Scottish Council on Human Bioethics

01.04.2017 **Position Statement on:**

Assisted Suicide

The Scottish Council on Human Bioethics (SCHB) recognises that some persons may wish for assistance to end their lives which they find unbearable. It understands that these are very difficult situations where a lot of compassion and sympathy is required. However, the concept of assisted suicide cannot be supported by the SCHB for the following reasons:

1. Palliative care can address the physical suffering of a terminally ill person

Advocates of assisted suicide suggest that it would enable persons, who become terminally ill and find themselves in an unbearable situation, to avoid suffering a slow, drawn-out death.

In response to this the SCHB notes that:

Physical suffering and/or other symptoms can be effectively addressed, in up to 95% of patients, with appropriate medication, when treated by healthcare professionals with the relevant expertise.[1,2]
Similarly, patients with an illness such as motor neurone disease (a serious progressive neurological disorder) are often afraid of choking to death. But studies from the most experienced hospice units have demonstrated that, with appropriate palliative care, this virtually never happens.[3]

In addition, the administration of appropriate amounts of sedative drugs may be considered as an appropriate alternative, when persons are in the dying stages, to manage agitation, distress and restlessness. These indications can occasionally occur when patients are no longer capable of working through their issues or are barely conscious as a result of their disease rather than drugs. In these cases, palliative care can help patients (and sometimes their families), by calming their symptoms.
Usually, the treatment is a matter of gradually increasing the level of drugs according to effect. However, if a patient is very agitated there are occasions when a rapid use of larger doses of drugs is essential for the safety of the patient and others.

Experts agree, therefore, that most physical suffering can be relieved by a holistic range of measures including surgery. When the suffering is caused by psychological distress or depression, this can usually be identified and an appropriate medical response provided.[4] Thus, physical suffering or depression should not be a motive for assisted suicide if appropriate palliative care is available.[5]

Nonetheless, there will always be occasions where a patient's symptoms cannot be completely controlled. Generally, these are patients who cannot resolve an issue or cannot cope with a symptom, such as severe

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[1] Organisations such as the Hospice Movement reveal that suffering can be adequately alleviated in all but the rarest cases.
See also: http://www.bbc.co.uk/ethics/euthanasia/against/against_1.shtml Pain: Some doctors estimate that about 5% of patients don't have their pain properly relieved during the terminal phase of their illness, despite good palliative and hospice care.

[2] When correctly used to relieve pain in a patient who is terminally ill, morphine should never cause death. By contrast it may lengthens life and improves its quality. This is because the therapeutic dose of morphine, which relieves pain, is virtually always well below the toxic dose which ends life and because the relief from pain which it brings removes stress factors in the patient's condition. In addition, toxic doses risk causing increased agitation in some patients.

[3] Unfortunately not many motor neurone disease patients die in a hospice as they need longer term care than that provided by such centres. It is important, for society to increas funding to manage these patients in hopsices. The hospice movement has shown that with good enough care these patients can have quality of life and a peaceful end.
Neudert C, Oliver D, Wasner M, Borasio GD., The course of the terminal phase in patients with amyotrophic lateral sclerosis. J Neurol. 2001 Jul;248(7):612-6.

[4] Sometimes, depression is not appropriately treated in end of life patients due to a range of factors such as failure to diagnoses depression and failure to identify the underlying causes of depression.
See: Linda Ganzini, Elizabeth R Goy, Steven K Dobscha, Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross sectional survey, BMJ 2008; 337, a1682

[5] French National Consultative Ethics Committee for health and life sciences, The End of Life, Personal Autonomy, the Will to Die, 2013, p. 14.

breathlessness. Some may also have significant psychological and/or existential distress which they find difficult to address. Almost all patients with symptoms which cannot be completely controlled have elements of this distress which is not recognised as physical.

These individuals, who are already drowsy and dying of their illness, may then request some form of sedation to relieve the suffering, in which case it may be possible to manage their distress and agitation while minimising side effects. In other words, drugs are administered and monitored to induce a state of decreased or absent awareness (unconsciousness) in order to increase comfort in the dying process while not shortening life.[6]
This of course is dose dependent and high levels of opiates can limit fluid intake, as well as suppress respiration. Rarely, agitation is such that very high doses are required but clinicians tend to be wary of using high doses in case they bring about premature death.[7]
It is very unusual for palliative care to use continuous sedation to keep a lucid patient asleep in order to address intolerable physical and/or mental distress. Deliberately sedating patients to deal with their suffering is a very rare occurrence in the UK.

However, it is important that patients with difficult symptoms are aware that complete relief is sometimes beyond the realm of medicine. In this regard, it should be noted that palliative care not only includes medical assistance but endeavours to provide non-clinical support and the right environment for patients to express and work through their distress.[8] Thus, few patients request assisted suicide when their physical, emotional and spiritual needs have been adequately addressed.

2. Inherent human dignity is enduring and can never be lost

Advocates of assisted suicide suggest that individuals should be able to determine their own dignity and quality of life, unrestricted by the moral, cultural, religious, or personal beliefs of others. For example, it has been proposed that persons who fear that they will lose their dignity during the final stages of a terminal illness should be able to 'die with dignity' before these stages occur.

In response to this, the SCHB notes that:

Palliative care respects the human dignity of individuals at all the stages in which they find themselves. But a distinction should be made between inherent human dignity (which reflects the permanent, immeasurable, indivisible, inviolable and equal value as well as worth of all persons) and non-inherent human dignity (which is a variable dignity that can be lost and is dependent on, for example, a person's social interactions, professional position in life, how he or she is treated, or on other variables).

It is indeed incorrect to suggest that any person can ever lose his or her inherent human dignity so that a life becomes worthless or meaningless. Though inherent human dignity is not a scientific concept, it should be recognised in every person to an equal extent. This is in accordance with the ***United Nations' Universal Declaration of Human Rights*** which affirms in its preamble "*the inherent dignity and … the equal and inalienable rights of all members of the human family"* as *"the foundation of freedom, justice and peace in the world".*
In other words, the principle of equality associated to the inherent dignity of all human beings demands that all individuals believe that they have the same dignity.
This means that society has a choice between believing that all individuals have the same inherent dignity which enables a just and civilised society to exist. Or it can believe and accept that some individuals can actually lose their inherent dignity either completely or partially so that their lives should be ended. In this case a society based on equal rights ceases to (and cannot) exist.

At present, human beings live in a society where inherent human dignity is universal and where each and every person is expected to acknowledge, respect and recognise the equal and inherent dignity of others

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[6] Nathan I Cherny, Sedation for the care of patients with advanced cancer, *Nature Reviews Clinical Oncology* 3, 492-500 (2006).
Susan Anderson Fohr. 'The Double Effect of Pain Medication: Separating Myth from Reality', Journal of Palliative Medicine. April 2005, 1(4): 315-328.
Nigel Sykes, Andrew Thorns, 'Sedative Use in the Last Week of Life and the Implications for End-of-Life Decision Making', Arch Intern Med. 2003;163(3):341-344.

