Physician-assisted suicide
(The Netherlands, the State of Oregon and the practice of the European Court of Human Rights)

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Abstract

In my thesis I will explore what is physician-assisted suicide, on which basis it can be legalized since the right to die does not exist and is tried to be avoided by all jurisdictions. The question of physician-assisted suicide is quite difficult and controversial. There are quite strong argument on the both sides: the right to life as a fundamental right which protects the person`s life and the principle that the life is sacred. On the other hand there are such rights as right to dignity, personal autonomy and right to respect for private life. In addition, physician-assisted suicide is quite tangible because it very easy to cross the line of its noble goal of releasing the people from suffering. It needs very careful observation and regulation.

At first I will look on the rights which can be extended to the right to physician-assisted suicide. For better understanding of the issue it is necessary to explore the development of physician-assisted suicide through the time and the current regulation and practice (the Netherlands and the State of Oregon).

Contents

Introduction

Physician-assisted suicide is quite sensitive topic in the modern society. The possibility of abuses exists in both cases: whether it would be legalized or not, because in both cases the issue embraces quite important for each person right. So, it should be well considered how to regulate on this question in order not to violate basic human rights.

In my thesis I would like to argue about the necessity of the physician-assisted suicide for terminally ill patients whose suffering cannot be effectively reduced by palliative treatment. On the examples of the legislation of the State of Oregon in the United States and the Netherlands which were one of the first jurisdictions who allowed and regulated on that issue, I want to prove that there are ways to legalize physician-assisted suicide and also define the problematic questions which can and should be improved in that area.

The State of Oregon became the first jurisdiction where the physician-assisted suicide is permitted and not punishable in the world and however the Netherlands regulated on this issue only in 2002 the practice of assisting in suicide and performing the other euthanasia acts goes back to the 1970s. So, it has long practice and way of development which was done by the courts.

What is not less important is having in mind the importance of the European Convention on Human Rights in nowadays world and the European Court of Human Rights as the body, which interprets the written rights of the Convention and which ruled also on the issue of assisted suicide and the basic human rights from which the right to physician-assisted suicide can be derived.

I want to develop question how does right to physician-assisted suicide coexist with other rights. And whether such right exists on the ground of personal autonomy, dignity, how this right co-works with the right to life. What is self-determination of the person and how far should it go? What are the tasks of the state and how far can they go in person`s protection? Does the person actually needs protection and where is this between what is need to be protected and the intervening?

By looking at the jurisdictions where it is (such as the Netherlands and the State of Oregon in the U.S.) legal I would like to see whether physician-assisted suicide is regulated duly, which problems do they meet while legalizing and regulating this practice. If there are problems, I will try to see whether there are ways to solve them.

In my first chapter I would look through important rights such as right to life, personal autonomy, respect for private life and right to dignity. I will examine whether the right to assisted suicide can be derived from one/some of these right or how can it be placed in the legal system.

In the second chapter I will look through the notion of assisted suicide and the history, with an attempt to understand the development of the assisted suicide throughout the history and which lessons can be taken out of history.

The next chapter discusses the regulation of assisted suicide in the State of Oregon and in the Netherlands, which differences, similarities and concerns do these jurisdictions have. Also I would like to look through safeguards which these systems use in order to protect vulnerable groups of people.

In the last, forth chapter I would like to observe the situation which exists in practice.

Chapter I: The basic rights concerning physician-assisted suicide

The right to physician-assisted suicide is not recognized by any jurisdiction as a right and so it should be derived from other rights which already exist. There were attempts to derive the right to die or the right to physician-assisted suicide from different rights such as: the right to life, the right to dignity, to personal autonomy and the right to respect for private life. The attempts were taken either by further development of the notion, of the scope of each right in the legislation or by interpretation by the Courts (Supreme, Constitutional courts or by the European Court of Human Rights).

In this chapter I would like to deal with these rights, will explore the scope of these rights and their development through the time; how the courts interpret all these rights concerning the right to physician-assisted suicide. Also I will try to find which rights are better suited for the reasons of legalization of physician-assisted suicide.

1.1. The right to life

Right to life is the first right which falls into my mind while thinking on assisted suicide. What does this right means and what does it cover? Does it includes right to die, is there right to die and can assisted suicide be derived out of right to life?

