections to be obeyed. Thus, supposedly ironclad protections against abuse — such as the doctrine of force majeur and the stipulation that patient give multiple requests for euthanasia — quickly ceased meaningfully to constrain mercy killing. As a consequence, Dutch doctors now legally kill terminally ill people who ask for it, chronically ill people who ask for it, disabled people who ask for it, and depressed people who ask for it.\textsuperscript{63}

Unlike their professional counterparts in other nations, Dutch physicians have led the way in permitting the practices — practices that illustrate how physician-advocacy of induced death can expand and be used to justify virtually unlimited euthanasia and


\textsuperscript{62} The Groningen Protocol was promulgated in 2005 and established a set of guidelines to be followed for the purpose of euthanizing infants in the Netherlands. The Groningen Protocol was based on reports from Dutch physicians concerning the deaths of 22 infants who were born with spina bifida. Dutch physicians were not being prosecuted when they euthanized newborns with spina bifida based on the Prins case in 1997. Prins was a physician who escaped prosecution after he euthanized an infant with spina bifida. The Groningen Protocol allows euthanasia of infants when the parents give consent and when the child is considered to lack an "acceptable" quality of life. These decisions are made based on quality-of-life judgements that are connected to the new eugenics ideology promoted by Peter Singer of Princeton University that is becoming more prevalent in our current culture. Alex Schadenberg, "Troubling trends on euthanasia in Europe". Available at www.theinterim.com/2008/june/15euthanasia.html (Accessed on 15.3.09).

assisted suicide. Because the list of those "eligible" has steadily lengthened, to the point that it now includes depressed people without organic illness. And now, the Dutch government has opened the legal door to killing patients with Alzheimer's disease. In doing so, the nation sent a powerful message to Alzheimer's patients and their families: The lives of those with this dreaded disease are so burdensome and undignified that they are not worth maintaining or protecting. Thus in course of time the nation has moved from assisted suicide to euthanasia, from euthanasia of people who are terminally ill to euthanasia of those who are chronically ill, from euthanasia for physical illness to euthanasia for mental illness, from euthanasia for mental illness to euthanasia for psychological distress or mental suffering, and from voluntary euthanasia to involuntary euthanasia or as the Dutch prefer to call it "termination of the patient without explicit request". Therefore there is the question of the slippery slope, which has been the Dutch experience i.e. involuntary euthanasia being carried on in the name of voluntary euthanasia.

Despite this carnage, Dutch doctors are very rarely prosecuted for such crimes, and the few that are brought to court are usually exonerated. Moreover, even if a doctor is found guilty, he or she is almost never punished in any meaningful way, nor does the murderer face discipline by the Dutch Medical Society.

To conclude, the Netherlands, in particular, has been subjected to a relentless campaign of vilification. Critics allege that the legalization of voluntary euthanasia has led to a breakdown of trust in the medical profession and all sorts of other dire consequences. But if these allegations are true, no one has told the Dutch. Despite a change of government in the Netherlands since voluntary euthanasia was legalized in

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64 Wesley J. Smith, “Compassion or Callous - Assisted suicide undermines our essential humanity”. Available at www.discovery.org/a/2076 (Accessed on 25.2.09).
66 Ibid.
67 Ibid note 63.
68 The government in power, The Purple Coalition, which lasted until 2002, introduced legislation on abortion, euthanasia (The Termination of Life on Request and Assisted Suicide (Review Procedures) Act, 2002) and gay marriage. The Purple coalition also marked a period of remarkable economic prosperity. The Purple coalition parties together lost their majority in the 2002 elections due to the rise of Pim Fortuyn List, the new political party led by the flamboyant populist Pim Fortuyn. Visit en.wikipedia.org/wiki/Politics_of_the_Netherlands. (Accessed on 18.10.09).
2002, no effort has been made to repeal the measure. There is simply no public support for such a move.\textsuperscript{69} 

In publishing its procedures for pediatric euthanasia, the medical center explained that the "approach suits our legal and social culture," although it acknowledged that it was "unclear to what extent it would be transferable to other countries."\textsuperscript{70} The Dutch say that know how voluntary euthanasia is practiced in their country, they know that legal euthanasia has improved, rather than harmed, their medical care, and they want the possibility of assistance in dying, if they should want and need it. Is that a choice that everyone should have?\textsuperscript{71} Killing is sold to the public as a last resort justified only in cases where nothing else can be done to alleviate suffering. But once the reaper is allowed through the door, the categories of killable people expand steadily toward the acceptance of death on demand.\textsuperscript{72}

\subsection*{5.2.2 Holland}

On April 10, 2001, a Dutch law permitting both euthanasia and assisted suicide was approved that went to effect on April 1, 2002.\textsuperscript{73} The law provides that:

1. The physician "has terminated a life or assisted suicide with due care." The requirement that the procedure be carried out in a medically appropriate fashion transforms the crimes of euthanasia and assisted suicide into medical treatments.\textsuperscript{74}

2. Specifically allows euthanasia for incompetent patients. Persons 16 years old and older can make an advance "written statement containing a request for termination of life" which the physician may carry out. The written statement need not be made in conjunction with any particular medical condition. It could be a written statement made years before, based upon views that may have changed. The physician could administer euthanasia based on the prior written statement.\textsuperscript{75}

\textsuperscript{69} Peter Singer, “Right to Die”. Available at www.utilitarian.net/singer/bye/200701--.htm (Accessed on 23.3.09).
\textsuperscript{71} Visit en.wikipedia.org/wiki/Politics_of_the_Netherlands (Accessed on 18.10.09).
\textsuperscript{72} Supra note 63.
\textsuperscript{73} Supra note 10.
\textsuperscript{74} Ibid.
\textsuperscript{75} Ibid.
(3) Teenagers 16 to 18 years old may request and receive euthanasia or assisted suicide. A parent or guardian must "have been involved in decision process," but need not agree or approve.76

(4) Children 12 to 16 years old may request and receive euthanasia or assisted suicide. A parent or guardian must "agree with the termination of life or the assisted suicide."77

(5) A person may qualify for euthanasia or assisted suicide if the doctor "holds the conviction that the patient's suffering is lasting and unbearable." There is no requirement that the suffering be physical or that the patient be terminally ill.78

(6) II oversight of euthanasia and assisted suicide will be done by a "Regional Review Committee for Termination of Life on Request and Assisted Suicide" after the death of the patient. Each regional committee will be made up of at least 1 legal specialist, 1 physician and 1 expert on ethical or philosophical issues. An expert in "philosophical issues" is one who has expertise regarding the "discussion on the prerequisites for a meaningful life."79

(7) The burden of proof is on the prosecutor who will be required to show that the termination of life did not meet the requirements of due care. The prosecutor will not receive information about any euthanasia death unless it is forwarded by a Regional Committee.80

The UN Human Rights Committee (2001) stated that the studies have demonstrated a disturbingly high incidence of euthanasia being carried out in Holland without the patient’s explicit request and an equally disturbing failure by medical professionals to report euthanasia cases to the proper regulatory authority.81

5.2.3 Belgium

For some time, there was no formal registration and authorization procedure for the end-of-life decisions in medical practice in Belgium. Although euthanasia was illegal and

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76 Ibid.
77 Ibid.
78 Ibid.
79 Ibid.
80 Ibid.
81 Supra note 49 at 459.
was treated as intentionally causing death under criminal law, prosecutions were exceptional and generally speaking, the practice of euthanasia was tolerated.  

On 28 May 2002, The Belgium Act on Euthanasia was passed that entered into force on 23 September 2002. Section 2 defines euthanasia as ‘intentionally terminating life by someone other that the person concerned at the latter’s request’. Section 3(1) provides that the physician who performs euthanasia commits no criminal offence when he/she ensures that (i) (a) the patient has attained the age of majority or is an emancipated minor and is legally competent and conscious at the moment of making he request, (b) the request is voluntary, well-considered and repeated and is not the result of any external pressure, (c) the patient is in a medically futile condition of constant and unbearable physical or mental suffering that cannot be alleviated, resulting from a serious and incurable disorder caused by illness or accident, (ii) and when he/she has respected the conditions and procedures provided in this Act. Section 3(2) prescribes the other conditions to be fulfilled by the physician before carrying out euthanasia in each case:

1. inform the patient about his/her health condition and life expectancy, discuss with the patient his/her request for euthanasia and the possible therapeutic and palliative courses of action and their consequences.

2. Be certain of the patient’s constant physical or mental suffering and of the durable nature of his/her request.

3. Consult another physician about the serious and incurable character of the disorder and inform him/her about the reasons for this consultation.

4. if there is a nursing team that has regular contact with the patient, discuss the request of the patient with the nursing team or its members.

5. if the patient so desires, discuss his/her request with relatives appointed by the patient.

6. be certain that the patient has had the opportunity to discuss his/her request with the persons that he/she wanted to meet.