[7] In a Europe-wide study, the highly variable results bring into question whether existing guidelines for pain relief were applied appropriately. Bilsen J. et al. Drugs used to alleviate symptoms with life shortening as a possible side effect: end-of-life care in six European countries, *J Pain Symptom Manage*. 2006 Feb;31(2):111-21.

[8] For example, with the consent of the patient, the number of visitors may be reduced so that he or she can work things through.

which cannot be created, modified or destroyed by an individual, a majority or a State. It is also independent of the suffering a person may experience in contrast to non-inherent human dignity which can be affected by suffering. Indeed, in a civilised society, suffering cannot take precedence over inherent human dignity. The worthiness and value of a life cannot depend on how much pleasure or suffering a person experiences during his or her life.

Legalising assisted suicide would mean that society would accept that some individuals can actually lose their inherent human dignity and have lives which no longer have any worth, meaning or value.
It would also mean denying the inherent dignity which is due to an individual, in order for him or her to be legally killed. In other words, it would give the message that the value of a human life is only based on subjective choices and decisions and whether this life meets certain quality standards.

In this regard, it should be noted that a society that no longer believes in the inherent dignity of human life cannot offer any valid arguments against the taking of life of others, who may be considered unworthy of life. It becomes a society that has lost its trust in the inherent value and meaning of life and cannot comprehend why it should be endured.
This is in complete opposition to a responsible, civilised, benevolent and compassionate society which continues to affirm and defend the lives of all its members and the notion that every human life is full of value, meaning and richness even though persons may be aged, dependent on others or may have lost their autonomy. Therefore, in order to function consistently, society must reject assisted suicide if it does not want to undermine its most basic and fundamental values.[9]

3. Inherent human dignity and the proper functioning of society takes precedence over absolute autonomy

Advocates of assisted suicide suggest that a person's fear of disability and dependency should enable him or her to die while he or she is still autonomous and that assisted suicide would enable self-determination to exist. In other words, individuals have the right to take decisions concerning their own life and death situations in accordance with their own values and beliefs. These should not be imposed by a court, a physician or a family member. It is a question of freedom and equality in the face of death.
Thus, advocates of assisted suicide suggest that nobody has the right to impose on the terminally-ill and the dying an obligation to live out their lives when they themselves have persistently expressed the wish to die.

In response to this, the SCHB notes that:

Full and complete individual autonomy undermines the concept of inherent human dignity. Indeed, though the concept of individual autonomy is very important in society, the recognition of an individual's absolute autonomy contravenes the very basis of inherent human dignity and the proper functioning of an interactive society. Accepting such an extreme form of autonomy would represent the atomisation and isolation of each human being. Civilised society, as such, would then cease to exist. In the same way as car drivers do not demand absolute autonomy in the manner in which they drive, individuals cannot demand absolute autonomy in the manner in which they live or die.
Moreover, autonomy cannot take precedence over inherent human dignity. It is only because society believes in the inherent human dignity of persons, that it respects their autonomy.[10]

In addition, being dependent on others should never be associated with a loss of dignity. All are born dependent on others, and many will die dependent on others. Being dependent on others at different times in a person's life is a basic characteristic of human existence.

Finally, the legalisation of assisted suicide may undermine the autonomy and impose a level of coercion on medical and other health care professionals or on dependent and vulnerable individuals. They may then feel obliged to carry out an act of assisted suicide against their wishes or personal beliefs.

4. Inherent human dignity is grounded on an interdependent society

Some supporters of assisted suicide argue that persons should be able to decide, for themselves, whether or not they have lost their dignity and that this decision does not have any consequence for other members of society.

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[9] French National Consultative Ethics Committee for health and life sciences, The End of Life, Personal Autonomy, the Will to Die, 2013, p. 16-18. http://www.ccne-ethique.fr/sites/default/files/publications/avis_n_121_du_ccneeng.pdf

[10] Likewise, the concept of a person being a burden to society is inimical to autonomy, as somebody who truly is autonomous by definition cannot be a burden.

In response to this, the SCHB notes that:

Again, a distinction should be made between inherent and non-inherent human dignity. In an interactive society, making a choice about the value of a life (even one's own) means making a decision about the value of other lives.

As the UK Supreme Court judge, Baroness Brenda Hale, indicated "*Respect for the dignity of others is not only respect for the essential humanity of others; it is also respect for one's own dignity and essential humanity. Not to respect the dignity of others is also not to respect one's own dignity*."[11]
But the reverse is also true: 'Not to respect one's own inherent dignity is not to respect the inherent dignity of others'. The senior lawyer, Patrick Devlin, indicates "*The reason why a man may not consent to the commission of an offence against himself beforehand or forgive it afterwards is because it is an offence against society*."[12]
In other words, persons who consider that their lives are no longer worth living or that they have lost their inherent dignity are, in a way, indirectly indicating that the lives of persons in similar or in worse situations are also not worth living and should be ended. It would mean that inherent human dignity is no longer inviolable or universal.

Similarly, persons who believe that their lives are no longer worth living or that they have lost their inherent dignity must reject the worth, value and meaning that others, such as their family, friends and even society, are recognising in their lives. In addition, for a person to consciously deny and reject the value, meaning and worth given by others to his or her life, without attenuating circumstances such as a psychological disorder, means rejecting these other persons' capacity to confer dignity which is tantamount to undermining their personhood.
As the House of Lords Medical Ethics Select Committee in 1994 indicated, belief in the special worth of human life is at the heart of civilised society. It is the fundamental value on which all others are based, and it is the foundation of both law and medical practice.[13] The prohibition of intentional killing is thus the cornerstone of the law and social relationships. It protects each individual impartially, embodying the belief that all are equal. Dying is not only a personal or individual affair. The death of a person affects the lives of others, often in ways and to an extent which cannot be foreseen. This means that, with assisted suicide, the interests of the individual cannot be separated from the interest of society as a whole[14] - personal opinions about worth, meaning and value of human life matter to the whole of society.

5. Assisted suicide should not be considered as a medical procedure

It is often suggested that assisted suicide should be considered as a medical procedure undertaken by healthcare professionals.

In response to this, the SCHB notes that:

Assisted suicide actually undermines the traditional goal of medicine, namely to cure and care but not to harm or kill patients.
It is also important to recognise that it is not easy, from a psychological perspective, for a physician (or any other person) to take part in assisted suicide.[15]

Research, moreover, indicates that the most sustained demands for assisted suicide are actually considered by persons suffering from existential problems or because they have an extreme concept of control and independence.[16] Thus, the argument in favour of assisted suicide is more about control than medicine.

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[11] Brenda Hale, Dignity, Journal *of Social Welfare & Family Law.* Vol. 31, No. 2 (2009), pp. 101–108 (p.106).

[12] Devlin, P., The Enforcement of Morals, London, 1965, p. 6.

[13] House of Lords Select Committee Report on Medical Ethics, HL 21-I, 31 January 1994 - paragraph 34.

