Assisted dying: a review of international legislation

The issue of assisted dying in the UK is increasingly receiving media and academic journal attention. Such reporting often cites, but in little depth, existing legislation in other countries. Such international legislation may also shape future UK assisted dying legislation.

The emotive issue of assisted suicide has received significant media attention in recent months in the UK. In September 2008 23-year-old Daniel James from Worcestershire died in a Dignitas clinic in Switzerland. In October 2008 the House of Lords ruled against clarifying the law on assisted suicide – something sought by multiple sclerosis sufferer Debbie Purdy [R(on the application of Purdy) v DPP 2008], who wanted to know in advance whether her husband would be prosecuted if he were to assist and accompany her to a Dignitas clinic. In November 2008 legislation was passed in Washington state, USA, allowing physician-assisted suicide, while December 2008 saw the controversial TV broadcast of the assisted suicide of Colin Ewert in a Dignitas clinic. In January 2009, a drama – *A Short Stay in Switzerland* – inspired by the story of Dr Anne Turner, who took her own life in a Dignitas clinic in 2006, was aired on BBC TV. In recent months, Lord Joffe has stated his intention to reintroduce his Assisted Dying for the Terminally Ill Bill (House of Lords, 2005) seeking to legalize physician-assisted suicide and active euthanasia.

Usually only very brief mention is made of international legislation when issues of assisted dying are being reported and discussed. This article provides a more in-depth analysis of how certain nations have resolved such end of life issues, by reviewing international assisted dying legislation and how this may shape future UK legislation.

Switzerland

Euthanasia is illegal in Switzerland. However, assisted suicide has been legal since 1942 when the Swiss Penal Code first became operative. This is because Article 115 takes account of both motive and intent, criminalizing only those who, for selfish reasons, incite or assist someone to commit suicide. Examples of such self-serving ends include:

> **'to satisfy [one's] own material or emotional needs… the possibility of eliminating some major problem for the family, or other motives such as gaining an inheritance, relieving [oneself] of the burden of supporting the individual… or eliminating a person [one] hated.'**

Thus, anyone who assists in a suicide will be acting in accordance with the law provided that he/she is motivated by 'unselfish' reasons. Since Article 115 requires nothing else, the person giving assistance does not need to be medically trained and the patient does not have to be a Swiss resident. The only qualifying condition is created by Articles 16 and 18 of the Civil Code, which relate to legal capacity and mean that any person who desires to have assistance committing suicide must have capacity, which excludes the mentally ill or incapacitated. The 'assistance' permitted by Swiss law is limited to prescribing and preparing lethal doses of medication, usually a drink containing barbiturates, and does not extend to directly administering the drug, which the patient must do his-/herself. Since 1998 Dignitas clinics based in Switzerland, which provide assisted dying services, have been involved in over 870 deaths.

The United States of America

Physician-assisted suicide has been legal in Oregon since 1998, when the Oregon Death with Dignity Act 1997 came into effect. Measure 16 had originally been passed by Oregon voters in 1994 by a 51% majority but was subsequently challenged by the US Supreme Court as unconstitutional. In 1997, following an appeal, it was passed again with a 60% majority. This Act permits a competent adult resident suffering from an 'incurable' and 'irreversible' disease with a prognosis of less than 6 months to receive a prescription for lethal drugs. There are numerous safeguards provided in the Act, including a waiting period of 15 days between the initial request and writing a prescription. Only the patient is permitted to administer lethal medication, prohibiting euthanasia. As required by the Act, an annual report is published and in 2008 88 prescriptions for lethal doses of medication were written. There were 60 assisted suicides carried out under the Act, which was less than 0.2% of the total number of deaths in the State (Oregon Department of Human Services, 2009).

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In November 2008 Washington state passed the Death with Dignity Initiative, with a 59% majority. The Washington Death with Dignity Act 2008 is based on the Oregon legislation, providing similar safeguards to regulate physician-assisted suicide. However, the Washington legislation seeks to distinguish prescribing lethal prescriptions to patients from 'assisted suicide' and actions taken in accordance with the Act are required to be referred to as 'obtaining and self-administering life-ending medication' and not 'suicide.'

The Netherlands

'Euthanasia' in the Netherlands refers to any action intended to terminate life following a request from the patient, and encompasses both physician-assisted suicide and active euthanasia. This was legalized in 2002 under the Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002. However, before this, euthanasia was freely practised despite being prohibited by the Dutch Penal Code. This situation evolved from case law, beginning in 1973 when Dr Postma admitted injecting and killing her paralysed mother (Nederlandse Jurisprudentie, 1973). Despite being convicted the court decided that euthanasia could be acceptable in certain circumstances, such as when a doctor is simultaneously faced with the conflicting moral duties of upholding a law which demands respect for life and acting in a patient's best interests. This led to the development of various guidelines that outlined the circumstances in which euthanasia could be seen as acceptable and, therefore, those who performed it would not be prosecuted. The 1984 Leeuwarden and Rotterdam criteria (Otlowski, 1997) stated:

- The patient must repeatedly and explicitly express the desire to die
- The patient's decision must be well-informed, free and enduring
- The patient must be suffering from severe physical or mental pain with no prospect of relief
- All other options for care must have been exhausted, or refused by the patient
- Euthanasia must be carried out by a qualified physician
- The physician must consult at least one other physician
- The physician must inform the local coroner that euthanasia has occurred.