84 Ibid.
85 Ibid.
According to section 3(3), if the physician believes that patient is clearly not expected to die in the near future, he/she must also consult a second physician, who is a psychiatrist or a specialist in the disorder in question and inform him/her of the reasons for such a consultation. The physician consulted reviews the medical record, examines the patient and must be certain of the constant and unbearable physical or mental suffering that cannot be alleviated and of the voluntary, well-considered and repeated character of the euthanasia request. The physician consulted reports on his/her findings. The physician consulted must be independent of the patient as well as of the physician initially consulted. The physician informs the patient about the result of this consultation. The physician must allow at least one month between the patient’s request and the act of euthanasia.\textsuperscript{86}

Section 3(4) further provides that the patient’s request must be in writing. The document is drawn up, dated and signed by the patient himself/herself. If the patient is not capable of doing this, the document is drawn up by a person designated by the patient. This document must be annexed to the medical record. The patient may revoke his/her request at anytime in which case the document is removed from the medical record and returned to the patient.\textsuperscript{87}

Section 3(5) provides that all the requests formulated by the patient, as well as any action by the attending physician and their results, including the reports of the consulted physician are regularly noted in the patient’s medical record. Section 4 in Chapter II deals with Advance Directives i.e. in cases where one is no longer able to express one’s will, every legally competent person of age, or emancipated minor can draw up an Advance Directive instructing a physician to perform euthanasia if the physician ensures the existence of certain prescribed circumstances.\textsuperscript{88}

5.2.4 Luxembourg

Following the footsteps of the Netherlands and Belgium, Luxembourg Parliament adopted a law decriminalizing euthanasia on 19 February 2008. It permits euthanasia in certain circumstances. These are: the patient must be in a terminal condition, the patient must be in unbearable pain with no hope for improvement in their condition, the patient

\textsuperscript{86} Ibid.
\textsuperscript{87} Ibid.
\textsuperscript{88} Ibid.
must make a voluntary request, the patient's doctor must consult with another doctor, a
living will which must be lodged with the Direction de la Sant.\textsuperscript{89}

5.2.5 Switzerland

The practice of assisted suicide in Switzerland has led many people to believe that
the practice has been legalized in that country. That is not the case. There is an important
distinction between the Swiss situation and that of the Netherlands and Belgium where
the law considers euthanasia and/or assisted suicide to be "medical treatment."\textsuperscript{90}

According to Swiss law\textsuperscript{91},

\begin{quote}
Whoever, from selfish motives, induces another to commit
suicide or assists him therein shall be punished, if the
suicide was successful or attempted, by confinement in a
penitentiary for not more than five years or by
imprisonment.
\end{quote}

The key words are "from selfish motives." Thus, in Switzerland, there is no
prosecution if the person assisting a suicide successfully claims that he is acting
unselfishly. While this results in de facto legalization, assisted suicide is not legal, only
unpunishable, unless a selfish motive is proven. Thus Switzerland has tolerated assisted
suicide for many years. Suicide groups have been assisting suicide within Switzerland
based on a legal interpretation of their 1918 suicide law. In other words, Switzerland
never legalized assisted suicide, but tolerates the practice based on a legal
interpretation.\textsuperscript{92}

Only Switzerland allows foreigners to make use of their clinics, which has given rise
to the morbid industry of "death tourism" in the country.\textsuperscript{93} Swiss charity "Dignitas" was
founded in 1998 and has helped hundreds of people across Europe to commit suicide.
Thus, it is a suicide facilitating organization and takes advantage of Switzerland's liberal
laws on assisted suicide which suggest that a person can be prosecuted only if they are

\textsuperscript{89} Visit http://www.station.lu/edito-9306-details-of-new-law-on-euthanasia.html - 25k (Accessed on
2.1.11).
\textsuperscript{90} Supra note 10.
\textsuperscript{91} The Penal Code of Switzerland, Article 115.
\textsuperscript{92} Alex Schadenberg, "Troubling trends on euthanasia in Europe". Available at www.theinterim.com /2008
\textsuperscript{93} Jenna Murphy, John Jalsevac, “Assisted Suicide Gains Ground in British Courts”, 13 June 2008.
acting out of self interest. Campaigners see the absence of a complete ban on assisted suicides as tacit permission to proceed - although their stance has never been tested in the Swiss courts. Live with dignity, die with dignity” is the slogan of Dignitas. The charity is run by lawyer Ludwig Minelli, who believes that he is helping people “die with dignity.” He plans to create sort of a Starbucks for suicide: a chain of death centers "to end the lives of people with illnesses and mental conditions such as chronic depression." He believes that all suicidal people should be given information about the best way to kill themselves, and, according to him , "if they choose to die, they should be helped to do it properly." Dignitas admits to having assisted the suicides of many people who were not terminally ill. The story about Minelli illuminates a deep ideological belief within the euthanasia movement: that we own our bodies, and thus, determining the time, manner, and method of our own deaths, for whatever reason, is a basic human right.94 The Dignitas clinic has now changed its suicide technique from the use of a prescription to that of the plastic bag with helium (an exit bag). The clinic is known for its encouragement of suicide tourists from countries around the world where euthanasia is not permitted or tolerated, who go to Switzerland to die. It is estimated that two out of three people who die at their suicide clinic are suicide tourists. Minelli has stated that they have changed their technique to eliminate the need for a physician to agree to assisting the death, because even many physicians who support assisted suicide would often refuse to write lethal prescriptions for people who weren’t dying or suffering.95

There is another organization called “Exit” which is far more serious and accepted in Switzerland for assisted suicide.96

The Zurich Declaration issued at the 1998 Bi-annual Convention of World Federation of Right to die Societies97 states:

We believe that we have a major responsibility for ensuring that it becomes legally possible for all competent adults,

95 Supra note 53.
96 Supra note 1 at 47.
97 The WFRD is an umbrella group made up of 37 national euthanasia advocacy organizations, including Compassion and Choices and Hemlock founder Derek Humphry's Euthanasia Research and Guidance Organization (or ERGO). Available at www.weeklystandard.com/Content/Public/Articles/000/.../124abkbr.asp (Accessed on 6.6.12).
suffering severe and enduring distress, to receive medical help to die, if this is their persistent, voluntary and rational request. Such medical assistance is already permitted in the Netherlands, Switzerland and Oregon (USA). It should also be noted that, one need not be dying or even sick to experience severe and enduring distress. 98

In Europe, the euthanasia lobby is becoming bolder and more extreme. They have let go of their traditional anthems of voluntary euthanasia for the competent and suffering to that of language that would lead to euthanasia as a human right. 99

5.2.6 United Kingdom (UK)

Before 1961, suicide was regarded as a felony in England. It was a crime to commit suicide. A person who had met his end after committing suicide was not allowed Christian burial, but would have to be so done in a public highway. Not only this. The property of the person concerned used to get forfeited to the crown. Attempted suicide was a misdemeanour and anyone who attempted it and failed could be prosecuted and imprisoned, while the families of those who succeeded also could potentially be prosecuted. 100 In part, that reflected religious and moral objections to suicide as self-murder (felonia de se). Augustine and Thomas Aquinas had formulated the view that whoever deliberately took away the life given to them by their Creator showed the utmost disregard for the will and authority of God and jeopardised their salvation, encouraging the Church to treat suicide as a sin. However, prosecutions for assisting suicide in UK are rare. 101 However, the Suicide Act, 1961 specifically decriminalizes suicide and attempt to suicide. Section 1 of the Act reads: “The rule of law whereby it is a crime for a person to commit suicide is hereby abrogated.” In English law ‘mercy-kilings’ under the Homicide Act, 1957, are treated as manslaughter. Section 4 of the Act reads:

It shall be manslaughter, and shall not be murder, for a person acting in pursuance of a suicide pact between him

98 Supra note 94.
100 Louis Bloom Cooper, Gravin Drewry, Law and Morality, 201-207 (1976).
Section 2(1) of the Suicide Act, 1961 imputes criminal liability for complicity in another’s suicide. It reads:

A person who aids, abets, counsels or procures the suicide of another, or an attempt by another to commit suicide, shall be liable on conviction on indictment to imprisonment for a term not exceeding fourteen years.\textsuperscript{102}

Thus, U.K. citizens cannot obtain assisted suicide, and must move out of the country to do so. But, it should be noted that there is a strong movement for legalizing assisted suicide in the country. It should be noted that the principles followed by English and American Courts regarding the right to personal autonomy and self-determination have already been discussed in chapter 4. The following cases will elaborate those principles.

\textit{Airedale NHS Trust v. Bland}\textsuperscript{103} caused a great deal of hue and cry, especially in the media. The House of Lords allowed for the withdrawal of feeding tubes in spite of the fact that the patient was neither brain-dead nor was he on artificial respirators. Anthony Bland was diagnosed as being in a persistent vegetative state and the doctors affirmed no chance of recovery. It was accordingly with the concurrence of Bland’s family, as well as the consultant in charge of his case and the support of two independent doctors, that the Airedale N.H.S. Trust as plaintiff in this action applied to the Family Division of the High Court for declarations that they might lawfully discontinue all life-sustaining treatment and medical support measures designed to keep Bland alive in his existing persistent vegetative state including the termination of ventilation nutrition and hydration by artificial means; and lawfully discontinue and thereafter need not furnish medical treatment to Bland except for the sole purpose of enabling Bland to end his life and die peacefully with the greatest dignity and the least of pain suffering and distress. After a hearing, the President of the Family Division declined to make the declarations sought. The Official Solicitor, acting on behalf of Anthony Bland, appealed against that decision to the Court of Appeal, who dismissed the appeal. With the leave of the Court of Appeal,


\textsuperscript{103} 1993 (2) W.L.R. 316 (H.L.). Available at http://www.worldlii.org/uk/cases/UKHL (Accessed on 20.10.09).
the Official Solicitor appealed to the House of Lords. The House of Lords too dismissed the appeal. However, in the context of existence in the persistent vegetative state of no benefit to the patient, the principal of sanctity of life, which is the concern of the state, was stated to be not an absolute one. Distinction between the cases in which a physician decides not to provide, or to continue to provide, for his patient, treatment or care which could or might prolong his life, and those in which he decides, for example, by administering a lethal drug, actively to bring his patient's life to an end, was indicated and it was then stated as under:

But it is not lawful for a doctor to administer a drug to his patient to bring about his death, even though that course is prompted by a humanitarian desire to end his suffering, however great that suffering may be: see Reg. v. Cox (unreported), 18 September, 1992. So to act is to cross the Rubicon which runs between on the one hand the care of the living patient and on the other hand euthanasia - actively causing his death to avoid or to end his suffering. Euthanasia is not lawful at common law. It is of course well known that there are many responsible members of our society who believe that euthanasia should be made lawful but that result could, I believe, only be achieved by legislation which expresses the democratic will that so fundamental a change should be made in our law and can, if enacted, ensure that such legalized killing can only be carried out subject to appropriate supervision and control.104

It was further held that:

Sanctity of life entails its inviolability by an outsider. Subject to exceptions like self-defence, human life is inviolate even if the person in question has consented to its violation. That is why although suicide is not a crime,

104 Id. at 368.
assisting someone to commit suicide is. It follows that even if we think Anthony Bland would have consented, we would not be entitled to end his life by a lethal injection.\(^{105}\)

It was for the legislature to bring about a change by enacting a suitable law providing sufficient safeguards to prevent any possible misuse. In *St. George’s Healthcare NHS Trust v. S*\(^{106}\) it was held that a person has the right to refuse life-sustaining treatment as part of his rights of autonomy and self-determination. A competent patient cannot be compelled to undergo life-saving treatment.\(^{107}\)

In *Cox*\(^ {108}\) a doctor injected a lethal amount of potassium chloride in order to kill a patient who was suffering intense pain from rheumatoid arthritis. The expert opinion was that the drug shortened life and otherwise had no analgesic value. The jury convicted Dr. Cox of attempted murder. His prosecution involved a number of elements which made it unusual: the patient was not terminally ill; the drugs injected were non-therapeutic; their sole effect was to kill; Cox could not argue that his purpose was to relieve pain. Despite his conviction it is noticeable that the consequences for him were limited. He was lucky to face the charge of attempted murder and not murder. Further, the General Medical Council admonished him, but only on the grounds that although he had acted in good faith he had not lived up to the high standards expected of the medical profession. His regional health authority continued to employ him subject to certain restrictions.\(^{109}\)

After these cases, the House of Lords set up a Select Committee on Medical Ethics to investigate the related issues surrounding medical treatment decisions at the end of life. The committee received extensive evidence and in the report, it drew a distinction between assisted suicide and physician assisted suicide but its conclusion was unambiguous:

> As far as assisted suicide is concerned, we see no reason to recommend any change in law. We identify no circumstances in which assisted suicide should be

\(^{105}\) *Airedale NHS Trust v. Bland* (1993) 1 All ER 821 at 855.