"Everyone has the right to life."[1] Every society recognizes that human life is sacred or that this right is inherent and the most important for the human beings, and so "no one shall be arbitrarily deprived of his life"[2] (under certain legal systems there is possibility of death sentence but it is strictly regulated and can be enforced only by judicial order). Most constitutions contain right to life but not all of them regulate the scope of the right or regulate but only a certain aspects such as prohibition of arbitrary deprivation of life. Further interpretation of this right is mostly let to the Constitutional Courts.[3]

The right to life means the protection against killing -it can be seen in three main points: the state (public authorities a representatives) may not kill; the state should protect the person against the threat from the other authorities/ persons; the state should create conditions for the protection of life.[4]

The right to life was first declared in the Declaration of Independence of the United States in 1776, where it was found as an inalienable right. This right was also recognized by the Universal Declaration of Human Rights (1948) and by the European Convention on Human Rights (1950). In 1966 the International Covenant on Civil and Political Rights stated that "every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life."[5] So, starting from the American Declaration of Independence in the 18th

1 The Universal Declaration of Human Rights, art. 3
[2] International Covenant on Civil and Political Rights, art. 6
[3] Bertrand Mathieu, *The right to life in European constitutional and international case-law.* (Strasbourg: Council of Europe Publishing, 2006), 11-12
[4] Ibid. at 44
[5] UN General Assembly, *International Covenant on Civil and Political Rights*, 16 December 1966, art. 6

century and more widely after World War II the right to life has been recognized by many jurisdictions at the State and international level.

Article 2 of the European Convention on Human Rights states that "[e]veryone's right to life shall be protected by law." The Article covers also the exceptions to that right, but it does not interpret the right or does not provide the scope of the right. The European Court of Human Rights stated that "the right to life is an inalienable attribute of human beings and forms the supreme value in the hierarchy of human rights."[6]

In case of *Pretty v. the United Kingdom* in which an applicant suffering from motor neuron disease and paralyzed claimed the right to die which could be derived (as she claimed) from the right to life. The applicant asked not to prosecute her husband in case he will help her to end the life (she could not commit suicide by herself due to her health condition) and one of her claims were that prohibition of assistance in suicide is against the article 2 of the Convention and so violates her right to life. The Court ruling in that case found no violation of the Article and also gave interpretation on the scope of the right to life held that "[Article 2] …. cannot be interpreted as conferring a right to die or to enlist the aid of another in bringing about one's own death"[7] and "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."[8] So, the right to physician-assisted suicide cannot be derived from the right to life and the notion of this right does not expands to the right to die. The decisions of European Court of Human Rights are binding for all Member States to the European Convention on Human Rights. Though the Member States can expand the scope of the

[6] *K.-H. W. v. Germany*, app. no. 37201/97, 22/03/2001, para. 96
[7] *Pretty v. the United Kingdom*, app. no. 2346/02, 29/04/2002, para. 14 (5)
[8] *Pretty v. the United Kingdom*, app. no. 2346/02, 29/04/2002, para. 40

rights (but they cannot limit it), but they do not necessarily need to have rights and its interpretation in their constitutions.

1.2. The right to personal autonomy and the right to private life

Autonomy – is a word which has Greek origin: "autos" means self and "nomos" means rule, law, and governance. As it defined by law dictionary autonomy is "an individual's capacity for self-determination."[9]

The question of personal autonomy was raised for a long time in philosophy. One of the first steps in defining this notion were made by Kant. Kant encouraged "to make use of your *own* understanding … without direction from another."[10] This philosopher saw the autonomy as a characteristic which is free from emotions, which is based on rational perception of the situation, without considering the time and place of the situation. The notion of autonomy significantly changed from that time, but the main points still have a place in modern society.

Autonomy can be understood as a moral category which means possibility to make one`s own decisions without any improper influence by others. "[E]very competent person has the right to make momentous personal decisions, which invoke fundamental religious or philosophical convictions about life's value for him."[11] And so, "that fundamental value would be violated if

[9] Black's Law Dictionary (9th ed. 2009), autonomy seen at http://international.westlaw.com/
[10] Immanuel Kant, *Practical Philosophy* (Cambridge University Press, 1996), 17
[11] Ronald Dworkin *Introduction to Assisted Suicide: The Philosophers` Brief,* The New York Review of Books, Vol. 44 No. 5, March 27, 1997 cited in Violeta Besirevic, *The right to life v. right to die: euthanasia, the ultimate civil liberty or an act of murder?* (PhD Thesis, Central European University, 2005), 24

others (the state, the doctor) could continue a person's life against his will, which would make that life one without freedom and autonomy."[12]

Personal autonomy is recognized as the right of every person. It is closely linked to such rights as personal liberty, dignity and the right to respect for private life. Personal autonomy includes the right of personal development, the possibility to make autonomous choices and have one`s own views and certain understandings; also the right not to be subject to arbitrary restrictions. According to Joseph Raz (legal philosopher) three preconditions should be fulfilled before person can exercise his/ her personal autonomy. Person should be capable to understand the options and to make his/ her choice; there should be "sufficient number of options to choose among for choice to be meaningful"[13] and the decision should be without any manipulations and influences.