[14] House of Lords Select Committee Report on Medical Ethics, HL 21-I, 31 January 1994 - paragraph 237.

[15] See: EXIT - LE DROIT DE MOURIR, https://www.youtube.com/watch?v=7iNYTj_G03k

[16] Linda Ganzini, et. al., Physicians' Experiences with the Oregon Death with Dignity Act, The New England Journal of Medicine, Vol 342, February 2000.

6. Assisted suicide would undermine the relationships of health care professionals with their patients

Advocates of assisted suicide suggest that curing disease and bringing about death are not mutually exclusive roles since the intention, in both cases, is to relieve suffering. It is further argued that the primary role of the physician is to care for his or her patients, which must therefore entail respecting their autonomous wish to die.

In response to this, the SCHB notes that:

While all admit the inevitability of death, intentionally and actively pursuing the death of a patient, fundamentally changes the role of the physician, changes the doctor-patient relationship and changes the role of medicine in society.

Some physicians may then become hardened to death and to causing death, particularly when patients are old, terminally ill, or disabled. Legalising assisted suicide would give persons, such as physicians, power that could be too easily abused, and a responsibility that they should not be permitted to have. It is not up to physicians to decide whether or not a life is worthwhile.[17] If assisted suicide was to be accepted, a number of vulnerable people and their families may begin to mistrust the real intentions of their doctors.

At present, when a patient discusses his or her wish for assisted suicide with his or her physician, this is framed primarily around trying to establish the reasons behind that wish. But if assisted suicide was to be legalised, it would very much change the discussion to one in which the patient is seeking the view and eventual support from the physician that his or her life no longer has any meaning or worth.

7. Assisted suicide should not be legalised just because it is occurring in secret

Advocates of assisted suicide suggest that the practice of clandestine, illegal assisted suicide carries the greatest potential for abuse. They argue that the pressures relating to end-of-life decisions will be more pernicious if assisted suicide remains an underground practice. Thus, the gap between law and practice must be reconciled if respect for the rule of law is to be maintained.

In response to this, the SCHB notes that:

The law should not be changed just because something, which is illegal and unethical, such as the killing of persons, is being practised in secret. If this happened it would completely undermine the rule of law in a country.
In addition, by prohibiting assisted suicide, it is possible to consider hard cases in which there is a measure of ambiguity, on a case by case basis, in an appropriate court of law and judged according to a good standard of fairness and compassion.

Moreover, as reflected by the situation in Belgium, legalising assisted suicide does not diminish the number of illegal acts. This number may even increase because a certain leniency may develop in undertaking such acts.[18] In some circumstances, there also seems to be some confusion as to what can be considered as an act of assisted suicide.[19]

8. International legal instruments oppose assisted suicide

It has been suggested that only those with religious or other non-secular beliefs are opposed to assisted suicide and that they should not be able to stop those who believe in the autonomy of the individual to choose when to die.

In response to this, the SCHB notes that:

The belief in the inherent dignity and inviolability of human life is, in fact, based on international globally accepted secular principles such as the ***United Nations' Universal Declaration of Human Rights.***

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[17] In very rare cases, physicians such as Harold Shipman, may actually feel empowered in being able to provoke death. Harold Shipman: The killer doctor, BBC News, 13 January 2004, http://news.bbc.co.uk/1/hi/uk/3391897.stm

[18] French National Consultative Ethics Committee for health and life sciences, The End of Life, Personal Autonomy, the Will to Die, 2013, p. 50.

[19] Agnes van der Heide et al., End-of-Life Practices in the Netherlands under the Euthanasia Act, *N Engl J Med* 2007; 356:1957-1965,

Moreover, the ***Council of Europe Parliamentary Assembly Recommendation 1418 (1999) on the Protection of the human rights and dignity of the terminally ill and the dying***[20], which is the latest text on the issue, indicates in Article 9.c. that:

The Assembly therefore recommends that the Committee of Ministers encourage the member states of the Council of Europe to respect and protect the dignity of terminally ill or dying persons in all respects by upholding the prohibition against intentionally taking the life of terminally ill or dying persons, while:

> *i. recognising that the right to life, especially with regards to a terminally ill or dying person, is guaranteed by member states, in accordance with Article 2 of the European Convention on Human Rights which states that "no one shall be deprived of his life intentionally";*
>
> *ii. recognising that a terminally ill or dying person's wish to die never constitutes any legal claim to die at the hand of another person;*
>
> *iii. recognising that a terminally ill or dying person's wish to die cannot of itself constitute a legal justification to carry out actions intended to bring about death.*

These texts emphasise the universal, absolute, inalienable nature of the concept of inherent human dignity. In other words, they support the notion that *no person* can lose his or her inherent human dignity at any time in his or her life. To reject such a notion would not only seriously challenge the whole concept of inherent human dignity but would be an extremely serious precedent in a world that has fought so hard to recognised the same inherent dignity in all persons.

9. Assisted suicide would undermine the protection due to the most vulnerable persons in society

By legalising assisted suicide, vulnerable people may begin to contemplate the procedure as a possible option for releasing family members, carers and the broader society from the responsibility of providing support. In other words, it may encourage them to believe that death is a greater good if they consider themselves to be a burden.

The House of Lords Select Committee recognised this risk by indicating in 1994: "*We are also concerned that vulnerable people - the elderly, lonely, sick or distressed - would feel pressure, whether real or imagined, to request early death. We accept that, for the most part, requests resulting from such pressure or from remediable depressive illness would be identified as such by doctors and managed appropriately. Nevertheless we believe that the message which society sends to vulnerable and disadvantaged people should not, however obliquely, encourage them to seek death, but should assure them of our care and support in life.*" [21]

This means that in a responsible and civilised society vulnerable persons need to know that society is committed first and foremost to their well-being, even if this does involve expenditure of time and money. The manner in which the weakest and most vulnerable members of society are treated reflects the true identity of a society because it reveals its core values.

Moreover, if it is the case that a person accesses assisted suicide in order to just make things easier for the carers, this may have profound consequences on the carers themselves who may then believe that they are the reason for the person's death.

10. The request to die may not reflect the patient's real wishes

Though sadness may be present in a patient faced with the news of his or her approaching death, this may be seen as a normal response in such a situation.
Generally, however, experience shows that once people receive appropriate palliative care and are comfortable, with their fears concerning suffering being addressed, they often change their minds about wanting to end their lives.[22]

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[20] Council of Europe Parliamentary Assembly Recommendation 1418 (1999), Protection of the human rights and dignity of the terminally ill and the dying, http://assembly.coe.int/documents/adoptedtext/ta99/erec1418.htm

[21] House of Lords Select Committee Report on Medical Ethics, HL 21-I, 31 January 1994 - p 49, para 239.

[22] Van Der Maas PJ, Van Delden JJM, Pijnenborg L, Looman CW. Euthanasia and other medical decisions concerning the end of life, Lancet, Vol. 338, 1991.