\(^{106}\) (1998) 3 All ER 673.

\(^{107}\) *Supra* note 49 at 482.


\(^{109}\) *Supra* note 49 at 428.
permitted, nor do we see any reason to distinguish between the act of a doctor or any other person in this connection.110

The Government in its response111 accepted this recommendation:

The Government can see no basis for permitting assisted suicide. Such a change would be open to abuse and put the lives of the weak and vulnerable at risk.”112

Therefore assisted suicide continued to be a crime under the English Law. For example, in October 2000, Nigel Pratten, who was suffering from the degenerative brain condition Huntington’s disease, took a dose of heroin on his 42nd birthday with the help of his mother Heather Pratten, and then sank into a coma. She was convicted of helping her son to die but given a conditional discharge on humanitarian grounds.113

However, a couple of years later came Dianne Pretty’s114 case. Pretty had been diagnosed with motor neurone disease several years before. Over time, the disease worsened and made it impossible for her to move or communicate easily even though her mental faculties remained normal. The illness resulted in her having to be looked after round the clock by her husband and nurses, meaning that she could not take her own life, which she had said she would do if she was able to. She stated a wish that her husband should be able to assist her in ending her life to which he agreed, but this would be classed as assisted suicide under section 2 (1) of the Suicide Act, 1961. Under section 2(4), no such prosecution could be instituted without Director of Public Prosecutions’s (DPP) consent. After DPP refused to provide the undertaking sought, Pretty applied for judicial review, seeking a declaration that the refusal was unlawful since it infringed

110 Thus, it recommended not to legalize assisted suicide. It stated that competent patients had every right to refuse treatment whereas the incompetent also had the right to be protected from aggressive over treatment to which the competent would object. It also recommended that adequate pain relief should be used even if this shortened life, and high quality palliative care should be made more widely available. The report also supported the use of living wills or advance directives, which set out the types of treatment that the patient would or would not accept in certain circumstances. HL Paper (1993-1994) 21-I. Cited in The Queen on the Application of Mrs. Dianne Pretty (Appellant) v. Director of Public Prosecutions (Respondent) and Secretary of State for the Home Department (Interested Party) (2002) 1 All ER at 17.

111 Government Response to the Report of the Select Committee on Medical Ethics, Cm 2553 (1994). Cited in The Queen on the Application of Mrs. Dianne Pretty (Appellant) v. Director of Public Prosecutions (Respondent) and Secretary of State for the Home Department (Interested Party) (2002) 1 All ER at 17.

112 Ibid.


certain of her rights under the European Convention for the Protection of Human Rights and Fundamental Freedoms, 1950 (as set out in Sch-1 to the Human Rights Act, 1998). Alternatively, she sought a declaration that section 2 (1) of the 1961 Act was incompatible with those rights in so far as it imposed a blanket prohibition on assisted suicide. She relied on the right to life under Article 2 of the convention (on the basis that it protected a person’s right to self-determination in relation to issues of life and death); the prohibition against inhuman or degrading treatment in Article 3 (on the basis that DPP’s refusal subjected her to such treatment), the right to respect for private and family life in Article 8 (on the basis that it recognized the personal autonomy of every individual and therefore necessarily involved a guarantee as against the state of a right to choose when and how to die); the right to freedom of thought under Article 9 (on the basis that it entitled her to manifest her belief in assisted suicide by committing it); and the prohibition by Article 14 of discrimination in the enjoyment of convention rights (on the basis that she was treated less favourably than those who were physically capable of ending their lives). The Divisional Court dismissed the application on the merits, but held that in any event the DPP’s decision was not amenable to judicial review. Pretty appealed to the House of Lords. The House of Lords held:

(a) A refusal by the DPP to give an undertaking not to prosecute was not amenable to judicial review in the absence of dishonesty, malafides or exceptional circumstances. In the instant case, however, there were such circumstances. It did not concern a straightforward situation in which a person sought an assurance after the event that he would not be prosecuted. It was therefore no answer for Pretty to be told that the matter should be dealt with at a criminal trial or on appeal. There would be no criminal trial in which the issue as to whether the DPP was acting compatibly with her convention rights could be tested. Accordingly, it was open to her to raise the issue by judicial review.

(b) Nevertheless, the appeal would be dismissed for the various reasons. The convention did not oblige a state to legalize assisted suicide. Article 2 did not acknowledge that it was for the individual to choose whether to live or die and it did not protect a right of

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115 The Queen on the Application of Mrs. Dianne Pretty (Appellant) v. Director of Public Prosecutions (Respondent) and Secretary of State for the Home Department (Interested Party) [2001] UKHL 61; (2002) 1 All ER.

116 Id. at 31-45 (para 67, 77, 78 and 124)
self-determination in relation to issues of life and death. Rather, it enunciated the principle of the sanctity of life and provided a guarantee that no individual should be deprived of life by means of intentional human intervention. That was the exact opposite of a right to end life means of intentional human intervention.\textsuperscript{117} Nor was article 3 engaged. The concept that no person should be subjected to inhuman or degrading treatment was singularly inapt to convey the idea that the state had to guarantee to individuals a right to die with the deliberate assistance of third parties. Further, it was doubtful whether the consequences of refusing to give the undertaking would attain the required minimum level of severity of ill treatment in view of the palliative care available to Pretty. Moreover, ‘treatment’ should not be given an unrestricted or extravagant meaning, and it could not plausibly be suggested that the DPP was inflicting inhuman or degrading treatment on Pretty, whose suffering derived from her disease. As regards article 8, it prohibited interference with the way in which an individual led his life and did not relate to the manner in which he wished to die. Nor was article 9 intended to give individuals a right to prfor any acts in pursuance of whatever beliefs they might hold.\textsuperscript{118} Similarly, article 14 did not assist Pretty. Although that provision was capable of extending to discrimination in the enjoyment of convention rights on the grounds of physical or mental capacity, Section 2(1) of the 1961 Act did not treat individuals in a discriminatory manner. The 1961 Act conferred no right to commit suicide, and there was no unequal treatment before the law in respect of the offence under section 2(1). The majority of the terminally ill individuals would be vulnerable, and it was the vulnerability of that class of persons which provided the rationale for making the aiding and abetting of suicide an offence under section 2(1). In any event, Pretty’s case did not engagae any convention right or freedom to which article 14 could be attached. Even if convention rights were engaged, section 2(1) struck the right balance between the rights of individuals and the public interest which sought to protect the weak and vulnerable. It was proportionate response for Parliament to conclude that the state’s interest in

\textsuperscript{117} Id. at 2-3.
\textsuperscript{118} Ibid.

215
protecting the lives of its citizens could only be met by complete prohibition on assisted suicide.\textsuperscript{119}

Diane Pretty died aged 43 on May 11, 2002, as her health had deteriorated over the last several months due to a series of lung and chest problems. Because of its unusual nature, the case had been in the headlines for months and if Ms. Pretty had won her plea it would have been a huge victory for the proponents of the idea of right-to-die with dignity. Since then several attempts to legalize assisted suicide in the UK have been rejected.\textsuperscript{120}

In February 2003, Lord Joel Goodman Joffe proposed as a Private Member's Bill, the "Assisted Dying for the Terminally Ill Bill", which would legalise physician assisted suicide. The bill aimed to enable a competent adult who is suffering unbearably as a result of a terminal illness to receive medical assistance to die at his own considered and persistent request; and to make provision for a person suffering from such a condition to receive pain relief medication.\textsuperscript{121} This Act does not extend to Northern Ireland. Section 1 of the Bill provided:

1. Authorization of assisted dying.

Subject to the provisions of this Act, it shall be lawful for:

(a) a physician to assist a patient who is a qualifying patient to die,

(i) by prescribing such medication, and

(ii) in the case of a patient for whom it is impossible or inappropriate orally to ingest that medication, by prescribing and providing such

\textsuperscript{119} Ibid
\textsuperscript{120} However, soon after Diane Pretty's move to the European Court of Human Rights, another case came up, in which a British woman paralyzed from the neck down won the right to die. The 43-year-old social worker, who was not named for legal reasons, was given the court decision by video link to her hospital bed that she could effectively sign her own death sentence. The ruling followed a growing clamor by patients to put their own rights first — ahead of doctors and the law — and to decide for themselves when it is time to die. Doctors at the hospital treating her had said it was against their ethics to switch off the machine needed to keep her alive. It was the first time in Britain that someone considered to be in control of her full mental faculties had asked doctors to switch off life support in this way. In other cases, doctors had asked courts to sanction the switch off for people in a permanent vegetative state. The Tribune, March 24, 2002. Available at www.sanfords.net/Newsletter/Vol5.htm (Accessed on 1.12.12).
\textsuperscript{121} Visit www.cmf.org.uk/publicpolicy/end-of-life/joffe-bill/(Accessed on 5.7.12).
means of self-administration of that medication, as will enable the patient to end his own life, and
(b) a person who is a member of a health care team to work in conjunction with a physician to whom paragraph (a) of this section applies.