Personal autonomy comes out when we talk about such aspects of life as marriage, birth of a child, finding profession and many-many other aspects. And the autonomy also becomes an argument which cannot be avoided while discussing euthanasia and particularly physician-assisted suicide. It gives the person the right to decide about the time and the manner of their end of life, but only the person, which is clearly defined by law, and so a terminally ill person. Each person shall have the right to determine the way of dying, the same as each person shall have right to determine the way of his/her life. This right shall not be under question. Although the European Convention on Human Rights does not explicitly mention the right to personal autonomy the Court in the case of

[12] Leenen H.J.J. *Handboek gezondheidsrecht. Deel I: Rechten van mensen in de gezondheidszor*g [Handbook of Health Law. Volume I: Individual Rights in the Context of Medical Care] (3d ed.). Alphen a/d Rijn: Samsom H.D. Tjeenk Willink cited in John Griffiths, Alex Bood and Helen Weyers - *Euthanasia and Law in the Netherlands* (Amsterdam: Amsterdam University Press, 1998), 170

[13] Neil M. Gorsuch. *The right to assisted suicide and euthanasia* Harvard Journal of Law & Public Policy (23 HVJLPP 599), Summer 2000 from http://international.westlaw.com/

Pretty v. the United Kingdom "considers that the notion of personal autonomy is an important principle underlying the interpretation of its [Article 8] guarantees."[14] So, in that case Court established the practice of applying of the notion of personal autonomy.

In the case of *Rodriguez v. British Columbia* (Attorney General) (to which the European Court of Human Rights referred) the Canadian Supreme Court decided that the prohibition of assisting in committing suicide deprives the person of their autonomy, while this person cannot do it by themself and suffers from some terminal illness.[15]

The European Court of Human Rights in *Pretty v. the United Kingdom* recognized the fact that personal autonomy plays a significant role in the matters of life and death.

> In the sphere of medical treatment, the refusal to accept a particular treatment might, inevitably, lead to a fatal outcome, yet the imposition of medical treatment, without the consent of a mentally competent adult, would interfere with person's physical integrity in a manner capable of engaging the rights protected under Article 8 § 1 of the Convention. As recognized in domestic case-law, a person may claim to exercise a choice to die by declining to consent to treatment which might have the effect of prolonging his life.[16]

Even though in the paragraph it is going not about physician-assisted suicide but about passive euthanasia but it establishes the rule that according to the article 8 the person has the right to decide upon her own body and life (what is covered by the notion of personal autonomy). The Court emphasized the importance of personal autonomy, which covers "the physical and psychological integrity of a person"[17], which practically means that person can decide independently upon her body ("in the sense of the right to make choices about one's own body"[18]), life, when and how

[14] *Pretty v. the United Kingdom*, app. no. 2346/02, 29/04/2002, para. 61
[15] *Rodriguez v. British Columbia (Attorney General)*, 1993 3 S.C.R. 519
[16] *Pretty v. the United Kingdom*, app. no. 2346/02, 29/04/2002, para. 63
[17] Ibid. at para. 61
[18] *Pretty v. the United Kingdom*, app. no. 2346/02, 29/04/2002, para. 66

he/she can die. However, the Court recognized personal autonomy only in the case of refusal/ refraining from the treatment, his logic of personal autonomy shows, that it should cover also cases when a person also needs assistance in dying. A person cannot be forced to do something just because it is good for her, the same rule should apply while the person decides, whether it is better to live or not, interference in such a situation should not also take place.

Very similar rule was established by the Supreme Court of the U.S. in the case *Cruzan v. Director, Missouri Department of Health* in which Nancy Cruzan got into a car accident after which her condition could be described as "persistent vegetative state"[19] and her parents claimed to "terminate the artificial nutrition and hydration procedures."[20] By that case it was established that the competent person has the right to refuse life-sustaining treatment according to the Due Process Clause with respect to personal liberty and right to self-determination.

There can be found several problematic points concerning personal autonomy and physician-assisted suicide. "The value of autonomy lies not in making just any choice but choices which are consistent with the principle of moral values."[21] Analyzing this phrase we can make a conclusion that as far as killing cannot be compatible with morality, it cannot be looked at as the exercise of personal autonomy. And physician-assisted suicide involves third person to exercise of one's will and the right to personal autonomy but this person cannot be obliged to do something, especially something morally wrong.

[19] *Cruzan v. Director, Missouri Department of Health*, 457 U.S. 261 (1990) in *Constitutional Law* Stone, Seidman, Sunstein, Tushnet Aspen Publishers, 1996, p. 1039
[20] *Cruzan v. Director, Missouri Department of Health*, 457 U.S. 261 (1990) in *Constitutional Law* Stone, Seidman, Sunstein, Tushnet Aspen Publishers, 1996, p. 1039
[21] Joseph Raz, *The Morality of Freedom (*Oxford: Clarendon Press, 1988), 412 cited in Violeta Besirevic, *The right to life v. right to die: euthanasia, the ultimate civil liberty or an act of murder?* (PhD Thesis, Central European University, 2005), 26