There is good evidence that a desire for death in terminally ill patients can vary with time and is closely associated with clinical depression which can be alleviated by personal support and treated in most cases.[23] States of delirium and/or confusion are common in palliative care patients and are sometimes so subtle that they are difficult even for clinicians to recognise. It is impossible to be absolutely confident that a request for a life to be ended does not arise from a disordered state of mind.
Moreover, detecting depression is very difficult even for a specialist practitioner, let alone a GP. This is especially difficult for a patient who has a chronic physical illness.
In other words, whilst many people are competent to make decisions about their wish for assisted suicide, many are not. This opens up the possibility that a decision to end a person's life could be made by a second person such as a nominated proxy. The complexities arising from such conditions could lead to serious abuse.

11. Neither suicide nor assisted suicide should be seen as acceptable outcomes

The attempted suicide of an individual, such as a young person, is never seen as something to be encouraged in society. Instead, great concern is raised regarding the individual's state of mind and the fact that he or she may need psychological assistance or counselling. It would be completely unethical to help someone commit suicide in these circumstances. As a result, it is difficult to consider how any form of assisted suicide can be considered.
Conversely, if assisted suicide were ever decriminalised it would mean that the suicide of individuals, such as healthy young persons, may also eventually be considered as acceptable to society. This would happen at the very moment when the Scottish government is trying to reduce the high suicide rates in some parts of the country with programmes such as ***Chooselife*** (www.chooselife.net).

Legalising assisted suicide would inevitable send the message that a disabled life has less value in society than a non-disabled one. Already in some countries, such as in Belgium, it is disabled people who are generally considered for assisted suicide. This only reinforces the stereotype that such people's lives are valueless, tragic, burdensome and insufferable.[24]

Moreover, with assisted suicide, as opposed to suicide, another person must believe that it would be preferable for the person who wishes to die not to continue living. In other words, assisted suicide, reflect the unacceptable belief by one person that another person has lost, or will lose, his or her value of life to such an extent that his or her life is not worth living and should be ended.

Finally, when society recognises that it is acceptable for one person to be willingly involved in the death of another, dangerous consequences are to be expected as to the manner in which the whole of society considers the value, meaning and worth of human life.

12. The legalisation of assisted suicide would lead to unworkable laws

Advocates of assisted suicide have suggested that legalising assisted suicide could give physicians some protection from the law.

In response to this, the SCHB notes that:

The legalisation of assisted suicide may impose upon medical professionals obligations which may be unworkable with the possibility of penalties (or prosecution) applying if these are not respected. Present legislation, however, is appropriate to address every different case while allowing compassion.

13. Gradual widening of categories

In certain countries, such as in Belgium and The Netherlands, there is now evidence of an incremental extension in the scope of assisted suicide. In other words, there is a steady increase in numbers with a

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[23] Linda Ganzini, et. al., Physicians' Experiences with the Oregon Death with Dignity Act, The New England Journal of Medicine, Vol 342, February 2000.

[24] A witness to the Canadian Senate Committee on Euthanasia and Assisted Suicide said: *"Canada has identified a suicide problem among its youth, and we have responded "How can we prevent it?" Canada has identified a suicide problem among Aboriginal peoples and we have responded "How can we prevent it?" Canada has identified a suicide problem among people with disabilities and we have responded "How can we assist them to kill themselves?"*
Keown, J. 2002. *Euthanasia, Ethics and Public Policy: An Argument Against Legislation.* Cambridge: Cambridge University Press, p. 280.

gradual widening of the categories of persons with respect, for example, to age and the seriousness of the condition, as well as who can be considered for assisted suicide, implying that the value and worth of certain lives, in these countries, is diminishing.

Scottish Council on Human Bioethics

01.04.2017 **Position Paper on:**

Assisted Suicide

1. Definitions and general information

Suicide: The intentional ending of one's own life. Includes:

- The vast majority of cases where the person ending his or her own life is not of sound mind with appropriate decision making capacity.

- The very rare cases where the person ending his or her own life is of sound mind with appropriate decision making capacity. These cases include:

    - Suicides with an active intervention whereby persons (who are not dying and are of sound mind with decision making capacity) make a conscious and contemporaneous decision to actively bring about their own death.

    - Suicides without an active intervention whereby persons (who are not dying and are of sound mind with decision making capacity) make a conscious and contemporaneous decision not to accept or to withdraw from life sustaining treatment with the *intention* of bringing about or hastening their own death.[25] This form of suicide recognises the prerogative of a patient not to accept a medical intervention even if it may save his or her life. This prerogative is recognised in most countries.[26,27]

      This kind of suicide is different from voluntary passive euthanasia in that the responsibility for the death rests solely with the person who dies.[28]

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[25] Harris, J.D.F. 1995. 'Physician-Assisted Suicide and Euthanasia: Let Me Count The Ways'. *Canadian Medical Association Journal* 153(7):884-885. For example: Woman who refused treatment after losing 'sparkle' dies, 3 December 2015, http://www.bbc.co.uk/news/uk-34991931; http://www.bailii.org/ew/cases/EWCOP/2015/80.html.

[26] It is important to realise that a refusal of life-sustaining treatment is not necessarily suicidal. Someone approaching the end of life may refuse treatment because it is burdensome or risky or because they are not convinced of the benefits.

[27] In the case of Airedale NHS v. Bland, Lord Musttill indicated that "*If the patient is capable of making a decision whether to permit treatment and decides not to permit it his choice must be obeyed, even if on any objective view it is contrary to his best interests. A doctor has no right to proceed in the face of objection, even if it is plain to all, including the patient, that adverse consequences and even death will or may ensue ...*".
An example of an application of this judgement is given in the case where a woman paralysed from the neck down was given the right to die - BBC - 2002: http://news.bbc.co.uk/1/hi/health/1887281.stm

Another example was the decision by a young paralysed severely ill Swedish man connected to a respirator to end his life in a "suicide clinic" in Switzerland. This started a debate in Sweden concerning the legal framework for a paralysed person to end his or her life with assistance.
According to Swedish law, persons have the right to decide whether or not they want to continue their treatment. In this case, the young man could have decided to turn off the respirator, leaving him to a painful death by suffocation. Debate then arose since it was unclear whether the physician in charge would have been legally entitled to put the patient to sleep before switching off the respirator in order to help him die a painless death. Finally, the Delegation on Medical Ethics of the Swedish Society of Medicine presented new guidelines about withholding and terminating treatment in March 2007. It was made clear that a physician could terminate treatment in these situations, and should also relieve a patient from pain in situations where the patient has decided to end his life by refusing further medical treatment.
Ethically Speaking, Issue 8, July 2007, Office for Official Publications of the European Communities, p.37.

These cases may be defined by some people as forms of passive suicide.

Sometimes, where the device is situated may be important. If, for example, a patient requests a doctor to turn off a pacemaker located outside the patient's body, such a request is generally regarded as a refusal of treatment and doctors are obligated to follow the patient's request. This is regarded as allowing the patient to die, but not killing the patient. However, if the pacemaker is located inside the patient's body and he or she makes the same request, questions may arise whether a doctor is obliged to follow the patient's request and whether shifting the pacemaker from outside to inside the patient makes an ethical or legal difference.