On 9 November 2005, Lord Joffe reintroduced his “Assisted Dying for the Terminally Ill Bill” into the House of Lords in a form which would legalize assisted suicide but not euthanasia. On 12 May 2006, the Bill was debated once again in the House of Lords; but it was rejected in the House of Lords, however, by 148 votes to 100.122

The British Medical Association is opposed to the legalization of euthanasia.123 Doctors at the BMA’s annual meeting in Belfast voted by 65 per cent to 35 per cent against physician-assisted suicide and voluntary euthanasia being made legal. More than 90 per cent opposed the legalization of non-voluntary euthanasia for patients who are not mentally competent to make a decision. Just over 80 per cent approved a proposal that, if euthanasia were to be legalized, there should be a clear demarcation between doctors who would be involved in it and those who would not. Doctors said that legalization of assisted dying would put terminally ill patients under increasing pressure to end their lives and their greatest fear was becoming an emotional and financial burden to their families. Therefore, right to die will become a duty to die, a duty to unburden their families. The Royal College of General Practitioners, which represents some 23,000 members, is of the view, that with current improvements in palliative care, good clinical care can be provided within existing legislation and that patients can die with dignity. A change in legislation is not needed. The Royal College of Nursing holds a similar view. In other words, doctors fear that the right to die will become a duty to die.124

In 2008, a British woman Debbie Purdy from Bradford, West Yorkshire, with multiple sclerosis was granted her request for a full judicial review in her quest to find out if her husband can help her commit suicide without fear of being prosecuted under

122 Ibid.
2(1) of the Suicide Act, 1961. Purdy, 45, said that she feared that her husband would be prosecuted if she chose to end her life with his assistance in Switzerland, where assisted suicide is legal. Purdy is currently a member of Switzerland's "Dignitas" group, which specializes in administering lethal doses of barbiturates to those who wish to die. She said that knowing whether or not Puente would be prosecuted will allow her to live longer. Purdy told that if she found out that her husband might be prosecuted she would have to kill herself sooner, before her condition degenerates to the point where she would need Puente's assistance.

This was a judicial review case in which the applicant sought to have the decision of the Director of Public Prosecutions declared invalid. She brought the case as the Director of Public Prosecutions, Sir Ken Macdonald, QC, had decided, contrary to her request, not to issue specific policy guidelines on the circumstances in which prosecutions for assisted suicide were likely. She argued that lack of proper guidance was a failure of an obligation on the DPP to provide clear law, and was a failure that infringed her right to private and family life under Article 8 of the European Convention on Human Rights. The proceedings were a claim for judicial review and a claim under the Human Rights Act, 1998.

However, the Divisional Court consisting of Scott Baker LJ. and Aikens J. held that Purdy’s rights under Article 8 of the European Convention on Human Rights were not infringed. Accordingly, her claim of breach of Article 8 of ECHR failed. It was further held that:

We cannot leave this case without expressing great sympathy for Ms Purdy, her husband and others in a similar position who wish to know in advance whether they will face prosecution for doing what many would regard as something that the law should permit, namely to help a loved one to go abroad to end their suffering when they are unable to do it on their own. This would involve a change

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126 Ibid.
127 Ibid.
in the law. The offence of assisted suicide is very widely
drawn to cover all manner of different circumstances; only
Parliament can change it.\textsuperscript{128}

The court however, gave Purdy permission to appeal its decision. The House of
Lords however allowed the appeal.\textsuperscript{129} Lord Hope opined that at the outset that it is no part
of their function to change the law in order to decriminalise assisted suicide. If changes
are to be made, this must be a matter for Parliament. Judges should not venture into that
arena, nor would it be right for them to do so. Their function as judges is to say what the
law is and, if it is uncertain, to do what they can to clarify it. Ms Purdy wants to be able
to make an informed decision as to whether or not to ask for her husband’s assistance.
She is not willing to expose him to the risk of being prosecuted if he assists her. But the
Director had declined to say what factors he will take into consideration in deciding
whether or not it is in the public interest to prosecute those who assist people to end their
lives in countries where assisted suicide is lawful. This presented her with a dilemma. If
the risk of prosecution was sufficiently low, she could wait until the very last moment
before she made the journey. If the risk was too high she will have to make the journey
unaided to end her life before she would otherwise wish to do so. Moreover she was not
alone in finding herself in this predicament. Statements have been produced showing that
others in her situation have chosen to travel without close family members to avoid the
risk of their being prosecuted. Others have given up the idea of an assisted suicide
altogether and have been left to die what has been described as a distressing and
undignified death. It is patently obvious that the issue is not going to go away.\textsuperscript{130} The

\textsuperscript{129} R (on the application of Purdy) (Appellant) v Director of Public Prosecutions (Respondent), [2009]
\textsuperscript{130} For example, final moments in the life of 59-year-old Briton Craig Ewert were shown on TV in
December 2008 as he takes a lethal dose of sedatives under medical supervision. It was a controversial
documentary, titled “Right to Die?.” The father-of-two had been diagnosed with motor neurone disease -- a
rare condition caused by the breakdown of nerve cells in the brain that control the muscles -- five months
before his death at Swiss euthanasia clinic, Dignitas. He decided that he didn't want to continue suffering as
a prisoner in his own body. Prime Minister Gordon Brown, on being questioned in the House of Commons,
hours before the documentary was screened, told the MPs: "I think it is very important that these issues are
dealt with sensitively and without sensationalism and I hope broadcasters remember that they have a wider
responsibility to the general public." He further explained his position: “I believe that it’s necessary to
ensure that there is never a case in the country where a sick or elderly person feels under pressure to agree
to an assisted death or somehow feels it’s the expected thing to do. That’s why I’ve always opposed
House of Lords allowed the appeal and required the Director to promulgate an offence-specific policy identifying the facts and circumstances which he will take into account in deciding, in a case such as that which Ms Purdy’s case exemplifies, whether or not to consent to a prosecution under section 2(1) of the 1961 Act.\(^{131}\)

In response to Debbie Purdy’s case, the Director of Public Prosecutions issued assisted suicide guidelines in 2010 as follows\(^{132}\):

a. The case of *Purdy* did not change the law: only Parliament can change the law on encouraging or assisting suicide.

b. This policy does not in any way "decriminalise" the offence of encouraging or assisting suicide. Nothing in this policy can be taken to amount to an assurance that a person will be immune from prosecution if he or she does an act that encourages or assists the suicide or the attempted suicide of another person.

c. A prosecution is more likely to be required if:

i. the victim was under 18 years of age;

ii. the victim did not have the capacity (as defined by the Mental Capacity Act 2005) to reach an informed decision to commit suicide;

iii. the victim had not reached a voluntary, clear, settled and informed decision to commit suicide;

iv. the victim had not clearly and unequivocally communicated his or her decision to commit suicide to the suspect;

v. the victim did not seek the encouragement or assistance of the suspect personally or on his or her own initiative;

vi. the suspect was not wholly motivated by compassion; for example, the suspect was motivated by the prospect that he or she or a person closely connected to him or her stood to gain in some way from the death of the victim;

vii. the suspect pressured the victim to commit suicide;

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\(^{131}\) Visit www.bryanandarmstrong.co.uk/ard/enews_article.asp?ID=1563 (Accessed on 16.8.12)

viii. the suspect did not take reasonable steps to ensure that any other person had not pressured the victim to commit suicide;

ix. the suspect had a history of violence or abuse against the victim;

x. the victim was physically able to undertake the act that constituted the assistance him or herself;

xi. the suspect was unknown to the victim and encouraged or assisted the victim to commit or attempt to commit suicide by providing specific information via, for example, a website or publication;

xii. the suspect gave encouragement or assistance to more than one victim who were not known to each other;

xiii. the suspect was paid by the victim or those close to the victim for his or her encouragement or assistance;

xiv. the suspect was acting in his or her capacity as a medical doctor, nurse, other healthcare professional, a professional carer [whether for payment or not], or as a person in authority, such as a prison officer, and the victim was in his or her care;

xv. the suspect was aware that the victim intended to commit suicide in a public place where it was reasonable to think that members of the public may be present;

xvi. the suspect was acting in his or her capacity as a person involved in the management or as an employee (whether for payment or not) of an organisation or group, a purpose of which is to provide a physical environment (whether for payment or not) in which to allow another to commit suicide.

xvii. On the question of whether a person stood to gain, (paragraph 43(6) see above), the police and the reviewing prosecutor should adopt a common sense approach. It is possible that the suspect may gain some benefit - financial or otherwise - from the resultant suicide of the victim after his or her act of encouragement or assistance. The critical element is the motive behind the suspect's act. If it is shown that compassion was the only driving force behind his or her actions, the fact that the suspect may have gained
some benefit will not usually be treated as a factor tending in favour of prosecution. However, each case must be considered on its own merits and on its own facts.

d. A prosecution is less likely to be required if:

i. the victim had reached a voluntary, clear, settled and informed decision to commit suicide;

ii. the suspect was wholly motivated by compassion;

iii. the actions of the suspect, although sufficient to come within the definition of the offence, were of only minor encouragement or assistance;

iv. the suspect had sought to dissuade the victim from taking the course of action which resulted in his or her suicide;

v. the actions of the suspect may be characterised as reluctant encouragement or assistance in the face of a determined wish on the part of the victim to commit suicide;

vi. the suspect reported the victim's suicide to the police and fully assisted them in their enquiries into the circumstances of the suicide or the attempt and his or her part in providing encouragement or assistance.133

Recently, in March 2012, Tony Nicklinson, 57, a man with “locked-in syndrome” has won the right to ask the courts to declare that a doctor can lawfully end his “intolerable” suffering. He sums up his life as “dull, miserable, demeaning, undignified and intolerable” since he suffered a stroke in 2005. He is a former rugby player and senior manager with an engineering company, has round-the-clock care and says he does not wish to “dribble my way into old age.”134

Mr. Justice Charles, sitting at the High Court in London, gave him the go-ahead for his legal challenge, agreeing that in certain “exceptional” circumstances the courts could step in to change the law. At present, he falls outside the guidelines on assisted suicide issued last year. The current guidelines say that although assisted suicide remains a crime in English law punishable with imprisonment up to 14 years, in certain circumstances a prosecution would be unlikely. Lawyers for the Ministry of Justice had