The other argument against physician-assisted suicide is that autonomy never exists in the raw. There always will be some influence: it can be depression, inadequate care; physician's or relative's influence. Patient cannot make choices independently and autonomously, they are under effects of pain, psychological stress; they do not want to be a burden to their relatives; also there can be some coercion by the relatives or even physician. So, in such a case legal physician-assisted suicide as euthanasia as a whole can be seen as a good ground for manipulation of the terminally ill person's conscious. All these factors have huge influence on the person`s decision and person`s own understanding of the situation. So, in such a case physician-assisted suicide and euthanasia as a whole can be seen as a good ground for manipulation of the terminally ill person's conscious. On the other hand, some kind of influence the people experience in many different situations in their everyday life but we cannot speak on not autonomous decisions. The mere fact of illness does not mean that the person lacks possibility to make autonomous and clear decisions and statements. Diane Pretty (*Pretty v. the United Kingdom*) suffered from motor neuron disease, she was "paralyzed from the neck down, has virtually no decipherable speech and is fed through a tube … [but] her intellect and capacity to make decisions are unimpaired."[22] This should be carefully assessed by the state because "clear risk of abuse undoubtedly exists"[23] but it should not be the main argument against the physician-assisted suicide.

While discussing autonomy it can be also useful to look on the intent of the patient while committing a suicide and the physician while assisting in suicide. Intent of the person can be seen as a manifestation of the autonomous will of the person, demonstration of his/her will, what the

[22] *Pretty v. the United Kingdom*, 2346/02, 29/04/2002, para. 8
[23] Koffeman, N.R. *(The right to) personal autonomy in the case law of the European Court of Human Rights (nota opgesteld ten behoeve van de Staatscommissie Grondwet).* External research report. (Leiden University, 2010), p. 20

real wish of the person. It do not necessarily will be death as such, it can be desire not to suffer, desire to free the relatives from moral or financial obligations etc. but in case of illness and pains death can be the only way to achieve these results. In such a case death will be only a foreseen result but not the primary goal, so we cannot speak on suicide or assisted suicide. We should define what on the intent was directed. And intent was directed on relief of suffering.

The right to personal autonomy is very connected to the right to respect for private life. The right to respect for private life was interpreted by the European Court of Human Rights very broadly. It includes right to choose lifestyle, sexual identity, development of personality, right to decide what to do with own life. But does this right includes the decision on physician-assisted suicide?

There were several recent cases which were ruling whether there is violation of the right to respect for private life while prohibiting the physician-assisted suicide or somehow limiting the right to die. Not depending on the fact whether there was violation of the article the Court did not grant any right to the physician to assist in patient`s suicide. However the European Court of Human Rights did not prohibited the states to regulate on that question, there were wide margin of appreciation given to the states.

To look on the cases of the European Court of Human Rights which decided on Swiss cases it worth to take a look on the legal situation with the assisted suicide in Switzerland. The practice of assisted suicide is not legalized in Switzerland though it is not punished if the person can successfully proof that she assisted in someone`s suicide without any selfish motives, it is crucial moment under Swiss law.[24] According to Swiss Penal Code "Whoever, from selfish motives, induces another to commit suicide or assists him therein shall be punished, if the suicide was

[24] Patients Rights Council - http://www.patientsrightscouncil.org/site/switzerland/

successful or attempted, by confinement in a penitentiary for not more than five years or by imprisonment."[25]

In 2011 the Court in case of *Haas v. Switzerland* decided whether the State should ensure possibility to the ill person to obtain the lethal dose of medication in order to end his life without pain according to the right to respect for private life. The Court held that prescription on such medication as sodium pentobarbital had legitimate aim of the state especially concerning the fact that the assisted suicide in Switzerland is not a punishable under certain circumstances and if the person has enough reasons for ending his/ her life it would not be a problem to find physician to write a prescription and so there is no violation of the right to respect for private life. The Court confirmed that the right to avoid the undignified end falls within the scope of Article 8 (as it stated in *Pretty v. the United Kingdom*), confirmed wide margin of appreciation of the States to legislate on the issue of assisted suicide but found that the State did not violate his right because he has all means to find someone to assist in his suicide. The Court did not answer the question about positive obligations towards the right to die.

Very important case for future practice of the European Court of Human Rights was held in May 2013. The case of *Gross v. Switzerland* was brought by the elderly woman who was not terminally ill but wanted to end her life. She was refused in obtaining the lethal medicine and so she claimed the violation of the right to respect of her private life because she lacked the possibility to decide on time and way of her death. The Court found violation of article 8 by stating that "Swiss law, while providing the possibility of obtaining a lethal dose of sodium pentobarbital on medical prescription, does not provide sufficient guidelines ensuring clarity as to the extent of this right.

[25] Article 115 of the Penal Code of Switzerland cited in Patients Rights Council - http://www.patientsrightscouncil.org/site/switzerland/

There has accordingly been a violation of Article 8 of the Convention in this respect."[26] The Court pointed that the decision concerns only the lack of the guidelines which can lead to anguish of the person. This decision opens the possibility to use the article 8 in cases of assisted suicide without mentioning the right to die.

1.3. Right to dignity

Everybody understands the notion of dignity, everybody wants his/ her dignity to be respected. But what is actually dignity? And what is dignity in legal context?

