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Euthanasia and Assisted Suicide

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While medical life-ending behavior occurs in a great many jurisdictions, only very few have explicitly legalized euthanasia, physician-assisted suicide, or both. There are various forms of medical life-ending behavior that are classified as *euthanasia*. These include “active voluntary euthanasia,” when medical intervention takes place, at a patient's request, to end the patient's life; “passive voluntary euthanasia,” when medical treatment is withdrawn or withheld from a patient, at the patient's request, to end the patient's life; “active nonvoluntary euthanasia,” when medical intervention takes place, without the patient's request, to end the patient's life; and “passive nonvoluntary euthanasia,” when medical treatment or life support is withdrawn or withheld from a patient, without the patient's request, to end the patient's life.

In addition, there is *physician-assisted suicide*: suicide using a lethal substance prescribed, prepared, or given to a patient by a doctor for self-administration for assisting the patient to commit suicide. Finally, the term *double effect* is reserved for the administration of drugs (usually large doses of opioids) with the intention of relieving pain, but foreseeing that this might hasten death, even though the hastening of death is not actually intended. The Australian Senate Legal and Constitutional Legislation Committee has used this definition.

Guidelines are usually in place to control medical conduct when it comes to double effect and passive nonvoluntary euthanasia (for instance in the case of severely brain-damaged newborns). Active euthanasia, to further a patient's request or not, usually remains a crime and often is classified as murder. The three jurisdictions with an exception to this rule are the state of Oregon in the United States and the neighboring European countries of the Netherlands and Belgium. There was a fourth jurisdiction, Australia's Northern Territory, but its Rights of the Terminally Ill Act 1995 was overruled within a year of its enactment by the Australian federal government and currently is defunct.

The legal frameworks in Oregon, Belgium, and the Netherlands differ considerably. What they have in common, however, is that they allow medical doctors exclusively to engage in medical life-ending conduct, which can only occur in response to a patient's repeated and considered request, and which is only available to seriously ill patients who can invoke the law to have their life terminated.

Euthanasia is an emotional issue that strikes at the core of the belief systems of proponents and opponents alike, as acutely evidenced by the Terri Schiavo case in Florida in 2005 and the Diane Pretty case in the United Kingdom in 2004. Opponents appeal to the sanctity of life, on one hand, and warn of compromising the medical profession, on the other. Legalization would cause role conflict for medical doctors. Opponents also warn of the slippery slope: legalization of certain life-ending conduct might make other **[p. 517 ↓]** life-ending conduct in the course of time more acceptable and frequent, which would erode the core civil right to life.

Opponents tend to remind us of the practice of nonvoluntary euthanasia of undesirables (such as the severely disabled) during the Nazi regime in Germany. Proponents argue that the decision whether to die or not is ultimately a personal choice. It is often couched in terms of the “right to die,” although arguably there is no such right anywhere, as doctors are never compelled to comply with any request, and only seriously ill patients might appeal to such a right anyway. Rather, the issue is whether there is a right to request to be helped to die, and what obligation that puts on medical professionals.

Popularity polls in many Western countries usually show majority support for the legalization of certain forms of legalized or assisted suicide. Within the medical profession, however, the situation is often not the same.

Oregon

Oregon's Death with Dignity Act, O.R.S. § 127.800 (2005), came into effect in 1997. It exclusively seeks to legalize physician-assisted suicide. That means that the law allows doctors to prescribe medication that patients might use to terminate their own lives. It is not intended for medical doctors to actively end the life of patients. The essence of the law is found in section 2.01, which describes who may initiate a written request for medication.

Only capable adults who are Oregon residents and determined, by a physician, to have a terminal disease and to wish to die can request life-ending medication. The request must be in writing. Their life expectancy should be no more than six months. In addition, the act stipulates that there must be at least fifteen days between the initial

patient request and the prescription of the medication. There must furthermore be at least two oral requests, and the final one must be, in written form as specified in the law. There must be at least forty-eight hours between the issuing of the written request and the actual prescription. Two independent witnesses are required to sign the written request. The patient is entitled to change his or her decision at any point. Usage of the act is infrequent but increasing The annual reports by Oregon's Department of Human Services show a steady increase in prescriptions for lethal doses of medication: 67 in 2003, 58 in 2002, 44 in 2001, 39 in 2000, 33 in 1999, and 24 in 1998. From 1998 to 2005, 246 Oregon citizens died under the act.

The Netherlands

In the Netherlands, doctors can perform both euthanasia and physician-assisted suicide. Some 2,000 cases are reported each year to designated euthanasia review committees, organized on a regional basis in five regions. Most of these cases involve euthanasia rather than physician-assisted suicide. While the law only came into effect in 2002, medical life-ending conduct has been medical practice for decades, sanctioned by Dutch High Court rulings. Those rulings established guidelines for medical practice, which have served as the basis for the Termination of Life on Request and Assisted Suicide Review Procedures Act (in effect since 2002).

Unlike in Oregon, patients in the Netherlands do not need to be terminally ill, although they usually are. Instead, the law speaks of “unbearable suffering” and of “no prospect of improvement.” In addition, the illness does not necessarily need to be of a somatic nature, but can be mental illness as well (as long as that illness does not prevent the emergence of a serious, repeated, and considered patient request). Thus, the scope for patients to die using the act is considerably wider. That is most poignant in the case of minors, whom the act does not specifically exclude. Despite its wide scope and the substantial trust placed in the medical profession to honor the spirit as well as the letter of the law, the act is not particularly controversial within the Netherlands. Legal debates focus on defining the legal boundaries of the criteria given in the act, but not on its existence per se.

Belgium

Belgium's euthanasia law came into effect in 2002. It is similar to the Dutch law in that it allows, in principle, for nonterminal patients to die using the act. It resembles the Oregon law in its explicit temporal **[p. 518 ↓]** safeguards, which are lacking in the Dutch process, which merely requires requests to be repeated and considered. The Belgian law's first year saw 170 officially reported cases. Notable in the Belgian situation is the prestigious composition of the review committees that, as in the Netherlands, serve as a filter between physician and the prosecuting authority. The law prescribes language and gender parity as well as the inclusion of full medical professors, senior lawyers, and experts in palliative care for the elderly. It consists of no fewer than sixteen members and appears to have the allure of a “euthanasia high court.” In comparison, Dutch committees require only three members to establish a quorum.

The Future

Thus far, euthanasia laws are rare. However, there is movement in favor in many jurisdictions, including California and Washington in the United States, France, Japan, and the United Kingdom. However, certainly for Oregon, it is true to say that the legislation is under siege from the United States federal government and subject to various legal challenges. It raises the issue of whether the criminal justice system is the natural habitat for the governance of medical life-ending behavior. Because of the entrenched nature of the debate, any change in the law in most countries would be difficult to achieve, as consensus on the issues involved seems very difficult to obtain.

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See also

- Decriminalization
- Discretion in Legal Decision Making
- Eugenics

- Health
- Homicide
- Netherlands and Flanders

Further Readings

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