133 Ibid.
134 “Locked-in Victim is Delighted at Victory in Fight for Right to Die”, The Times, 3 (13 March 2012).
sought to strike out the application, arguing that it was for Parliament, not the courts to
develop or change to provide a lawful route to ending suffering
at a time of his choosing with the assistance by positive action of a doctor, in controlled
circumstances that have been sanctioned by the court.” Judge Charles added that
Nicklinson was inviting the court to “cross the Rubicon”, between, the care of the living
patient, on the one hand, and euthanasia on the other. To this, Penney Lewis commented
that success for Mr. Nicklinson would mean that the defence of necessity would be
available in (another) small class of murder cases. In 2000, this defence was allowed by
the court of appeal in the case of _conjoined twins_. The court specifically excluded the
possibility of using the defence of necessity in euthanasia cases and clearly restricted it to
the circumstance of that case.135

5.2.7 The United States of America (USA)

The common law considered law suicide a crime against society, and anyone
who assisted another in the commission of a suicide, regardless of the purity of their
motives, would have been judged to have committed some form of homicide. By the mid
1800s, this attitude had begun to change, and society began to look at acts of self-killing
less as crimes and more as indications of social and psychological illnesses. As a result of
these changing views, the law and, to some extent, the church began to moderate their
views of suicide, eventually resulting in its decriminalization in most of the American
states.136 By the 1870s, the idea that the terminally ill should have a "right to die" was
fully articulated in Great Britain by a small but influential group of intellectuals who
argued for the legalization of such a right. Despite these efforts to foster recognition of a
"right to die" in England, American legal scholars showed little to no interest in the
subject. This is not to say, however, that American law was not changing, for indeed it
was. Yet the changes in the American legal attitude toward the "right to die" took place
not as a result of proposed legislative action but, much more quietly, as a result of judicial
determination.137

136 Supra note 1 at 18.
137 Ibid.
As early as 1902, the Texas Court of Criminal Appeals made a dramatic break with the common law and ruled that an individual who had committed suicide was not guilty of a crime against the state and, even more astonishing, that an individual who knowingly provided another with the means to commit suicide was not guilty of murder so long as no active role had been played in the employment of those means.138 The Texas court made its position even clearer in 1925, when it ruled that, in the absence of statutory authority, the provision of poison to another for the known purpose of aiding that person in the commission of suicide not only did not constitute murder but did not even rise to the level of manslaughter.139 However, it should be noted that these early Texas rulings were innovations in the law that many legislatures specifically defeated by passing statutes making any form of mercy killing or assisted suicide a criminal act; manslaughter convictions, usually with light or suspended sentences, were not uncommon.140

This new willingness to rethink the legal implications of self-killing manifested itself, in the 1930s, with the creation of an American society for the promotion of euthanasia. The Euthanasia Society of America was largely an outgrowth of its British counterpart, known as Britain’s Voluntary Euthanasia Legalization Society, and followed its lead in attempting to convince lawmakers to pass legislation formally recognizing the right of the terminally ill to control the time and nature of their deaths. Despite the fact that the proposed bills took great pains to spell out detailed procedures and safeguards, thereby ensuring that the person requesting euthanasia was in fact terminally ill and had voluntarily made the request, no legislature in the United States or Great Britain was yet willing to consider legalizing euthanasia.141

However, the Euthanasia Society of America did not allow this apparent legislative obstinance to impede their efforts. To the contrary, the society was buoyed by public opinion polls throughout the decade indicating that 46% of Americans were willing to consider the legalization of euthanasia.142 Supported by such data, the society, in 1938, attempted on several occasions to persuade New York State legislators to

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140 Ibid
introduce euthanasia legislation for debate. Each attempt was thwarted by a coalition of social groups, which included the Roman Catholic Church and various medical associations. As a result of their opposition and strong lobbying efforts, not a single legislator was willing to attach his name to the bill. In the face of these defeats, Dr. Foster Kennedy, the president of the Euthanasia Society of America, publicly adopted a substantially more radical position with respect to the proper employment of euthanasia in American society. Kennedy announced that he believed that euthanasia should be used to shorten the painful lives of those individuals who had been born defective. He argued that this was the most humane treatment of such individuals, one that would further serve to reduce the psychological and financial strain such cases placed on their families. Despite Kennedy’s hopes that his expansive view of euthanasia might generate greater public support, New York State legislative initiatives addressing the legalization of voluntary euthanasia failed in both 1941 and 1946. The latter proposal failed in spite of the fact that it was accompanied by a petition signed by 50 Protestant ministers and 1,500 doctors. After this failure, the society was moved to redirect its efforts from New York to New Hampshire, where Dr. Hermann Sanders had injected air into the vein of a terminally ill patient in order to bring about his death. Amazingly, even though Dr. Sanders readily admitted the truth of all allegations made against him, state prosecutors were unable to obtain a conviction. Despite this apparent show of support among the inhabitants of New Hampshire, the Society’s legislative initiative of 1950 once again failed. It is extremely likely that the advent of World War II and the horrors of the Holocaust were significantly detrimental to the society’s efforts to pass legislation. Many drew parallels between the atrocities of the Nazis’ euthanistic policies, particularly in light of Dr. Kennedy’s open advocacy for the use of euthanasia in the case of the physically and mentally disabled. However, the shock of the Holocaust was not long lived. Prior to the 1950s, modern medicine was not sufficiently advanced to generate much debate on the subject of euthanasia. Generally speaking, patients in a persistent vegetative state died from secondary illnesses and/or dehydration without excessive passage of time. Pneumonia, tuberculosis, and influenza were common before the

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143 Supra note 1 at 19.
144 Ibid.
145 Id. at 20.
widespread use of antibiotics. Heretofore, most people died at home and thus did not have the aid—or burden—of modern medical machinery. Advances in surgery and in disease and infection control, along with the advent of new technology such as intravenous feeding tubes, cardiopulmonary bypass machines, and ventilators, served not only to improve the general health of society, but also to increase the frequency with which individuals were kept technically alive, but in conditions that may be seen as personally undesirable. As a result, there was renewed interest in the cause of voluntary euthanasia in America. This reawakening was given a significant boost, in 1956, by a series of lectures given by James Carpentier in which he strongly advocated the need and, in some instances, the duty to provide euthanasia for terminally ill individuals suffering from untreatable pain. The lectures roused strong debate concerning the morality of euthanasia and brought the issue back into the forefront of American public controversies.\textsuperscript{146}

Recognizing the growing controversy caused by modern medical technology, the Roman Catholic Church, under the leadership of Pope Pius XII, issued directives intended to aid Catholics in their efforts to distinguish between types of medical care that they were obligated to receive (ordinary care) and medical treatments that they could morally refuse (extraordinary care). Included in the category of extraordinary care was the use of resuscitators and ventilators in those cases in which a clear medical determination of death had occurred, but the Pope went on to warn against the excessive use of pain medication that might interfere with consciousness and so with the individual's ability to prepare for death. This renewed interest in the issue of euthanasia notwithstanding, the next ten years produced no significant activities in the field. The lack of legislative and judicial activity was not representative of a lack of interest and, viewed in retrospect, simply appears to have been an example of the proverbial calm before the storm. As the events of the late 1960s erupted into a virtual firestorm of social controversy, the "right to die" issue was once again thrust into the mainstream of American politics.\textsuperscript{147}

\textsuperscript{146} Ibid.
\textsuperscript{147} Id. at 21.
In 1967, the first exemplar living will was introduced by the Euthanasia Society of America. One year later, a Florida physician-legislator put the nation's first "right to die" proposal before a state legislature. Despite the fact that the legislation was defeated, these activities helped bring about the creation of the Hasting Center, in 1969, and the Kennedy Institute of Ethics at Georgetown University, in 1970. By the mid 1970s, attempted suicide had been decriminalized in every state in the nation. In fact, a large number of states went even further and passed legislation that specifically "declared that the withholding or withdrawal of life sustaining procedures [did] not constitute suicide". The entire landscape of the "right to die" movement was changed forever, in 1973, by the emergence of "right to die" claims based for the first time not on religious beliefs but on the concept of a right to privacy. Prior to the mid 1970s, judicial activity in "right to die" cases was primarily limited to cases in which patients had chosen to refuse lifesaving medical treatment on religious grounds, as contained in the free exercise clause of the First Amendment. Nonetheless, such a claim was subject to the Court's determination of whether government intervention would unduly burden the challenger's freedom of religion and, if so, whether some compelling state interest existed that could justify the burden. Moreover, when the Supreme Court handed down its now historic 1973 decision in the case of Roe v. Wade, it not only opened the door for the legalization of abortion, it also acknowledged the idea that the individual's right to privacy was so strong that it extended to fundamental questions of life and death. From this point forward, the majority of "right to die" cases focused less on religious free exercise claims than on the individual's right to control what happens to his or her own body without the interference of government. It was precisely this type of argument that opened the way for the 1976 landmark case of In re Quinlan.

The Quinlan case involved a 22-year-old woman who, for reasons never fully determined, had lost consciousness and fallen into a persistent vegetative state. Ms. Quinlan was maintained in this state for several months by a respirator and feeding tube, without which she would have died. Eventually her father brought a petition before the

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148 ibid.

227
New Jersey Supreme Court requesting permission to withdraw "all extraordinary medical procedures," which, in the opinion of the family, included the respirator but not the equipment necessary for artificial feeding. In deciding the case, the New Jersey Supreme Court specifically chose not to base its decision on the free exercise clause of the First Amendment; it elected, rather, to set the standard for all "right to die" cases by basing its decision to allow the removal of the respirator on Ms. Quinlan's right to privacy, as exercised through her parent/guardian. In the course of rendering this decision, the court relied upon the statements of the attending physician and the hospital's "ethics committee," attesting to the fact that "there was no reasonable possibility of Karen's ever emerging from her present comatose condition to a cognitive, sapient state," as a critical element in its determination to allow discontinuation.\(^{152}\)

The *Quinlan* case was described as a galvanizing event. One result was that the total number of articles published concerning the "right to die" in the years "1975 and 1976 equaled or exceeded all articles published in the previous decade." He goes on to note that "from 1976 until the end of 1990, dozens of appellate court cases were decided in 17 states, affecting the use of life-support systems and other treatment of the terminally ill and those in a persistent vegetative state."\(^{153}\) The impact of the *Quinlan* case immediately made itself felt in California by virtue of the enactment of the nation's first living will law. By 1977, seven states had passed similar living will statutes and nearly all states had corresponding legislation before their legislatures.\(^{154}\)

In keeping with the trend toward a more liberal interpretation of the "right to die," in 1983 the Michigan Court of Appeals laid down a new interpretation of assisted suicide in the common law. In the case of *People v. Campbell*\(^{155}\) the court reversed its previous rulings, stating "that it is 'extremely doubtful' that aiding or soliciting a suicide was a crime at common law, and that suicide, by definition, excludes homicide." The court held that the act of providing a gun and bullets to a person who had expressed the intent to commit suicide, while "morally reprehensible," was not a crime under the existing law of Michigan, and it invited the legislature to adopt a provision regarding "inciting suicides".