[28] With voluntary passive euthanasia another person must agree that a person's life should be ended and takes responsibility for ending this life.

Assisted Suicide: The act whereby a person aids, abets, counsels or procures a suicide or an attempted suicide of another individual. It also includes encouraging or assisting the suicide or attempted suicide of another person.

Physician Assisted Suicide: The act whereby a physician prescribes a lethal medication to a person, but the person administers the dose himself or herself.

Palliative Sedation: Sedation in the context of palliative medicine is the monitored use of medications to bring about a state of decreased or absent awareness (i.e. unconsciousness) in order to relieve the burden of otherwise intractable suffering.[29]

Persons approaching the end of life: Individuals who are likely to die within the next 12 months.[30]

Persons whose death is imminent: Individuals who are likely to die within a few hours or days.

Direct Euthanasia may take the form of:

- Active Euthanasia: Generally understood as an active intervention to end the life of a person by someone else, by the use of drugs or other methods[31].

- Passive Euthanasia: Euthanasia without active intervention, whereby life sustaining treatment, nutrition and/or hydration are withheld or withdrawn from a patient by someone else with the primary intent of hastening a patient's death. In the UK, these terms are not generally used within the medical profession.[32] Passive euthanasia should be distinguished from the practice whereby medical treatment, nutrition and/or hydration can be withheld or withdrawn in specific circumstances but without having as its primary intent to bring about the death of a person.

2. Principles and purpose

Assisted suicide is generally considered as a procedure that enables a certain amount of certainty to exist that a person consents to terminate his or her life. This is because it is the person himself or herself who undertakes the 'killing' action. For example, if a physician injects poison, with the patient's consent, in order to hasten his or her death, this is active, voluntary euthanasia. If, on the other hand, the physician places poison by the patient's side, and the patient takes it, this is assisted suicide. The individual assisting the person who wishes to take his or her life will only then be considered as an 'assistant' in the intervention and not the principal actor. Through assisted suicide one seeks to avoid any risk of non-voluntary or involuntary euthanasia.

3. History

The Hippocratic Oath, which was written in the 4th Century BC and attributed to the Greek Hippocrates (c.a. 460-380 BC), who was considered as one of the fathers of western medicine, unequivocally prohibits euthanasia and assisted suicide. It states that: *"I will not give a lethal drug to anyone if I am asked, nor will I advise such a plan."*
On the other hand, the English philosopher, Francis Bacon (1561 – 1626) suggested that it was part of a physician's duty to alleviate pain even if that meant killing the patient.[33]

4. England and Wales – Legislation, Case law

4.1. Developments

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[29] Nathan I Cherny, Sedation for the care of patients with advanced cancer, Nature Reviews Clinical Oncology 3, 492-500 (September 2006)

[30] General Medical Council, Treatement and care towards the end of life: Good practice in decision making, May 2010, p. 8.

[31] Replies to the questionnaire for member States relating to euthanasia, Council of Europe, 20 January 2003, http://www.coe.int/T/E/Legal_Affairs/Legal_co-operation/Bioethics/Activities/Euthanasia/Answers%20Euthanasia%20Questionnaire%20E%2015Jan03.asp

[32] Ibid.

[33] End of Life Assistance (Scotland) Bill, Policy Memorandum, Scottish Parliamentary Corporate Body 2010.

Committing (or attempting to commit) 'self-murder' became a crime under common law in England in the mid-13th Century, but long before that it was condemned as a mortal sin in the eyes of the Christian Church though it had to be proved that the person was sane.[34]
But the ***Suicide Act 1961*** decriminalised such a deed in England and Wales. However, the Act stipulated that a person cannot aid or abet another person in committing suicide and thereby emphasised that the purpose of the Act was to decriminalise suicide, and not establish an individual right to obtain suicide.[35]
In the past, the main effect of the criminalisation of suicide was to penalise those who attempted to take their own lives. It also cast an unwarranted stigma on innocent members of the suicide's family and led to the unfortunate situation of patients recovering in hospital from a failed suicide attempt being prosecuted, in effect, for their lack of success.[36]

Since suicide ceased to be a crime in 1961, the question whether assisted suicide should also be decriminalised has been reviewed on more than one occasion.

In 1993, Hoffmann LJ indicated in the Court of Appeal (*Airedale NHS Trust v Bland* [1993] AC at 831) that *"the 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, assisting someone to commit suicide is."*

In 1994, the **House of Lords Select Committee Report on Medical Ethics** 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 the law. We identify no circumstances in which assisted suicide should be permitted, nor do we see any reason to distinguish between the act of a doctor or of any other person in this connection."*[37]

In February 2003, and following a proposal by Lord Joffe to introduce a ***Patient (Assisted Dying) Bill***, a House of Lords Select Committee prepared a report entitled "***Assisted Dying for the Terminally Ill Bill***" in April 2005. This report indicated that if an assisted dying bill was to be considered, it should distinguish clearly between assisted suicide and voluntary euthanasia. This led Lord Joffe to re-introduced a new version of his bill entitled ***Assisted Dying for the Terminally Ill Bill*** into the House of Lords on the 9th of November 2005 in a form which would legalise assisted suicide but not euthanasia. However, this was unsuccessful.

On the 11th of September 2015 an ***Assisted Dying Bill*** for England and Wales was brought before the House of Commons by Mr. Rob Marris MP. Under the proposals, persons with fewer than six months to live could have been prescribed a lethal dose of drugs, which they had to be able to take themselves. Two doctors and a High Court judge would have needed to approve each case. But MPs rejected this Bill in a free vote with 330 MPs voting against and only 118 in favour.[38]

4.2. Present situation

Committing or attempting to commit suicide is not, of itself, a criminal offence in England and Wales. However, assisted suicide is covered in England and Wales by the ***Suicide Act 1961*** which states that:

1. *The rule of law whereby it is a crime for a person to commit suicide is hereby abrogated.*

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[34] Before 1961, suicide was a felony, being regarded as self-murder ("*felonia de se*"). "*For this reason the property of a person who committed suicide was forfeited. A person who was present at the suicide of another and who assisted or encouraged the suicide, was guilty of murder as a principal in the second degree, and this applied equally where that person was the survivor of a suicide pact - Rex v Dyson (1823) Russ. & Ry 523; R v Croft [1944] KB 295.*"
In paragraph 4 of Judgments - R (on the application of Purdy) (Appellant) *v* Director of Public Prosecutions (Respondent), 2009, http://www.publications.parliament.uk/pa/ld200809/ldjudgmt/jd090730/rvpurd-1.htm (Accessed on 7 July 2010).
See also: When suicide was illegal – BBC – 4 August 2011 - http://www.bbc.co.uk/news/magazine-14374296

[35] Luke Gormally, "Walton, David, Boyd and the Legalization of Euthanasia", in John Keown (ed.), *Euthanasia Examined: Ethical, Clinical and Legal Perspectives* (1995), p 125.

