Assisted dying regimes

Introduction
A small number of jurisdictions now permit euthanasia and/or assisted suicide. This briefing note discusses how the law was changed in those jurisdictions, outlines the regulatory regimes, and summarises the empirical evidence of the practice of euthanasia and assisted suicide (defined in box 1).

How the law was changed to permit assisted dying

The Netherlands
In the Netherlands, euthanasia and assisted suicide were effectively legalised through the use of the defence of necessity in prosecutions of (primarily) doctors. The defence is available when the doctor faced a conflict between his or her duties to preserve life and relieve suffering. The courts held that only doctors can face such a conflict of duties because only doctors have a professional duty to relieve suffering; lay-persons (who include relatives) and nurses do not. Over some thirty years, the courts developed this duty-based defence of necessity in euthanasia cases, placing conditions on the defence, including: an express and earnest request; unbearable and hopeless suffering; consultation; careful termination of life; record-keeping; and reporting. These conditions became known as requirements of due care or careful practice. The Dutch legislature eventually codified the parameters of the defence in the Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001, which lists six due care criteria which must be met in cases of euthanasia and assisted suicide (see box 2). The judicially-developed necessity defence is still applied to cases involving incompetent persons, particularly neonates.

Belgium
Unlike in the Netherlands, there had been few criminal prosecutions in euthanasia cases prior to its legalisation in Belgium, so legal change had to come from outside the judiciary. The 1980s and 1990s witnessed a series of unsuccessful legislative moves to allow euthanasia. After a change of government and intense legislative debate, the Law on Euthanasia was passed in 2002. It allows only doctors to perform euthanasia. Assisted suicide is not explicitly covered, although Belgium’s oversight body, the Federal Control and Evaluation Commission (FCEC) has accepted cases of assisted suicide as falling under the law.1

Luxembourg
The Law on Euthanasia and Assisted Suicide came into force in Luxembourg in 2009 after a heated political and public debate. The law is closely based on the Belgian law, although it does specifically permit assisted suicide as well as euthanasia.

Box 1. Definitions

Euthanasia: an intervention undertaken with the intention of ending a life to relieve suffering. In the Dutch and Belgian contexts, the term euthanasia refers only to the termination of life upon request.

Some common (and often confusing) modifiers of euthanasia are:

- active: a deliberate intervention to end life
- passive: withdrawal/withholding of life-sustaining treatment
- voluntary: at the request of the person killed
- involuntary: in the absence of a request by the person killed, although that person is competent

Assisted suicide: any act which intentionally helps another person to commit suicide, for example by providing him or her with the means to do so. In the Netherlands, assisted suicide is often included in the term euthanasia. Legal regimes often permit only physician-assisted suicide which is commonly referred to as PAS.

Assisted dying: (voluntary active) euthanasia and assisted suicide. (Though sometimes used as a synonym only for assisted suicide.)

Switzerland
In Switzerland, it is a criminal offence to assist a suicide only where the assister has a selfish motive. This provision in the Penal Code has not changed since 1942. When it was originally drafted in 1918, “the attitudes of the Swiss public were shaped by suicides motivated by honour and romance, which were considered to be valid motives. Motives related to health were not an important concern, and the involvement of a physician was not needed.”

Euthanasia is not permitted in Switzerland, although as in many other European jurisdictions, the separate offence of murder at the victim’s request carries a lower minimum sentence than murder.

Oregon and Washington
Many US states allow legislation to be enacted if a majority votes for an initiative placed on the ballot following a petition signed by a minimum number of voters. Following two narrowly unsuccessful attempts to permit physician-assisted suicide by ballot initiative in Washington and California, Oregon voters passed the first Death with Dignity Act in 1994 by a majority of 52%. The Act permits the provision of a prescription for lethal medication to be self-administered by the patient. The Act was controversial from the moment the ballot measure was passed, and there were a number of ultimately unsuccessful legal challenges to it. Washington voters passed an almost identical Act in 2008 by a majority of 58%.
Features of assisted dying regimes
This section outlines the most important legal regimes permitting assisted dying: those in the Netherlands, Belgium and Oregon.

The requesting person’s condition and experience of suffering
The legal requirements relating to the requesting person’s condition and experience of suffering vary widely across these jurisdictions. It is notable that despite this variation, over 80% of all reported cases of euthanasia or physician-assisted suicide in the Netherlands, Belgium and Oregon involve cancer patients.

In the Netherlands, the “attending physician … must have been satisfied that the patient’s suffering was unbearable, and that there was no prospect of improvement”. The patient’s suffering need not be related to a terminal illness and is not limited to physical suffering such as pain. It can include, for example, the prospect of loss of personal dignity or increasing personal deterioration, or the fear of suffocation. A related due care criterion (see box 2) is that there must be “no reasonable alternative in light of the patient’s situation”. In cases where the source of the suffering is a psychological disorder, the patient’s reasonable decision to refuse a realistic treatment possibility (whether curative or palliative) which might ease his or her suffering does not stand in the way of a request for euthanasia based on that suffering.