\(^{152}\) *Id.* at 22.
\(^{154}\) *Ibid.*
While at the time of its decision, the court's new interpretation of the permissibility of assisted suicide under common law must have been little more than an interesting interpretation of the current status of the law, the true significance of the court's decision would not be felt until seven years later when, in 1990, Dr. Jack Kevorkian, relying on the Campbell decision and the lack of any Michigan statute making assisted suicide a crime, used his now infamous "suicide machine" to induce the death of three women (two from the State of Washington) in the State of Michigan.\[156\]

Dr. Kevorkian's actions were intended to draw public attention and to stimulate debate concerning the "right to die" and the proper role of the medical community in this process. As a result of his actions, Dr. Kevorkian was indicted on first degree murder; however, all charges were eventually dismissed, the court finding that the doctor had not caused the deaths of the women but had merely provided them with the means by which they could take their own lives. The court further concluded that the state had no law against assisting in a suicide and that therefore the doctor's actions could not be said to constitute a crime.\[157\]

By 1983, state courts had begun to support the "right to die" more aggressively, in some instances even setting aside the limiting provisions of state living will legislation. In the case of Barber v. Superior Court\[158\], the court ruled that, the provisions of the California living will statute notwithstanding, its citizens had the right to refuse medical treatment and that this right could not be limited by any interpretation of the state's statute. In 1984, a Georgia court also recognized that the right to die existed, independent of state legislation, and accepted statements of a mature teenager who was legally a minor, but who had clearly expressed a desire not to be kept alive by artificial means prior to events that left him in a coma. By doing so, the court extended the right to die beyond statutory authority and allowed the removal of all life-supporting systems.\[159\]

Finally, in 1985, the New Jersey Supreme Court handed down the landmark decision of In re Conroy\[160\], in which it ruled that even artificial feeding and hydration could be removed from an otherwise dying patient in the same way that any other

\[156\] Ibid.
\[157\] Id. at 22-23.
\[159\] Supra note 1 at 23
\[160\] 486 A. 2d. 1209 (1985).
medical treatment could be withdrawn. The Conroy decision stimulated similar legislation in several other areas. Following Conroy, the artificial administration of food and hydration became one of the most controversial right to die issues in years.\textsuperscript{161}

It is clear that the decade of the 1980s was a time in American history when the public refocused its interest in the "right to die" issue. This increased interest was demonstrated by a dramatic upsurge in the publication of "right to die" articles in professional journals, as well as in the mass media. In addition, the 1980s saw more national organizations than ever articulating their support for the "right to die." Simultaneously, state courts and legislative bodies took up the issue of the "right to die," with a gusto not before seen in the United States.\textsuperscript{162} If the 1980s can accurately be said to have produced a marked increase in "right to die" advocacy, then the 1990s can best be described as an explosion of the same. In June of 1990, the landscape of the "right to die" debate was changed forever as a result of the first U.S. Supreme Court decision addressing a variety of issues relating specifically to the "right to die." The case was that of Cruzan v. Director, Missouri Department of Health\textsuperscript{163}. In its five-to-four decision, articulated in the writings of Chief Justice Rehnquist, the Court upheld the right of the State of Missouri to require clear and convincing evidence of Ms. Cruzan's desire not to have her life artificially sustained once she fell into a persistent vegetative state. The Court went on to hold that the state had a further right to guard against any potential abuse of authority by her surrogate or guardian. This case recognized the power of a state (Missouri) to regulate the withdrawal of medical treatment from citizens who are terminally ill or in a persistent vegetative state. In addition, the Court ruled that each state has broad leeway to develop its own standard of proof for determining a person's wishes to have treatment removed or uninitiated. In reaching this decision, the Court expressed a preference for written directives, noting that past oral statements were generally suspect in legal transactions.\textsuperscript{164} Finally, the Court rejected the argument that a legal distinction can be made between the withdrawal of medical procedures providing food and hydration and those relating to other bodily functions. In the end, the Court concluded that once the

\begin{footnotes}
\item[161] Supra note 153 at 149-150.
\item[162] Id. at 90.
\item[164] Supra note 1 at 24.
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patient's wish not to have his or her life artificially sustained has been established, the removal of all medical treatments, regardless of their nature, was allowed.165

The Cruzan decision was handed down on June 15 of 1990. In July of the same year, the Hemlock Society of Oregon attempted unsuccessfully to pass an assisted suicide referendum in the State of Washington. This failure came as a surprise to many, given that polling data had indicated broad support for assisted-suicide. The effect that the Cruzan case had on the Washington referendum is uncertain. In November 1990, Ms. Cruzan's case was back in the news when her court-appointed guardian filed a new petition to remove life support from Ms. Cruzan. Supported by new testimony from three of her friends, the Missouri trial court now ordered the removal of Nancy Cruzan's feeding tube. Despite the fact that this new ruling was never contested by the State of Missouri, several "right to life" organizations filed petitions in both state and federal courts seeking to stay or overturn the trial court decision. When those efforts were unsuccessful, a crowd of some 25 protesters were arrested while attempting to force their way into Nancy Cruzan's hospital room, supposedly to force the reinitiation of tube feeding. Their efforts were unsuccessful, and Cruzan died twelve days after the removal of her feeding tube on December 26.166

By the end of 1990, Dr. Kevorkian had initiated a series of assisted suicides in the State of Michigan and had propelled the issue onto the front pages of newspapers and TV news reports across the nation. Dr. Kevorkian's actions most certainly seemed to have encouraged Dr. Timothy E. Quill of Rochester, New York, to write an article for the New England Journal of Medicine in which he described his decision to prescribe barbiturates for one of his patients suffering from leukemia, knowing that she would use the medication not for treatment, but to end her life.167 Indeed, Dr. Quill went farther than to simply prescribe the medication; he actively referred his patient to the Hemlock Society for any further assistance or information she might need. Because of these actions, prosecutors attempted to charge Dr. Quill with violation of New York State's law against

165 Ibid
166 Supra note 153 at 4.
167 Supra note 1 at 24.
assisting in a suicide attempt. In the end, however, the grand jury refused to indict Dr. Quill, despite his open admissions.168

Almost immediately following the disposition of the Quill case, Derek Humphry, of the Hemlock Society, published his book entitled Final Exit. The book was on the best-seller list for almost the entire summer of 1991. Although the book was assailed by many as a suicide handbook that might be used by the young or by those suffering from depression or other conditions that impair judgment, others hailed the book as a liberating publication that, for the first time, allowed those who wished to follow its dictates the right to control the time and nature of their deaths.169 By the end of 1991, the United States Congress had taken steps to create a national policy in this area by passing the Patient Self-determination Act, which required all medical facilities receiving federal funds, including Medicare and Medicaid reimbursements, to inform all patients of their rights as a patient under applicable state laws and institutional regulations. The legislation further directed that the notification must include the right to refuse medical treatment, as well as the use of medical available treatment directives. The legislation was accompanied by an appropriation of 30 million dollars, to be spent between 1991 and 1994 on educational programs and implementing legislation.170

5.2.7.1 Oregon

By the end of 1994, popular support for the "right to die" within the State of Oregon had grown to such a level that a group known as Oregon Right to Die proposed the nation's third state referendum to allow terminally ill individuals to end their lives with the assistance of their doctors. Although similar legislation had failed both in Washington and California, public opinion polls showed that 60% of Oregon's citizens supported the proposal for allowing physician-assisted suicide. The legislation, known as Measure 16 or the Oregon Death with Dignity Act171, proposed allowing doctors to provide terminally ill patients with a prescription for lethal doses of medication, provided two doctors agree that the patient has less than six months to live, that the patient has clearly rejected every alternative, and that three requests for such assistance have been

168 Id. at 25
169 Ibid
170 Supra note 153 at 208-211.
made, the last of which is in writing. With the support of the state Democratic Party, the American Civil Liberties Union, and the National Organization for Women, in 1994 Oregon became the first state in the United States to pass a physician-assisted-suicide law.

In November 2014, Brittany Maynard, 29, the young, terminally ill American cancer patient who in recent months became the face of the controversial right to die movement, ended her life in Oregon. She was diagnosed with a likely stage 4 glioblastoma, a kind of malignant brain tumour. Within weeks, in course of researching possible treatments and realizing it was futile, she became an advocate of a dignified death instead of undergoing endless rounds of debilitating chemotherapy and radiation, which was already proving useless in her case. She had moved from California to Portland, Oregon with her family, to take advantage of the State’s physician assisted suicide laws. More recently, she became a campaigner for Compassion and Choices, an end of life choice advocacy organization fighting to expand death with dignity laws nationwide, launching an online video for them. She died voluntarily taking a fatal dose of barbiturates prescribed to her by a doctor, igniting a furious debate about the right to die issues. To the end, she maintained that what she was advocating was not really suicide, bit a form of preferred death in the face of great pain and suffering. To her, arguing against this choice for sick people seemed evil. She opined that people mix it up with suicide and that is really unfair because there was not a single part of her that wanted to die. But she was dying. She discussed with many experts how she would die from her disease and that was terrible, terrible way to die. So, being able to choose to go with dignity was less terrifying. So, she posted on the Facebook:

Goodbye to all my dear friends and family that I love.

Today… I have chosen to pass away with dignity in the face of my terminal illness, this terrible brain cancer that has taken so much from me… but would have taken so much.