[36] Judgements - 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) - House of Lords: http://www.parliament.the-stationery-office.co.uk/pa/ld200102/ldjudgmt/jd011129/pretty-2.htm

[37] House of Lords Select Committee Report on Medical Ethics, HL 21-1, 31 January 1994 - p 54, para 262.

[38] John Bingham, Right to die: MPs reject assisted dying law. The Daily Telegraph, 11 September 2015.

2. (1) 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.
(2) If on the trial of an indictment for murder or manslaughter it is proved that the accused aided, abetted, counselled or procured the suicide of the person in question, the jury may find him guilty of that offence.

Moreover, Section 2 of the ***Suicide Act 1961*** was amended with effect from 1 February 2010 by section 59 and Schedule 12 of the ***Coroners and Justice Act 2009*** which widened the possibility of prosecution to include encouraging or assisting the suicide or attempted suicide of another person.[39] This updated the language and made it clear that Section 2 applies to an act undertaken via a website in exactly the same way as it does to any other act.

In addition, the ***Suicide Act 1961*** includes assistance which may help another person make a journey to another country, in the knowledge that its purpose is to enable this person to end his or her own life.[40]

In February 2010, the **Director of Public Prosecutions (DPP)** in England and Wales published his ***Policy for Prosecutors in respect of Cases of Encouraging or Assisting Suicide***. This policy was issued as a result of the decision of ***R (on the application of Purdy) v Director of Public Prosecutions*** which required the DPP "*to clarify what his position is as to the factors that he regards as relevant for and against prosecution*" in cases of encouraging and assisting suicide.[41]
This clarification did not, in any way, 'decriminalise' the offence of encouraging or assisting suicide and nothing in the policy could 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.
But the DPP's 2010 policy[42] indicated that public interest factors tending to make a prosecution less likely were:

(1) the victim had reached a voluntary, clear, settled and informed decision to commit suicide;
(2) the suspect was wholly motivated by compassion;
(3) the actions of the suspect, although sufficient to come within the definition of the offence, were of only minor encouragement or assistance;
(4) the suspect had sought to dissuade the victim from taking the course of action which resulted in his or her suicide;
(5) 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;
(6) 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.

In addition, the evidence to support these factors must be sufficiently close in time to the assistance to allow the prosecutor reasonably to infer that the factors remained operative at that time. This is particularly important at the start of the specific chain of events that immediately led to the suicide or the attempted suicide.

5. Scotland – Legislation, Case Law

5.1. Developments

In contrast to England and Wales, suicide was never legally prohibited in Scotland and assisted suicide is not specifically defined in Scottish legislation but is likely to come under legislation concerning homicide.

Euthanasia and assisted suicide became devolved matters for the Scottish Parliament under the ***Scotland Act 1998***, Schedule 5 (Reserved Matters), Part II (Specific Reservations), Head J (Health and Medicines).

[39] Policy for Prosecutors in respect of Cases of Encouraging or Assisting Suicide Issued by The Director of Public Prosecutions, Crown Prosecution Service, February 2010, http://www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.pdf

[40] In paragraph 18 & 27 of Judgments - R (on the application of Purdy) (Appellant) *v* Director of Public Prosecutions (Respondent), 2009, http://www.publications.parliament.uk/pa/ld200809/ldjudgmt/jd090730/rvpurd-1.htm (Accessed on 7 July 2010).

[41] Policy for Prosecutors in respect of Cases of Encouraging or Assisting Suicide Issued by The Director of Public Prosecutions, Crown Prosecution Service, February 2010, http://www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.pdf

[42] Policy for Prosecutors in respect of Cases of Encouraging or Assisting Suicide Issued by The Director of Public Prosecutions, Crown Prosecution Service, February 2010, http://www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.pdf

On the 25th of October 2005, Mr. Jeremy Purvis MSP lodged a proposed physician assisted suicide bill in the Scottish Parliament. But this proposal only attracted five out of the required 18 parliamentary supporters within the specified time limit of one month after the draft bill was submitted. This meant that the proposed bill did not continue through the legislative process.

On the 23rd of April 2009, Ms. Margo Macdonald MSP presented a Private Member's ***Proposed End of Life Choices (Scotland) Bill***[43] to the Scottish Parliament which sought to legalise both euthanasia and assisted suicide. This obtained 20 signatures out of the required 18 parliamentary supporters meaning that the proposed bill could continue through the legislative process. In January 2010, Ms. MacDonald submitted her ***End of Life Assistance (Scotland) Bill*** to the Scottish Parliament.[44] But this was rejected on the 1st of December 2010 by 85 votes to 16 with two abstentions.

On the 18th of September 2012, Ms. Margo MacDonald MSP re-introduced a Private Member's ***Proposed Assisted Suicide (Scotland) Bill*** to the Scottish Parliament which sought to only allow licensed 'facilitators' to give lethal drugs to people as young as 16 who believed their quality of life was unacceptable because of a terminal illness or progressive life-shortening condition. This obtained 19 signatures out of the required 18 parliamentary supporters.[45] This meant that the proposed bill could continue through the legislative process and in November 2013, Ms. MacDonald submitted her ***Assisted Suicide (Scotland) Bill*** to the Scottish Parliament. Following her death in 2014, the Bill was taken over by Mr. Patrick Harvie MSP. However, this Bill was also rejected by a free vote of parliamentarians on the 27th of May 2015 by 82 votes to 36.

5.2. Present situation

Suicide is not a crime in Scots law and it is therefore not a criminal offence to attempt suicide though, if the circumstances warrant it, attempted suicide may (in very rare occasions) be prosecuted as a breach of the peace.
But encouraging or assisting another person to take his or her own life is another matter, as the sympathy which the law has for the suicide does not necessarily extend to those who facilitate suicide though there is no Scottish authority on this issue.

Since the term assisted suicide, as such, is not specifically defined in Scottish legislation, it may constitute the "art and part" of murder or culpable homicide.[46] This means that it is possible that a person who assists someone else, whether in the form of giving advice or the provision of the means, to commit suicide would be prosecuted for culpable homicide (a common law offence)[47], or for some lesser offence (such as assault or culpable and reckless injury/behaviour), although the lack of relevant case-law makes it difficult to establish how likely this is to happen in any particular case.

The present situation is best characterised by the Deputy Minister for Health and Community Care, who indicated, in a response before the Scottish Parliament on the 11th of November 2004, that "*Under Scots law, an act of euthanasia by a third party, including physician-assisted suicide, is regarded as the deliberate killing of another and would be dealt with under the criminal law relating to homicide. The consent of the victim would not be a defence and no degree of compassion on the part of the person who carried out the act would amount to a legal justification. There might be cases in which the circumstances of the offence would make a charge of culpable homicide more appropriate than one of murder, and a court would take all the circumstances of the case into account before sentence was pronounced. However, if the accused was convicted of murder, a sentence of imprisonment would be mandatory*."[48]

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[43] The proposal may be viewed at: http://www.scottish.parliament.uk/parliamentarybusiness/Bills/17939.aspx

[44] End of Life Assistance (Scotland) Bill Committee, 1st Report, 2010, available at: http://www.scottish.parliament.uk/parliamentarybusiness/PreviousCommittees/19514.aspx.