A case study of euthanasia for a 55-year-old woman suffering from end stage chronic obstructive pulmonary disease provides an in-depth perspective of the Dutch legislation (Janssen et al, 2008). In 2002 the Termination of Life on Request and Assisted Suicide (Review Procedures) Act was passed, which amended the Dutch Penal Code to legalize physician-assisted suicide and active euthanasia for those who acted with due care as specified by the Act. The new Act codified existing guidelines but decreased the age at which euthanasia is permissible to 12 years of age. In addition, guidelines have been developed for performing euthanasia on infants although this is still prohibited by law. The Groningen protocol (Verhagen and Sauer, 2005) outlines similar requirements to the 2002 Act but relies on agreement and consent from parents. The protocol has been openly followed on four occasions and has resulted in no prosecutions. However, since 2004 no cases of infant euthanasia have been reported. Overall, the number of people having a medically-assisted death in the Netherlands is falling (van der Heide et al, 2007).

Belgium

Euthanasia, defined as a third party intentionally ending the life of a patient at his/her request, was legalized in 2002 under the Belgian Act on Euthanasia (Belgian Ministry of Justice, 2002). The Act does not legislate for physician-assisted suicide or any other forms of life-shortening action. It is applicable to any capable patient over 18 years of age who is in a hopeless medical situation, defined as an incurable disease which causes the patient constant mental or physical suffering, and who has repeatedly expressed a wish to die. The patient must make a written request and a period of at least a month must follow before euthanasia is carried out. The Act also allows an advance directive, made in accordance with the law, to stand for 5 years. Acts of euthanasia are investigated by a Federal Control and Evaluation Commission, who can refer the case to the public prosecutor if it is thought that the conditions of the Act were not fulfilled.

Luxembourg

Luxembourg's Err/Huss Bill passed its second reading in March 2009 (Chambre Des Deputes, 2008) and legalized physician-assisted suicide and active euthanasia for patients suffering from incurable conditions in unbearable suffering, and who have asked repeatedly to have their lives actively terminated by a doctor. The law is similar to Belgian legislation, requiring two physicians to examine the patient, a commission to be set up to investigate the acts of euthanasia, and valid advance directives to be respected. The Bill was opposed by both the Prime Minister and the Grand Duke who, because of moral objections, refused to approve it if it were passed. This led to a controversial amendment to article 34 of the constitution that removed the Grand Duke's power to approve laws.

Australia

Australia's Northern Territory legalized physician-assisted suicide and active euthanasia in 1996 when the Rights of the Terminally Ill Act 1995 (Northern Territory's Legislative Assembly, 1995) came into effect. This allowed adults over the age of 18 years with unacceptable pain, suffering or distress as a result of a termi-

nal illness to receive medical assistance to commit suicide. Section 3 of this Act defined 'terminal illness' as an illness that would be fatal without extraordinary or unacceptable measures and 'assistance' as 'the prescribing of a substance, the preparation of a substance and the giving of a substance to the patient for self administration, and the administration of a substance to the patient.' Numerous safeguards were included in the legislation:

- The patient must be examined by two medical practitioners, one of whom has knowledge of psychiatry, who agree on the existence, seriousness and prognosis of the illness
- Full, free, informed consent with respect to the nature of the illness, outcome, and alternative treatment options, including palliative care, is obtained
- The patient must sign a certificate, witnessed by two practitioners who will gain no financial advantage
- There are two waiting periods between the first request, the signing of the certificate, and the implementation
- The patient's medical practitioner oversees the suicide
- Full records are kept and the death is certified and reported to the coroner.

Only four citizens had died under the Act before it was repealed 9 months later by the Parliament of Australia when it passed the Euthanasia Laws Act 1997. This Act prohibited any further euthanasia laws being passed by certain Australian territories. Recently, The Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008 has been introduced which could see all Australian states and territories once again free to self-govern euthanasia.

The UK

There have been over 100 cases of Britons having used the services of Dignitas. However, the UK has proved sympathetic to such assisted suicides, and no prosecutions have resulted under the Suicide Act 1961 (aiding, abetting, counselling or procuring the suicide of another can result, if convicted, in up to 14 years' imprisonment).