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172 Supra note 1 at 25. It should be noted that several attempts have been made to repeal the law, but failed. For example, In 1997, the Oregon Legislative Assembly referred to the ballot, Measure 51, which would have repealed the Act. However, Measure 51 was defeated on November 4, 1997. The Act was also challenged by the Bush administration, but was upheld by the U.S. Supreme Court, in Gonzales v. Oregon, 546 U.S. 243 (2006), thus opening the door to many more such laws across the nation for ending the lives of the terminally ill. Visit, www.supremecourtus.gov/opinions/ opinions.html. (Accessed on 18.10.09). Also see, supra note 8 at 108-110.
more. This world is a beautiful place, travel has been my greatest teacher, my close friends and folks are the greatest givers. I even have a ring of support around my bed as I type… Goodbye world. Spread good energy. Pay it forward.\textsuperscript{173}

\textbf{5.2.7.2 Michigan}

Assisted suicide is prohibited under The Michigan Penal Code of 1931.\textsuperscript{174} However, assisted-suicide activists selected Michigan as their next target, introducing the “Terminally Ill Patient’s Right to End Unbearable Pain and Suffering Act” in 1998. However, the proposal was resoundingly defeated on November 3, 1998.\textsuperscript{175}

\textbf{5.2.7.3 Maine}

Maine Revised Statute Ann. tit. 17-A, §204 prohibits assisted suicide in Maine. However, on November 7, 2000, Maine citizens were asked to approve the “Maine Death with Dignity Act.” The proposal was virtually identical to the Oregon law. However, voters who took the time to wade through the measure’s small print found that what was called “a doctor’s help to die” was not a commitment to providing care, concern, and pain control as long as the patient lived, but a prescription for a fatal drug overdose. The measure failed. This pattern has been repeated over and over again in the battles that have taken place in recent years. Since passage of the Oregon’s assisted-suicide law in November 1994, at least 54 assisted suicide and/or euthanasia measures have been introduced in 21 states. Not one has passed. On the other hand, between 1995 and 1999, seven states passed laws prohibiting assisted suicide.\textsuperscript{176}

\textbf{5.2.7.4 California}

California Penal Code prohibits assisted suicide under §401. In 1992, the citizens of California defeated a ballot measure to legalize physician-assisted suicide using lethal injection by a 54%-45% margin. However in 1999, AB 1592, the “California Death with Dignity Act” was introduced. The proposal was virtually identical to the Oregon law. However, strong grassroots opposition had an impact. AB 1592 died from lack of...
support. Recently, an assisted-suicide bill that allows doctors and nurses to suggest death by unconscious dehydration has barely passed the California State Assembly. AB 2747 would authorize total sedation without nutrition and hydration for depressed and confused patients, whether or not their natural death was imminent.\textsuperscript{177}

\subsection*{5.2.7.5 Washington}

Washington Criminal Code, §9A.36.060 specifically prohibits assisted suicide. However, Washington Initiative 1000 (I-1000), an adopted ballot measure dealing with aid in dying that was enacted in the US State of Washington in the November 4, 2008 general election. The effort was started by former Governor Booth Gardner.\textsuperscript{178}

I-1000 requires the patient to ingest the medication unassisted. The initiative is based on Oregon Measure 16, which Oregon voters passed in 1994. While the initiative is supported by Right to die proponents, Right to life proponents oppose it.\textsuperscript{179}

\subsection*{5.2.7.6 New York}

New York Penal Law prohibits assisted suicide under Section 125.15. In the cases of \textit{Vacco} v. \textit{Quill}\textsuperscript{180} and \textit{Washington} v. \textit{Glucksberg}\textsuperscript{181}, the Court found that the New York and Washington state statutes making "assisting," "causing," or "aiding" in a suicide a crime did not violate either a physician's or a patient's right to equal protection or due process under the Fourteenth Amendment of the U.S. Constitution. In reviewing these cases, the U.S. Supreme Court unanimously reversed the ruling of the Second and Ninth Circuit Courts of Appeals, which had ruled that mentally competent, terminally ill

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\bibitem{note177}
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in 1991, the similar initiative 119 was rejected by Washington. After that, three attempts were made in the Washington State legislature to transform assisted suicide, which was a crime in Washington, into a "medical treatment." All three attempts failed. Available at www.patientsrightscouncil.org/site/washington/ (Accessed on 30.8.12).
\bibitem{note179}
Specific provisions of the initiative include: the patient must be an adult (18 or over) resident of the state of Washington, the patient must be mentally competent, verified by two physicians (or referred to a mental health evaluation), the patient must be terminally ill with less than 6 months to live, verified by two physicians, the patient must make voluntary requests, without coercion, verified by two physicians, the patient must be informed of all other options including palliative and hospice care, there is a 15 day waiting period between the first oral request and a written request, there is a 48 hour waiting period between the written request and the writing of the prescription, the written request must be signed by two independent witnesses, at least one of whom is not related to the patient or employed by the health care facility, the patient is encouraged to discuss with family (not required because of confidentiality laws), the patient may change their mind at any time and rescind the request. Visit en.wikipedia.org/wiki/Washington_Death_with_Dignity_Act (Accessed on 12.12.12.)
\bibitem{note180}
\bibitem{note181}
\end{thebibliography}
patients had a constitutionally protected right to receive medication for the purpose of ending their lives. However, in making this decision, the Court also made it clear that its ruling did not represent a constitutional hostility towards assisted suicide but rather expressed the opinion that decisions as to the legal status of physician-assisted suicide should be left up to the individual states.\(^{182}\)

### 5.2.7.7 Florida

Florida Statute prohibits assisted suicide under Section 782.08. The Florida State Supreme Court in *Krischer v. McLver*\(^ {183}\), upheld the constitutionality of Florida’s law prohibiting assisted suicide.\(^ {184}\) On February 25, 1990, Theresa Marie (“Terri”) Schiavo, then 26 years old and living in Florida, suffered a cardiac arrest because of a potassium imbalance in her body, possibly brought on by an eating disorder. She was revived, but lack of oxygen had destroyed the centers of consciousness in her brain. She remained in a vegetative state, which was eventually classified as persistent and, in all likelihood, permanent. Schiavo’s husband, Michael Schiavo, became her conservator. At first he and Terri’s parents, Robert and Mary Schindler, worked together to care for her, but in early 1993 they began to disagree. Michael Schiavo believed that his wife’s condition would never improve, but the Schindlers thought that she might recover some degree of consciousness if given the right therapy. In 1994, they filed the first of many suits that attempted to remove Michael from his position as Terri’s conservator. All were unsuccessful. Michael Schiavo petitioned a Florida court in 1998 to allow him to have Terri Schiavo’s feeding tube removed, claiming she had said that she would not want to be kept alive “on anything artificial.” The Schindlers, devout Catholics (as was Terri), vehemently opposed this move. Terri had left no written directives and very little in the way of spoken comments, but on February 11, 2000, Florida circuit court judge George Greer ruled that Michael Schiavo had provided “clear and convincing” evidence of Terri’s medical diagnosis (the Schindlers had claimed that she had more mental function than would appear in someone in a persistent vegetative state) and wishes and therefore

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\(^{182}\) Ibid.


could remove the feeding tube. The Schindlers appealed the decision, beginning the next stage of a long, bitter, and eventually very public personal and legal battle.\textsuperscript{185}

The contest between Michael Schiavo and the Schindlers over Terri Schiavo’s care eventually ended only with Terri Schiavo’s death on March 31, 2005, two weeks after her feeding tube had been removed for the final time and 10 days after a three-judge panel of the 11th Circuit Court of Appeals, to which the congressional legislation had transferred the case, refused to order the tube reinserted. The Supreme Court also turned down a last minute appeal. The Schiavo case established no legal precedents, but commentators agreed that it set a precedent in depth of conflicting emotions, not only in the Schindler-Schiavo family but also in the country at large. The case also brought a new degree of government intervention into what many felt should have remained a private or, at most, a judicial matter.\textsuperscript{186}

\subsection*{5.2.7.8 Colombia}

On 20 May, 1997, the efforts of a group that strongly opposed the "right to die" went terribly awry when their actions inadvertently led to the legalization of a limited form of euthanasia. In an effort to eliminate all references to euthanasia in Colombian law, an individual brought a lawsuit before the Colombian Supreme Court. After examining the arguments in the suit, the court made a 6 to 3 ruling that, in effect, spelled out the rights of a terminally ill person to engage in voluntary euthanasia. The ruling gave Colombian lower courts the power to produce written guidelines and make rulings on the appropriateness of euthanasia on a case-by-case basis.\textsuperscript{187}

\subsection*{5.2.7.9 Alaska}

Alaska Statute, 11.41.120 prohibits assisted suicide. The statute was challenged in \textit{Sampson and Doe v. State of Alaska}.\textsuperscript{188} The Alaska Supreme Court, held that the Alaska Constitution’s guarantees of privacy and liberty do not afford terminally ill patients the

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\textsuperscript{185} Supra note 8 at 105-106.
\textsuperscript{186} \textit{Id.} at 107.
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right to a physician's assistance in committing suicide and that Alaska's manslaughter statute did not violate Sampson and Doe's right to equal protection.  

5.2.7.10 Virginia

In 1998, Virginia enacted Va. Code §8.01-662.1, that provides that a person who commits an assisted suicide can be assessed a civil penalty. Thus, as stated earlier, it has become customary in the United States to accept passive euthanasia as a matter of private concern between patients and their doctors. The American Medical Association has recognized this practice and has incorporated it into its codes, stating that a doctor "has an ethical obligation to honor the resuscitation preferences expressed by the patient." As a result of this level of acceptance, the American Medical News reports that 70% of all those who die in American hospitals do so only after life-sustaining treatment has been withdrawn. While the trend is toward the acceptance of euthanasia, the United States has not equally embraced all forms of the act, and it is clear that only expressly voluntary euthanasia has any significant level of public support. Involuntary euthanasia is unquestionably considered homicide, regardless of its active or passive nature. Despite occasional advocacy for involuntary euthanasia, Americans have always maintained a strong moral and legal prohibition against such acts and have held them in violation of a person's right to life, self-determination, and privacy. Furthermore, in most U.S. states, active euthanasia—even if voluntary—is considered murder, regardless of the willingness or medical condition of the patient or of the motives of the actor. However, it is clear that social attitudes toward active, voluntary euthanasia are in flux and that support for assisted suicide is growing.