The Universal Declaration of Human Rights recognizes the inherent dignity of the people and states that "[a]ll human beings are born free and equal in dignity and rights."[27] The European Convention on Human Rights does not contain the right to dignity, does not provide any references to that right, but it is not under the question that this right runs through the Convention. The European Court of Human Rights stated held that "the very essence of [Convention] is respect for human dignity and human freedom."[28] The case *S.W. v. the United Kingdom* concerns Article 7 of the Convention which states that there should be no punishment without the law but from there we can derive the importance of dignity of the person. So, the right to dignity goes through the Convention but it is not explicitly covered by any of the Articles.

[26] *Gross v. Switzerland*, app. no. 67810/10, 14/05/2013, para. 67
[27] UN General Assembly, *Universal Declaration of Human Rights*, 10 December 1948, 217 A (III), art. 1
[28] *S.W. v. the United Kingdom*, app. no. 20166/92, 22/11/1995, para. 44

The right to dignity is an important part of some constitutions, even if it is not explicitly mentioned, than by the nature of law of this countries it is understandable. The Constitution of the United States does not have right to dignity, nor it provides the principle of dignity but the idea of the dignity appears already in the Federalist Papers, and namely in the First one, where Hamilton explains that the adoption of the Constitution "is the safest course for your liberty, your dignity, and your happiness"[29] (to the people of the State of New York). So, dignity was recognized as one of the most important values already at the time of the U.S. Constitution emerging and as one of the principles on which the Constitution stands. In the nowadays United States dignity plays very important role, all claims concerning the right to die or right to choose the time and the way of dying appeal to the dignity. It can be seen even from the name of the Oregon Statute – Oregon Death with Dignity Act.

Sometimes this right overlaps with other rights such as right to personal autonomy, right to liberty, exactly the rights which play an important role in the issue of physician-assisted suicide. Losing of dignity or undignified death/ last days of life are usually seen as the most important reasons for requesting the physician-assisted suicide/ euthanasia and in the discussion of its legalization.

In the case of *Pretty v. the United Kingdom* the applicant was "frightened and distressed at the suffering and indignity that she will endure if the disease runs its course"[30] and so she claimed the right to have control over the time and way of her death. She claimed the right to die not to lose her dignity. That is how right to dignity comes on the stake in the issue of the physician-assisted suicide. The Court recognizes that the right to respect for human dignity is the very essence of the

[29] The Federalist No. 1, Independent Journal October 27, 1787 [Alexander Hamilton] from http://www.constitution.org/fed/federa01.htm

[30] *Pretty v. the United Kingdom*, app. no. 2346/02, 29/04/2002, para. 8

Convention.[31] At the same time the Court in its decision referred to the Recommendation 1418 of the Council of Europe which stated 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. recognizing that the right to life, especially with regard to a terminally ill or dying person, is guaranteed by the 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. recognizing 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. recognizing 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.[32]

It can be understood that the Court and the Council of Europe do recognize the right to dignity, protection of dignity but it cannot be used to request the physician-assisted suicide or other acts which can bring to the death of the terminally ill person.

"Terminal illness, despite all medical, nursing and palliative care, lead to physical and psychological exhaustion, incontinence, decubitus and fatigue, all considered by the patient to be symptoms of degradation and the complete loss of human dignity."[33] And so, the person's right to choose the time and way of his/ her death means to him/her, that he/ she will die in a dignified manner, which also means that the person was respected as a human being, that his/ her interests were valued. This leads back to the autonomous side of the notion of the person`s dignity.

Already in the one of the first physician-assisted suicide cases in the Netherlands (*Schoonheim* case, 1984), the Supreme Court justified this practice by referring "to the patient`s "unbearable

[31] *Pretty v. the United Kingdom*, app. no. 2346/02, 29/04/2002, para. 65
[32] Council of Europe, *Recommendation 1418 on Protection of the human rights and dignity of the terminally ill and the dying* (1999), para. 9 (c)
[33] Violeta Besirevic, *The right to life v. right to die: euthanasia, the ultimate civil liberty or an act of murder?* (PhD Thesis, Central European University, 2005)

suffering", the prospect of increasing "loss of personal dignity" and the risk that it might become impossible for the patient to "die in a dignified manner"."[34] This can lead to the explanation that dignity plays significant role in the person`s right to choose death.

In this chapter I looked through the main rights which concerned the physician-assisted suicide and the right to die. The right to die does not exist in any jurisdiction: either on the State level or on the international/ European. The right to physician-assisted suicide was derived from other rights such as right of the personal autonomy, self-determination with the possibility to choose the way of life, some main landmarks of one`s own life, the possibility to choose to live or to die, to determine the time and way of dying. Very close right to this is the right to respect for private life, this right considered by the European Court of Human Rights as the most suitable to accept the practice of the physician-assisted suicide without actually creating the right to die. The right to dignity plays here important role and this right is almost always, almost in each case on stake when the patient claims the assisted suicide. The people consider the terminally illness without any chance to recover and only with unbearable pains to be degrading and the death in such a way is undignified, the person feels the loss of its dignity as one of the supreme values of his/ her being. The right to life cannot be considered here as a right which leads to extension of its scope in order to derive the right to die here. So, it can be concluded that different rights can be used to practice the physician-assisted suicide.