In Belgium, the “patient [must be] 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”. As in the Netherlands, there is no requirement that the patient be suffering from a terminal illness, although additional procedural requirements are imposed if the patient is “clearly not expected to die in the near future”. Again there must be “no reasonable alternative” to euthanasia. However, euthanasia is permissible only if the disorder is incurable, so a patient’s reasonable refusal of potentially curative treatment will prevent access to euthanasia. The reasonable refusal of a palliative treatment possibility will not have this effect.

The Netherlands permits assisted suicide in cases where the source of the patient’s suffering is a psychiatric rather than a physiological disorder. In such cases, the patient may not reject “a realistic alternative to relieve the suffering”. In Belgium, the permissibility of euthanasia or assisted suicide in psychiatric cases was initially unclear. Since legalisation, the Federal Control and Evaluation Commission (FCEC) has accepted six psychiatric cases (which constitute less than 1% of all reported cases). Of these, five patients suffered from serious and incurable depression and one from psychosis with repeated suicide attempts.

In Oregon, the patient must be suffering from a terminal disease, defined as “an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months”. There is no additional requirement relating to the patient’s experience of the disease or any minimum level of suffering.

The request
In the Netherlands, the patient’s request must be “voluntary and carefully considered”. The patient must be competent to make such a request and the attending physician must consult a psychiatrist if he or she suspects the patient is incompetent. The request must also be well-informed.

In Belgium, the patient must be “legally competent”. The request must be both “completely voluntary” and “not the result of any external pressure”. The doctor must inform the patient about “his health condition and life expectancy” and “the possible therapeutic and palliative courses of action and their consequences”.

In Oregon, the competence, voluntariness and information requirements are set out in some detail. The patient must have “the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patient’s manner of communicating if those persons are available.” Two witnesses must attest that the patient is acting voluntarily and is not being coerced to sign the request. The patient must make an “informed decision … that is based on an appreciation of the relevant facts and after being fully informed by the attending physician of: (a) his or her medical diagnosis; (b) his or her prognosis; (c) the potential risks associated with taking the medication to be prescribed; (d) the probable result of taking the medication to be prescribed; (e) the feasible alternatives, including, but not limited to, comfort care, hospice care and pain control.”

The requesting person’s age
The Dutch law applies also to patients under the age of majority (18). A patient between the ages of 16 and 18 who is “capable of making a reasonable appraisal of his own interests” may request euthanasia or assisted suicide. The parent(s) or guardian does not have a veto, but must be consulted. Patients aged between 12 and 16 must pass the same test of capacity. In addition, the consent of the parent(s) or guardian is required.

In Belgium, euthanasia is legal only for patients over the age of 18 and for minors over the age of 15 who have been legally emancipated by a judicial decision. No cases involving minors have been reported. The Oregon and Luxembourg laws apply only to patients over the age of 18.

Box 2. The Dutch due care criteria
The due care criteria are set out in section 2(1) of the 2001 Act.
“The attending physician must:

a. be satisfied that the patient has made a voluntary and carefully considered request;
b. be satisfied that the patient’s suffering was unbearable, and that there was no prospect of improvement;
c. have informed the patient about his situation and his prospects;
d. have come to the conclusion, together with the patient, that there is no reasonable alternative in the light of the patient’s situation;
e. have consulted at least one other, independent physician, who must have seen the patient and given a written opinion on the due care criteria referred to in a. to d. above; and
f. have terminated the patient’s life or provided assistance with suicide with due medical care and attention.”

Consultation and referral
All of the regimes require another physician to confirm the fulfilment of the legal requirements. A number of additional functions may be served by a consultation requirement, including quality control; avoidance of idiosyncratic judgments; provision of information to the attending physician; and enabling effective retrospective scrutiny of actions and decisions.

In the Netherlands, the independent physician must see the patient and give a written opinion on the extent to which the due care
criteria are met (see box 2). The consultation requirements are more stringent if the patient’s suffering is due to a psychiatric disorder. The state-funded programme Support and Consultation on Euthanasia in the Netherlands (SCEN) trains physicians to be consultants and to provide support and advice for doctors treating patients at the end of life. Most reported euthanasia cases involve a SCEN consultant.