On three occasions, Lord Joffe has introduced a bill to legalize assisted dying. The Assisted Dying for the Terminally Ill Bill 2004 applied to competent adults suffering unbearably as a result of a terminal illness with an agreed prognosis of a 'few months' and would, if they so desired, allow them to receive medical assistance to die, defined as 'either providing the patient with the means to end the patient's life or if the patient is physically unable to do so ending the patient's life.' There were numerous qualifying conditions, which had many similarities to international legislation. A select committee was established to consider the Bill and it recommended several changes, leading to significant amendments and its reintroduction in 2005. The new Bill, which sought to legalize physician-assisted suicide but not active euthanasia, was defeated on its second reading in 2006, by a margin of 148–100. Despite this Lord Joffe plans to introduce a fourth version of the Bill to Parliament in the near future. Margo MacDonald, an MSP, intends to introduce a similar bill into the Scottish Parliament. While the Prime Minister has indicated his opposition to such legislation the government has issued its intent to simplify and modernize the language of the Suicide Act 1961 (House of Commons, 2008).

The future of assisted dying legislation in the UK

With a flurry of media headlines revitalizing the debate, there seems to be an increasing push towards assisted dying legislation in the UK and it is inevitable that this issue will again be brought before Parliament. Previous UK bills have included numerous safeguards which demonstrated an agreement with the international community as to the central importance of carefully regulating physician-assisted suicide and euthanasia to avoid improper application of the law. There are many vital issues to consider in any assisted dying legislation. Of these, first there is a need to pay particular attention to protecting the vulnerable (Ganzini et al, 2000). Opponents of Lord Joffe's Bill often argued that vulnerable people might consider themselves to be a burden to their family or others and might perceive a 'duty to die' (Templeton, 2004). No such evidence to justify concerns about the negative impact of assisted dying legislation on potentially vulnerable groups such as disabled and elderly people was found in Oregon and the Netherlands (Battin et al, 2007).

A second important consideration is that of ensuring valid consent has been obtained, which highlights the need for a thorough assessment of a patient's capacity. A study in Oregon found that, despite legal safeguards, three out of 18 patients who received lethal prescriptions met criteria for depression (Ganzini et al, 2008). This prompted the suggestion of making psychiatric assessment mandatory in any assisted dying legislation (Ryan and Shaw, 2008), a view which was echoed by the House of Lords Select Committee reporting on the 2004 UK Bill (House of Lords, 2005). Interestingly, in the Oregon study, none of the 49 people who died as a result of physician-assisted suicide in 2007 had received psychiatric evaluation (Ganzini et al, 2008). As part of ensuring valid consent, the option of palliative care should be thoroughly explored.

There are fears that people may choose physician-assisted suicide because they have inadequate symptom control and the House of Lords Select Committee recommended that any future bill should view assisted dying as complementary, rather than an alternative, to good quality palliative care and more than a single consultation would be needed. A Belgian study demonstrated how palliative care and assisted dying legislation

Acts relating to assisted dying

- Northern Territory's Legislative Assembly (1995) Rights of the Terminally Ill Act 1995. http://www.nt.gov.au/lant/parliament/committees/rotti/rotti95.pdf (accessed 31 January 2009)
- Oregon Death with Dignity Act (1997) Legislative Statute. http://oregon.gov/DHS/ph/pas/ors.shtml (accessed 31 January 2009)
- Washington Death With Dignity Act (2008) Initiative Measure 1000. http://wei.secstate.wa.gov/osos/en/Documents/I1000-Text%20for%20web.pdf (accessed 31 January 2009)
- Termination of Life on Request and Assisted Suicide (Review Procedures) Act (2002) http://www.nvve.nl/assets/nvve/english/euthlawenglish.pdf (accessed 31 January 2009)

have actually reinforced each other (Bernheim et al, 2008) and a survey of physicians in Oregon found the introduction of the Death With Dignity Act acted as a spur to over three-quarters of participants to further their training and knowledge in palliative care (Ganzini et al, 2000).

Advocates for a change in UK law suggest that legalizing assisted dying could be done with adequate safeguards and that this would indeed provoke improvements in palliative care (Murphy, 2008). Others suggest that current UK legislation, recently bolstered with the advent of the Mental Capacity Act 2005, provides patients with adequate choices about end-of-life care while still providing protection for vulnerable groups and hence there is no need for the introduction of assisted dying legislation (Stone and Minton, 2008). While patient care and safety is pre-eminent in any assisted dying legislation, Bosshard et al (2008) note that against the background of increasing public acceptance of assisted dying in Europe, the fundamental question of the appropriate role for doctors in an area that goes beyond medicine remains contentious.

Conclusions

With increased media reporting and discussion, and the inevitability that the subject of assisted dying will again soon be reviewed by Parliament, it will be interesting to see how any future UK assisted dying legislation may be influenced and shaped by similar existing international legislation. BJHM

Conflict of interest: none.

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KEY POINTS

- Only a handful of countries and two American states have enacted assisted dying legislation.
- In the UK there has been increasing media coverage of assisted suicides occurring abroad and Lord Joffe has announced his intention to introduce another Assisted Dying for the Terminally Ill Bill.
- Any assisted dying legislation should incorporate inherent and stringent safeguards.
- Future assisted dying legislation should incorporate mandatory psychiatric assessments.