[34] John Griffiths, Alex Bood and Helen Weyers, *Euthanasia and Law in the Netherlands*, (Amsterdam: Amsterdam University Press, 1998), 63

Chapter II: The nature of physician-assisted suicide

In this chapter I would like to reveal the essence of the euthanasia and the physician-assisted suicide. To understand the best way to regulate the physician-assisted suicide it should be understood its notion and nature. I would like to explain what euthanasia is and what types of euthanasia exist, the difference between them and only after, it is possible to see what physician-assisted suicide is, how it matches up with other types of euthanasia. Also it is very important to see the development of the issue of physician-assisted suicide in the world as a whole and in the chosen jurisdictions (the State of Oregon, the Netherlands and the development of the understanding by the European Court of Human Rights).

To understand what assisted suicide is, I would like to start with defining what is euthanasia, the main differences between the types of euthanasia and then I come specifically to physician-assisted suicide and its main features.

2.1. Assisted suicide and euthanasia

The term euthanasia comes from Greek word euthanatos, which means "good death" or "easy death".[35] Black`s Law Dictionary gives following definition of euthanasia as "the act or practice of killing or bringing about the death of a person who suffers from an incurable disease or

[35] Random House Webster's Unabridged Dictionary 670 (2d ed. 2001) cited in Stephen Hoffman. *Euthanasia and physician-assisted suicide: a comparison of E.U. and U.S. law* Syracuse Law Review (63 SYRLR 383), 2013 from http://international.westlaw.com/

condition, esp. a painful one, for reasons of mercy. Euthanasia is something regarded by the law as second-degree murder, manslaughter, or criminally negligent homicide."[36]

Physician-assisted suicide, which I will deal with in my work, can be seen as "any act which intentionally helps another to commit suicide"[37] by "providing him with the means to do so"[38], which can include "providing a prescription for lethal medication"[39], supplying necessary medication, "setting up the elaborate machine created by Dr. Jack Kevorkian."[40] Black`s law dictionary defines assisted suicide as "the intentional act of providing a person with the medical means or the medical knowledge to commit suicide."[41]

Even though physician-assisted suicide and euthanasia can be understood very closed to each other these notions are quite different. Physician-assisted suicide occurs in case when the patient decides to terminate his life and the physician assists him in one or another manner, but the patient himself makes the final act either with presence of his physician or not.[42] Euthanasia does not necessarily require person`s request and the final act is conducted by the physician.[43]

Depending on the acts and omissions, on the request of the patient euthanasia can be divided in active and passive, voluntary, non-voluntary and involuntary. Voluntary, non-voluntary and

[36] Henry Campbell Black, *Black's Law Dictionary* 7th ed. Bryan A. Garner, editor. (St. Paul, Minn. : West Group, 1999), 575
[37] Penney Lewis, *Assisted Dying and Legal Change* (Oxford Univ. Press, 2007), 5
[38] Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001 (Netherlands), s.1 (b)
[39] The Oregon Death with Dignity Act, Oregon Revised Statute §§ 127.800 to 127.890, (1997)
[40] Penney Lewis, *Assisted Dying and Legal Change* (Oxford Univ. Press, 2007), 5
[41] Henry Campbell Black, *Black's Law Dictionary* 7th ed. Bryan A. Garner, editor. (St. Paul, Minn. : West Group, 1999), 1447
[42] Stephen Hoffman. *Euthanasia and physician-assisted suicide: a comparison of E.U. and U.S. law* Syracuse Law Review (63 SYRLR 383), 2013 from http://international.westlaw.com/
[43] Ibid.

involuntary euthanasia differs depending on the presence of consent and the request of the person. So, when we are talking about voluntary euthanasia it means that the person requested to end her life in one or another manner at a certain point of her life under certain circumstances. Non-voluntary euthanasia take place when the person does not have possibility to request or consent on euthanasia, he/ she is in coma for example. But involuntary is a kind of euthanasia which is conducted against the will of the person.

The question of active and passive euthanasia can be seen as a question of killing the person (refers to active) and letting him/her die (refers to passive euthanasia).

2.2. The history of physician-assisted suicide

It is very important to look through the history of assisted suicide and its development through the time in order to understand the processes which occur to the society, to understand conceptions of death, suicide, assistance in suicide, theirs legal understanding and changes which happen in different times under different circumstances, how all historical conceptions influence nowadays understanding and regulations. The historical approach to understanding of assisted suicide is quite common in deciding cases on that issue.