In Belgium, the consulting physician must examine the patient and the medical record and ensure that the suffering requirement has been met. Moreover, if the patient “is clearly not expected to die in the near future”, there is a mandatory additional consultation with either a psychiatrist or relevant specialist (and a waiting period of at least one month). Although a consultation with a palliative care expert is not legally required, many Catholic hospitals in Flanders impose such a palliative filter in addition to the statutory criteria. In Oregon, the attending physician must refer the patient to “a consulting physician for medical confirmation of the diagnosis, and for determination that the patient is capable and acting voluntarily.” Further, a counselling referral must be made if either the attending or consulting physician suspects that the patient “may be suffering from a psychiatric or psychological disorder, or depression causing impaired judgment”. Physician-assisted suicide (PAS) is allowed only if the counsellor determines that the patient is not suffering from such a condition.

The person providing assistance
In the Netherlands, the courts originally required that the person who provided euthanasia was the patient’s treating physician. The current requirement focuses more closely on its purpose: the doctor must know the patient sufficiently well to be able to assess whether the due care criteria are met (see box 2). Cases in which there is no pre-existing doctor-patient relationship are likely to be closely investigated.

The Belgian Act requires that the physician have “several conversations with the patient spread out over a reasonable period of time” in order to be certain of the persistence of the patient’s suffering and the enduring character of his or her request. The Dutch purpose-focused argument (that in order to assess whether the due care criteria are met, the doctor must have some familiarity with the patient) might also be applied in Belgian euthanasia cases. However, the legislative history makes clear that the patient should be able to bypass his or her attending physician if so desired – from which one might infer that there is no requirement for a pre-existing physician-patient relationship.

In Oregon, the attending physician is defined as “the physician who has primary responsibility for the care of the patient and treatment of the patient’s terminal disease”. The evidence suggests that many patients who sought assisted suicide had to ask more than one physician before finding one who was willing to provide a prescription. Over the first three years of operation of the Oregon law, only 41% of patients received their prescription from the first physician asked. This suggests that in many cases there was no longstanding or pre-existing physician-patient relationship. The median duration of that relationship in Oregon over the first ten years was 11 weeks. The range was between 0 and 1440 weeks. Commentators opposed to the Oregon law have raised the possibility that a patient refused PAS by one physician on the grounds of failing to meet one of the statutory criteria may obtain the prescription from a more accommodating physician.

The laws in Belgium and Oregon contain conscientious objection provisions. Although there is no such provision in the Dutch law, it is nonetheless clear that “no doctor has any obligation to accede to a request [for euthanasia], however well-founded.”

Reporting and scrutiny
Termination of life on request and assisted suicide remain criminal offences in the Netherlands. The defences inserted into the Penal Code by the Act require the doctor to report the case as euthanasia or assisted suicide to the municipal pathologist, who then passes the file to the relevant Regional Review Committee (RRC). If the RRC finds that the doctor did not act in accordance with the due care criteria (see box 2), the case is referred to the Public Prosecution Service. Thirty eight cases were referred between 1999 and 2008 (0.19% of reported cases). No prosecutions have been brought following these referrals.

Empirical evidence
Most of the evidence is either of the frequency of particular end of life decisions (obtained from surveys completed anonymously by doctors) or of cases reported to the relevant authority. This section summarises key evidence, much of which is about the Dutch experience. Many of the empirical claims made about the practice of assisted dying under existing legal regimes misrepresent the data, take it out of context or neglect important comparisons with jurisdictions where assisted dying is prohibited.

What is known about the frequency of end of life decisions
Chart 1. Rates of euthanasia, PAS and termination of life without request
Chart 1 shows the percentage of all deaths in specific years that were cases of euthanasia (EUT), PAS or termination of life without request (TLWR). It combines data from a number of different anonymous prevalence surveys of doctors, and of cases reported to the relevant authority. This section summarises key evidence, much of which is about the Dutch experience. Many of the empirical claims made about the practice of assisted dying under existing legal regimes misrepresent the data, take it out of context or neglect important comparisons with jurisdictions where assisted dying is prohibited.
What is known about vulnerable groups

In 2007, researchers examined data from the Netherlands and Oregon in order to see if members of vulnerable groups were more likely to receive assistance in dying (either euthanasia or PAS).

They examined the frequency of such assistance in ten groups of potentially vulnerable patients, defined by gender, age, ethnicity, educational and socio-economic status, illness and disability. They found "no evidence of heightened risk ... with the sole exception of people with AIDS." Instead, they concluded, "the available data ... shows that people who died with a physician’s assistance were more likely to be members of groups enjoying comparative social, economic, educational, professional and other privileges.”

Endnotes

5. ODHiH (2010) Twelfth Annual Report Table 1.
11. Smets et al. Legal euthanasia in Belgium: characteristics of all reported euthanasia cases. Medical Care 2010;48:187-192, Table 2.
16. ODHiH (2001) Oregon’s Death with Dignity Act: Three Years of Legalized Physician-Assisted Suicide (Table 3) (no further data has been reported).
18. Oregon Dept. of Human Services (2008) Tenth Annual Report (no further data has been reported).