[45] http://www.scottish.parliament.uk/parliamentarybusiness/Bills/46127.aspx

[46] Replies to the questionnaire for member States relating to euthanasia, Council of Europe, 20 January 2003, http://www.coe.int/T/E/Legal_Affairs/Legal_co-operation/Bioethics/Activities/Euthanasia/Answers%20Euthanasia%20Questionnaire%20E%2015Jan03.asp

[47] Replies to the questionnaire for member States relating to euthanasia, Council of Europe, 20 January 2003, http://www.coe.int/T/E/Legal_Affairs/Legal_co-operation/Bioethics/Activities/Euthanasia/Answers%20Euthanasia%20Questionnaire%20E%2015Jan03.asp

[48] Scottish Parliament Official Report - 11.11.04: http://www.scottish.parliament.uk/business/officialReports/meetingsParliament/or-04/sor1111-02.htm#Col11876

In Scotland, the Lord Advocate has decided not to issue guidance on assisted suicide but has said that a person encouraging or assisting a suicide could be guilty of culpable homicide.

The last person in Scotland convicted of culpable homicide for assisting to end the life of another person took place in 2006. In this case a man helped to end the life of his brother, who was suffering from Huntington's disease. The man was eventually admonished.[49]

6. Legislation, Case Law and Regulations - International

6.1. International

Council of Europe:

European Convention on Human Rights:

Two articles of the European Convention on Human Rights (ECHR) protect the right to life, namely:

Article 2.1:
Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.

Article 8:
1. Everyone has the right to respect for his private and family life…..
2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

Council of Europe Parliamentary Assembly Recommendation 1418 (1999):

The latest provisions on the subject are included in Article 9.c. of the Council of Europe Parliamentary Assembly Recommendation 1418 (1999) which states that:

The Assembly therefore recommends that the Committee of Ministers encourage the member states of the Council of Europe to respect and protect the dignity of terminally ill or dying persons in all respects by upholding the prohibition against intentionally taking the life of terminally ill or dying persons, while:

> *i. recognising that the right to life, especially with regards to a terminally ill or dying person, is guaranteed by member states, in accordance with Article 2 of the European Convention on Human Rights which states that "no one shall be deprived of his life intentionally";*
>
> *ii. recognising that a terminally ill or dying person's wish to die never constitutes any legal claim to die at the hand of another person;*
>
> *iii. recognising that a terminally ill or dying person's wish to die cannot of itself constitute a legal justification to carry out actions intended to bring about death.*

Case Law from the European Court of Human Rights:

The Position of Detained Persons[50]

In *Reeves* v *The Commissioner of Police for the Metropolis* [2000] 1 AC 360, the House of Lords held that where police officers were aware that a prisoner was a suicide risk they had a duty to take reasonable care not to allow a prisoner to kill himself. Respect for personal autonomy did not preclude the taking of steps to "*control a prisoner's environment in non-invasive ways calculated to make suicide more difficult*".

[49] The Scottish Parliament, End of Life Assistance (Scotland) Bill Committee Report, November 2010, paragraph 17, http://www.scottish.parliament.uk/s3/committees/endLifeAsstBill/reports-10/ela10-01-vol1.htm, Accessed on the 29th of November 2010.

[50] Memorandum from the Attorney General, House of Lords, http://www.publications.parliament.uk/pa/ld200405/ldselect/ldasdy/86/5012004.htm

In *Keenan* v *The United Kingdom* (3 April 2001) 33 EHRR 38, the applicant's mentally ill son committed suicide in Exeter prison where he was serving a sentence of four months' imprisonment for assaulting his girlfriend.
The applicant complained that the prison authorities had failed to protect her son's right to life and that he had been subjected to inhuman and/or degrading treatment in the period before his death.
The Court found that the lack of effective monitoring of Keenan's condition and the lack of informed psychiatric input into his assessment and treatment disclosed significant defects in the medical care provided to a mentally ill person known to be a suicide risk.

In *Secretary of State for the Home Department* v *Robb* [1995] Fam 127, an adult prisoner began to refuse all nutrition. Medical experts agreed that he was of sound mind and fully understood the consequences of his decision to refuse food and that death would result.
The Home Secretary sought a declaration that the physicians and nursing staff responsible for the prisoner might lawfully observe and abide by the prisoner's refusal to receive nutrition and might lawfully abstain from providing him with hydration and nutrition for as long as he retained capacity to continue to maintain his refusal. In the course of the judgement, it was stated that the state interest in preventing suicide had no application in such a case and the refusal of nutrition and medical treatment in the exercise of the right of self-determination did not constitute an act of suicide.
This means that an adult prisoner of sound mind and capacity has a specific right of self-determination which entitles him to refuse nutrition and hydration.

Pretty v United Kingdom:
In *Pretty v United Kingdom*[51]*,* the European Court of Human Rights indicated that a so-called 'mercy killing' was legitimately prohibited by the State under Article 2 of the ECHR:
"The consistent emphasis in all the cases before the Court has been the obligation of the State to protect life. The Court is not persuaded that the 'right to life' guaranteed in Article 2 can be interpreted as involving a negative aspect … it is unconcerned with issues to do with the quality of life or what a person chooses to do with his or her life … nor can it create a right to self-determination in the sense of conferring on an individual the entitlement to choose death rather than life."
"The Court accordingly finds that no right to die, whether at the hands of a third person or with the assistance of a public authority, can be derived from Article 2 of the Convention."
Furthermore, the European Court of Human Rights did not consider that the United Kingdom's blanket ban on assisted suicide was disproportionate in the context of Article 8: *"It does not appear to be arbitrary to the Court for the law to reflect the importance of the right to life, by prohibiting assisted suicide."*

Haas v. Switzerland:
In *Haas v. Switzerland,* in 2011, the European Court of Human Rights declared, in a unanimous verdict, that there is no human right to assisted suicide.
A 57-year-old Swiss national, Ernst G. Haas, felt that he could no longer live a dignified life after battling a serious bipolar affective disorder for 20 years. He twice attempted suicide, but then sought to use a strong prescription-only drug to kill himself. But no psychiatrist would prescribe it for him. He then asked the Swiss government for permission to obtain the drug without a prescription but was refused.
He argued that Article 8 of the European Convention on Human Rights (which guarantees a right to privacy) imposed on the State a "positive obligation" to create the conditions for suicide to be committed without the risk of failure and without pain.
The European Court of Human Rights in its 2011 decision acknowledged that there may appear to be a right to suicide implied in Article 8. This has been strengthened by the 2002 Pretty case, in which the Court considered that there may be a right for a British woman to kill herself if she found life undignified and distressing.
However, Article 2 of the Convention also guarantees the right to life and most member states give the right to life more weight than the right to suicide. It also recognised that states have a broad margin of appreciation in such matters.[52]

The court therefore concluded that states have no direct responsibility to help their citizens commit suicide by providing lethal drugs and also ruled that respect for the right to life compels the state to prevent a person from committing suicide if such a decision is not taken freely and with full knowledge.