At first I would like to look through the history of development of understanding of suicide and the attitude towards this act in the history. Suicide was understood as "deliberately put[ting] an end to his own existence, or commit[ting] any unlawful malicious act, the consequence of which is his own death."[44] Under English common law which made a great influence on the U.S. suicide

[44] Cruzan v. Director, Missouri Department of Health, 457 U.S. 261 (1990) cited in Shelly A. Cassity. *To die or not to die: the history and future of assisted suicide laws in the U.S.* Utah Law Review, 2009 from http://international.westlaw.com/

was a crime and was punished: as this act was recognized as a crime against the state all property was confiscated, but this made harm to the relatives of the person who did a suicide. As about the person herself there were punishments with the goal to dishonor the victim such as denial in Christian burial and were buried in the highway. After a time (in the U.S. in the mid-1800s) suicide was decriminalized because the relatives of the person were recognized as innocent and that they should not be responsible for the act of suicide of another person. And the person himself was already dead and it made no sense to punish him/ her.

In the early 20th century the question of decriminalization of assisted suicide was raised and assisted suicide was legalized by criminal appeals court in Texas taking into account the fact that suicide itself was not a crime any more. This attempt was overruled after a short time.[45] After a few decades a few cases emerged which allowed to refuse medical treatment according to patient`s intent. I would like to look closer on the development of the assistant suicide and its regulation starting from the early ages as the courts in the United States refer to the history and as in my opinion it plays very important role for a nowadays understanding and regulation.

"I will not give a lethal drug to anyone if I am asked, nor will I advise such a plan" [46] says the Hippocratic Oath approximately round 400 B.C[47], which was a requirement for future doctors historically. Nowadays the Oath is not obviously a precondition to become a physician, but the requirement not to kill and not to advise in ways of death is still alive.

[45] Shelly A. Cassity. *To die or not to die: the history and future of assisted suicide laws in the U.S.* Utah Law Review, 2009 from http://international.westlaw.com/

[46] "U.S. National Library of Medicine" accessed on March 5, 2014 https://www.nlm.nih.gov/hmd/greek/greek_oath.html

[47] Emily Wada. *A Pretty picture: the margin of appreciation and the right to assisted suicide* Loyola of Los Angeles International and Comparative Law Review (27 LYLAICLR 275), Spring 2005 from http://international.westlaw.com/

The issue of euthanasia and physician-assisted suicide was problematic and discussed in early history, even in ancient Greece and Rome. As judge Reinhardt claimed in the *Washington v. Glucksberg*[48] noted that suicide as also assisted suicide was often tolerated and permissible in ancient Greece and Roman Empire. Though there were a lot of discussions among philosophers. For example, Plato argued that suicide is "running away" from the reality, from the duties implied on that person[49] but he made exceptions when the suicide can be justifiable such as: "(1) judicial order; 2) excruciating misfortune; or (3) moral disgrace."[50] So, from here we can see that suicide could be permissible under some circumstances and conditions.

After emergence of Christianity it was quite different and opinions were changed to opposing euthanasia in any form and so the Hippocratic Oath was brought back to life. Also according Christian doctrine suicide and assistance in suicide of another person was seen as sin. In the 13th century, suicide was condemned by Aquinas who made the teaching about suicide such an issue which influenced Christianity for centuries. He was at the opinion that suicide is "(1) contrary to the natural inclination of self-preservation and charity whereby everyone should love himself; (2) an injury to the community as well as the individual; and (3) an insult to the Creator`s right over man."[51]

[48] *Washington v. Glucksberg* 521 U.S. 702 (1997) – State of Washington banned the assisted suicide in its Natural Death Act of 1979 and so the petitioners claimed that this act violates Due Process Clause of 14th Amendment to the U.S. Constitution.

[49] Plato, Phaedo 74 (Benjamin Jowett trans., 2000) cited in **23 HVJLPP 599** Harvard Journal of Law & Public Policy THE RIGHT TO ASSISTED SUICIDE AND EUTHANASIA Summer 2000 THE RIGHT TO ASSISTED SUICIDE AND EUTHANASIA Neil M. Gorsuch

[50] Plato, Laws 202, 220 (Benjamin Jowett trans., 2000) cited in Neil M. Gorsuch. *The right to assisted suicide and euthanasia* Harvard Journal of Law & Public Policy (23 HVJLPP 599), Summer 2000 from http://international.westlaw.com/

[51] Thomas Aquinas, Summa Theologica 70 (Paul E. Sigmund ed. & trans., 1988) cited in Neil M. Gorsuch. *The right to assisted suicide and euthanasia* Harvard Journal of Law & Public Policy (23 HVJLPP 599), Summer 2000 from http://international.westlaw.com/

In the second half of the 19th century morphine was widely used to relieve pain, but also became a means of intentional killing of the people. Samuel Williams was one who advocated such use of morphine and this received attention in the medical and scientific world. But most doctors did not support the idea of intentional killing of the patient with the help of morphine or other such pain relieving medicine.[52]

In 1930s in some countries such as United States and the United Kingdom, movements for legalization of euthanasia were started. In 1935 the Voluntary Euthanasia Legalisation Society was founded in Great Britain by C. Killick Millard, but was defeated by the House of Lords in the following year. In 1938 the very similar society - the Euthanasia Society of America - was founded in the United States.[53]

But over time the situation changed and in the 1950s the World Medical Association condemned euthanasia and physician-assisted suicide and at the same time the polls showed that less people than in 1930s supported physician-assisted suicide particularly in the US (round 36%).[54] Also in the 1950s there were attempts to amend the United Nation Declaration of Human Rights with the purpose of including the right to end suffering of the person by means of euthanasia or physician-assisted suicide. But the attempt did not reach its goal.