194 Ibid.
5.2.7.11 Montana

The Montana Supreme Court in December, 2009, affirmed in the case of <i>Baxter v. State of Montana</i> that physician-assisted suicide is not "against public policy" in Montana. The Court further ruled that state law protects doctors in Montana from prosecution for helping terminally ill patients die. The court declined to rule on the larger question of whether physician-assisted suicide is a right guaranteed under Montana's Constitution.\footnote{Visit http://euthanasia.procon.org/view.timeline.php?timelineID=000022. (Accessed on 15.9.2013.)}

5.2.7.12 Massachusetts

On 6 November 2012, Massachusetts voters rejected the Death with Dignity ballot measure by less than 60,000 votes. The measure would have legalized physician-assisted suicide by allowing doctors to prescribe a lethal dosage of medicine to people with less than six months to live.\footnote{Ibid.}

5.2.7.13 Vermont

On May 20, 2013, Vermont becomes fourth State to allow physician-assisted suicide, which is the first time when physician-assisted suicide has been made legal in the United States via the legislative process. Like the laws in Oregon and Washington, Vermont’s law implements safeguards to govern physicians who are now allowed to prescribe death-inducing medication to terminally ill residents of the state. However, those safeguards expire on July 1, 2016 at which point physician-assisted suicide will be overseen by professional practice standards already in place to govern physician conduct.\footnote{Ibid.}

5.2.8 Australia

As part of a federation, each of Australia’s six states and two territories has the right to institute its own unique laws regarding euthanasia, similar to the way U.S. states have independent lawmaking authority, although this power can be superseded by the national legislature. Therefore, while active euthanasia is currently illegal throughout the nation, this is only because the national government has blocked the efforts of states and territories to enact laws legalizing euthanasia, despite the fact that support is growing for the recognition and legalization of such legislation. The Northern Territory of Australia in
1995 enacted a legislation known as the 'Right of Terminally Ill', which allowed patients to end their lives with the help of doctors after being diagnosed as terminally ill by two doctors, after a cooling off period. The Act allowed terminally ill patients to commit medically assisted suicide, either by the direct involvement of a physician or by procurement of drugs. It required a somewhat lengthy application process, designed to ensure that the patients were both mentally competent to make the decision and in fact terminally ill. Under the Act, a patient had to be over 18 and be mentally and physically competent to request his or her own death. The request had to be supported by three doctors, including a specialist who confirms that the patient is terminally ill and a psychiatrist who certifies that the patient is not suffering from treatable depression. Once the paperwork was complete, a nine-day cooling-off period was required before the death could proceed. However, the Australian Parliament repealed that, as it has the constitutional authority to do in the case of territorial legislation, but not before at least four deaths pursuant to the legislation occurred. Despite this action, the debate over euthanasia is still an issue of significance in Australia.198

5.2.9 Canada

In Canada, physician assisted suicide is illegal under Section 241(b) of the Criminal Code of Canada. Moreover, the Canadian Supreme Court in Sue Rodriguez v. British Columbia (Attorney General)199 rejected the plea of Rodriguez, a woman of 43, who was diagnosed with Amyotrophic Lateral Sclerosis (ALS) to allow someone to aid her in ending her life. But, two years later, Ms. Rodriguez received the assistance of an unknown doctor and ended her life, in direct defiance of the court's decision.200

5.2.10 France

France is another country in which there is sharp contradiction between the declared state of the law and actual medical practice. Technically, French law makes no distinction between assisting in a suicide, which is illegal, and aiding a terminally ill patient in facilitating his or her own death. In addition to the illegality of the act, the French National Ethical Committee formally opposes the legalization of euthanasia, fearing that it will give doctors "an exorbitant power over the life of an individual" and that economic

considerations might improperly play a role in the decision to terminate life. For all practical purposes, it would appear that euthanasia does not occur in France; however, it is reported that French doctors commonly give terminally ill patients a "lytic cocktail," a mixture of sedatives that is intended to produce death. Once again, we find that practice flies in the face of the apparent illegality of the act of euthanasia.201

5.2.11 Germany

Germany is one of the few countries that has a law specifically making active euthanasia a crime. Acts of mercy killing, or "killing on request," are punishable under German Penal Code Article 216 as low-level homicide, and those who are found guilty can be sentenced to up to five years in prison. Passive euthanasia, on the other hand, is widely accepted and is legally regarded as a matter to be determined by consultation between the individual patient and his or her doctor. In September 1994, the German constitutional court extended the right to all citizens to use passive forms of euthanasia by ruling that doctors could not only withdraw life-sustaining treatment from patients who were in the process of dying, but could direct the removal of such treatments from all terminally ill patients. In addition to this expanded access to passive euthanasia within the medical community, Germany has no laws forbidding assisted suicide. It is, therefore, permissible to provide another with any aid necessary to bring about his or her death, provided the actual act is willingly and knowingly performed by the individual wishing to die. So open is this event that Deutsche Gesellschaft Fur Hummanes Sterben (DGHS), Germany's equivalent to the American Hemlock Society, openly provides advice on how to commit suicide and will even provide those who wish so to do with the necessary drugs. Despite this apparent openness concerning the "right to die," it is unlikely that euthanasia will ever be formally legalized in Germany.202

5.2.12 Japan

Despite the fact that the first international conference on voluntary euthanasia was held in Tokyo in 1996, like most Eastern cultures, Japan is still very much opposed to the idea of legislation that would legalize euthanasia. Japanese doctors frequently follow the practice, once popular in the United States, of not informing the patient when he or she is

201 Id., at 43.
202 Ibid.
terminally ill. On those rare occasions when it is publicly revealed that a doctor or some other member of the medical profession has taken an affirmative act to bring about the early death of an otherwise dying patient, Japanese society reacts with shock. Despite this fact, a 1990 survey conducted by the Japanese Medical Association indicated that three quarters of the doctors responding believed that the provisions of a patient's living will should be respected. However, even in the face of such support, in 1992 Japan's Society for Dying with Dignity did not believe that Japanese society is ready to consider legislation to legalize active euthanasia. This position changed somewhat in 1995, when a Japanese district court in Yokohama established a four-part test to determine whether or not a particular act of mercy killing would be considered murder in Japan. The test indicated that the act would not be considered a crime if:

1. the patient was suffering from unbearable pain,
2. the death of the individual was inevitable and imminent,
3. all alternative measures had been taken to relieve the pain, and
4. the patient made a clear statement of his or her desire to shorten his or her life or hasten death.203

In making this ruling, the district court found Dr. Tokunaga guilty of murder, because there had been no clear expression by the patient concerning either pain or the desire to hasten death. This ruling has opened the door for Japanese doctors to treat pain aggressively, even if such treatment hastens death.204

5.2.13 New Zealand

While euthanasia is clearly illegal in New Zealand, as in many countries, the will and desire to prosecute and punish those who aid in the deaths of others for humanitarian reasons is quite weak. A strong case in point is the 1999 prosecution of an 87-year-old man who aided his wife in her desire to die by helping her take sleeping pills and then placing a plastic bag over her head. In this particular case, while the husband was prosecuted, he was charged with the low-level crime of manslaughter, rather than premeditated murder and, in the end, received a sentence of only two years' supervision. Prosecutors in the case were clearly influenced by the fact that the defendant's wife was

203 Id. at 43-44.
204 Ibid.
suffering from constant pain and that he was clearly motivated by his desire to show her compassion. While this ruling does not condone euthanasia, it has been cited by New Zealand’s Voluntary Euthanasia Society as a decision that will likely encourage others to engage in similar acts.205

5.2.14 South Africa

In a speech made to her nation’s Parliament, Health Minister Mantombazana Tshabalala-Msimang characterized euthanasia as an “equal constitutional right to life and to human dignity”. Under South African law at the time of her statement, physician-assisted suicide is clearly a criminal act; however, the South Africa Law Commission has introduced proposals that would allow doctors to withdraw life support from dying patients or prescribe pain medication at levels that are likely to hasten death. The commission, however, stopped short of recommending the legalization of active voluntary euthanasia. The proposal to legalize euthanasia in South Africa has been strongly opposed by the African Christian Democratic Party, who takes the position that such a law would be not only unethical but dangerous and unconstitutional.206

(5.3) Conclusion

While the debate surrounding euthanasia has clearly existed in many cultures for hundreds of years, it is an issue that has been dragged to the forefront of modern society by the advent of technology. Industrial development brought with it not only the technical and medical advancements necessary to artificially prolong life but also a society sufficiently affluent to afford those procedures. In conjunction with these factors, the individualistic nature of such countries as the United States led to a heightened sense of autonomy and the right to privacy. Out of the conflict between the opposing ideals of preserving all life and giving individuals the ability to choose non-treatment or even death, a debate has arisen over whether we are discussing the emergence of new rights or simply the recognition of old ones that never before faced serious challenge. This conflict manifests itself in the contradictory legislative and judicial treatments of the problem. Judicial authorities have been much more willing to view the controversy over the

205 Id., at 44.
existence of a "right to die" as one involving the recognition of a preexistent right, while legislatures have been simultaneously pushed to legislate both for and against the nascence of what many view as a modern creation.207

The net effect of this controversy is that many countries have chosen to avoid becoming enmeshed in it and have followed an intentional policy of legal prohibition and practical tolerance. Within such passively permissive systems, euthanasia is publicly condemned by the law but socially recognized and tolerated, provided it stays out of the public's eye. The difficulty, then, becomes that in denying the practice of euthanasia as a common event, society relinquishes its authority to regulate its application and so its ability to protect those most vulnerable to the misuse of euthanasia.208

Only in a few countries have governments been willing to accept the status of euthanasia as a modern conundrum that will not go away but must be dealt with. In these countries efforts are being made to come to grips with the reality of a technological age that promises only to make the issue of euthanasia an increasingly complex problem that cannot be ignored. Thus, these countries have opted to give limited recognition to the "right to die," while doing the best they can to give full protection to everyone's right to ongoing life.209

207 Id., at 47.
208 Id., at 47-48.
209 Id., at 48.