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[51] European Court of Human Rights. (29 April 2002) *Fourth Section Case of Pretty v. The United Kingdom (Application no. 2346/02) – Judgment*. Strasbourg: European Court of Human Rights. Available at http://cmiskp.echr.coe.int/tkp197/view.asp?action=html&documentId=698325&portal=hbkm&source=externalbydocnumber&table=F69A27FD8FB86142BF01C1166DEA398649, Accessed 29 November 2010

[52] http://www.humanrightseurope.org/2011/01/court-judgement-on-swiss-assisted-suicide-row/

6.2. Other countries

Netherlands:[53]

In the Netherlands, the ***Termination of Life on Request and Assisted Suicide (Review Procedures) Act*** came into effect on the 1st of April 2002. The Act incorporates an amendment to Article 293 of the Criminal Code to the effect that although any person who terminates another person's life at that person's express and earnest request remains liable to a term of imprisonment or a fine, such an act shall not be an offence if it is committed by a physician who notifies the municipal pathologist of this act in accordance with the relevant legislation and fulfils the stipulated due care criteria, by which the attending physician must:

- be satisfied that the patient has made a voluntary and carefully considered request;
- be satisfied that the patient's suffering is unbearable, and that there is no prospect of improvement (note: it is not a condition that the patient is terminally ill or that the suffering is physical);
- have informed the patient about his or her situation and his or her prospects;
- have concluded, together with the patient, that there is no reasonable alternative in the light of the patient's situation;
- 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 the four above indents; and
- have terminated the patient's life or provided assistance with suicide with due medical care and attention.

Similarly, any person who intentionally incites another to commit suicide, if suicide follows, is normally punishable under Article 294 of the Criminal Code by a term of imprisonment or fine, but commits no offence if the above due care criteria are fulfilled.
The new legislation also includes regulations regarding termination of life on request and assisted suicide involving minors. Children aged 16 and 17 can, in principle, make their own decisions. Their parents must, however, be involved in the decision-making process regarding the ending of their life. For children aged 12 to 16, the approval of parents or guardian is required.
Finally, the legislation offers an explicit recognition of the validity of a written declaration of will regarding euthanasia. The presence of a written declaration of will means that the physician can regard such a declaration as being in accordance with the patient's will. The declaration has the same status as a concrete request for euthanasia. Both oral and written requests allow the physician legitimately to accede to the request. However, he or she is not obliged to do so.

In all cases, the physician must report his or her act to the municipal pathologist. The report is then examined by a regional review committee to determine whether it was performed with due care. The judgement of the review committee is then sent to the Public Prosecution Service, which uses it as a major factor in deciding whether or not to institute proceedings against the physician in question.
If the committee agrees that the physician has practised due care, the case is closed. If not, the case is brought to the attention of the Public Prosecutor who has the power to launch its own investigation if there is a suspicion that a criminal act may have been committed.

Belgium:

In Belgium, the 2002 legislation making possible Euthanasia does not allude to 'assisted suicide' though the country enables similar procedures to The Netherlands. Thus the law does not specify the method to be used by the physician, even though he or she must describe it in the official form to be forwarded to the Federal Evaluation and Control Commission.
In 2014, Belgium became the only country in Europe that officially allowed children of all ages to access euthanasia and assisted suicide, provided parental consent is granted.

Switzerland:[54]

The Swiss 1942 legislation on assisted suicide is a special case in Europe. Article 115 of the Criminal Code specifies that what makes assisted suicide punishable is the existence of a selfish motive. It should be noted, however, that the drafting of Article 115 was not motivated by medical considerations. Originally, it

[53] Parliamentary Assembly, Euthanasia, Doc. 9898, 10 September 2003, Report, Social, Health and Family Affairs Committee

[54] Parliamentary Assembly, Euthanasia, Doc. 9898, 10 September 2003, Report, Social, Health and Family Affairs Committee

was aimed at exonerating from punishment someone who lent a weapon to a friend wishing to commit suicide because of, for example, an unhappy love affair.
But Article 115 is now used for assisted suicide, which was not the legislator's intention.

Luxembourg:

As of March 2009, Luxembourg legalised euthanasia and assisted suicide. In the legislation, individuals suffering from a terminal or incurable illness are able to have their lives ended after receiving the approval of two doctors and a panel of experts.

United States of America:

The states of **Washington State, Montana, Vermont, California** followed **Oregon** in making physician assisted suicide possible.

Oregon:

Assisted suicide first became possible in the state of Oregon since the ***Death with Dignity Act (1997)*** was passed on the 27th of October 1997. This allows patients who are residents of the state to request medical assistance in order to obtain drugs so that they can commit suicide when there is a diagnosis of terminal illness and a prognosis of death within six months. Two oral requests separated by 14 days must be made, and doctors and/or care staff are not forced to act against their consciences if they do not want to adhere to the measures in the act.
Furthermore, Oregon has a similar reporting mechanism to the Netherlands for monitoring of the deaths.

Deborah Whiting Jaques (Executive director and chief executive officer of the Oregon Hospice Association) said **"***It is interesting to note that when people who had got a prescription were asked why they were seeking to use that legal alternative in the states of Oregon and Washington, nearly 97 per cent of Oregonians and 100 per cent of Washingtonians said that the primary reason was the loss of autonomy.*"[55]

Dr. Linda Ganzini, Professor of psychiatry and medicine and a senior scholar of the centre of ethics and health care at Oregon Health and Science University, also indicated that **"***The problem is that in Oregon we really admire these very independent, individualistic people as part of our history. Some people may come across them and say, "They are control freaks," but in Oregon we admire them, ...*"
Dr. Ganzini also added: "*It would be highly unusual for a patient to choose assisted suicide purely because of pain that they were experiencing that could not be treated. Interestingly, the majority of patients who pursue assisted suicide in Oregon have very low symptom burden when they pursue it; they are anticipating symptom burden in the future, such as pain, that will undermine their autonomy. It is really not about pain.*"[56]

Canada:

Suicide was considered a criminal offence in Canada until 1972, after which it was removed from the Criminal Code. Physician-assisted suicide has been legal in the Province of Quebec since the 5th of June 2014. It was then declared legal across the whole of Canada because of the Supreme Court's decision Carter v Canada (AG), of 6th of February 2015.

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[55] Deborah Whiting Jaques Scottish Parliament, End of Life Assistance (Scotland) Bill Committee, Official Report, *Tuesday 7 September 2010, Col. 54,* http://www.scottish.parliament.uk/s3/committees/endLifeAsstBill/or-10/ela10-0402.htm

[56] Linda Ganzini**,** Scottish Parliament, End of Life Assistance (Scotland) Bill Committee, Official Report, *Tuesday 7 September 2010, Col. 64-67,* http://www.scottish.parliament.uk/s3/committees/endLifeAsstBill/or-10/ela10-0402.htm