[52] "ProCon.org: Euthanasia" accessed on March 5, 2014 http://euthanasia.procon.org/view.timeline.php?timelineID=000022
[53] "Britannica: academic edition" accessed on March 5, 2014 http://www.britannica.com/EBchecked/topic/196711/euthanasia?anchor=ref66817
[54] "ProCon.org: Euthanasia" accessed on March 5, 2014 http://euthanasia.procon.org/view.timeline.php?timelineID=000022

More discussion in the United States over physician-assisted suicide started in 1990 with Dr. Jack Kevorkian`s death machine. It was such a machine, "known as the Mercitron or Thanatron"[55], which delivered a lethal dose of medicine into a person`s body by pressing the button by this person who could not commit suicide by other means. He made it for people who had no hope of getting better but suffered too much. There is claim that Dr. Kevorkian was seeking not only for legalizing of physician assisted suicide as an act of helping other to end his/her life, but also the practice of euthanasia as an act of intentional killing of other person.[56] His aim was "to make euthanasia a positive experience …. [he was] trying to knock the medical profession into accepting its responsibilities, and those responsibilities include assisting their patients with death."[57] To stop him in his activities his State of origin enacted a Statute which prohibited assisted suicide. There were four trials, but there was not enough evidence and finally in 1999 he was convicted for 10 years. Kevorkian`s activity made the public speak on the issue of physician-assisted suicide, the possibilities of reducing suffering and whether it is needed or not.

In 1997 in the case of *Washington v. Glucksberg* Supreme Court checked several Washington Statutes which banned physician-assisted suicide. It was decided that there is no such right in the Constitution as the right to die. Court found such a ban reasonable as the State protected the vulnerable group of people and that the human`s life belongs to state interest.

[55] Dominic Rushe, "Dr Death' Jack Kevorkian, advocate of assisted suicide, dies in hospital" The Guardian, 4 June 2011 from http://www.theguardian.com/world/2011/jun/04/dr-death-jack-kevorkian-suicide

[56] Brian Murphy, Kevorkian Silent, Starts Prison Term, Detroit Free Press, (Apr. 14, 1999) http://www.freep.com/news/xtra2/qkevo14.htm cited in Harvard Journal of Law & Public Policy Summer 2000 Article THE RIGHT TO ASSISTED SUICIDE AND EUTHANASIA Neil M. Gorsuch 23 Harv. J.L. & Pub. Pol'y 599

[57] Dominic Rushe, "Dr Death' Jack Kevorkian, advocate of assisted suicide, dies in hospital" The Guardian, 4 June 2011 from http://www.theguardian.com/world/2011/jun/04/dr-death-jack-kevorkian-suicide

The history of physician-assisted suicide in the Netherlands was quite different from the one in the U.S. It started in the 1970s even though it was not legalized and regulated until 2002.

In 1973 Postma case took place in the Netherlands, this was a case where the physician hastened the death of her mother after several request for that. Even though the physician was convicted but the court set up some criteria for the situations when the physician would not be guilty for not keeping the patient alive. It became a landmark case which opened the road for some more cases on the issue of euthanasia and physician-assisted suicide. In 1981 the Rotterdam Court (*Wertheim case*) made a decision by which it set out some guidelines for the act of physician-assisted suicide. The guidelines of the Court included:

> 1. The patient must be experiencing unbearable pain (physical or mental);
> 2. The patient must be conscious;
> 3. The death request must be voluntary;
> 4. The patient must have been given alternatives to euthanasia and time to consider these alternatives, must be well informed on the current situation and the prognosis;
> 5. There must be no other reasonable solutions to the problem;
> 6. The patient`s death cannot inflict unnecessary suffering on others;
> 7. There must be more than one person involved in the decision to give assistance in suicide;
> 8. Great care must be taken in actually making the death decision.[58]

In 1984 the case *Alkmaar* (or *Schoonheim* case) took place in which the physician was acquitted for the first time in cases of euthanasia. The physician euthanized a 95-year-old woman who even though she was not terminally ill, but chronically ill and her condition became worse and she felt her life to be unbearable. The Dutch Supreme Court recognized the possibility of losing of personal dignity and the fact that person probably would not die in a dignified manner. After investigating

[58] Carlos Gomez, *Regulating Death* (New York: Free Press, 1991), 32. cited in Chelsea Pietsch, Research Officer SCBI, *Development of Euthanasia and Physician-Assisted Suicide in the Netherlands* and John Griffiths, Alex Bood and Helen Weyers, *Euthanasia and Law in the Netherlands*, (Amsterdam: Amsterdam University Press, 1998), 59

of all merit of the case the Court concluded that physicians can use an argument of necessity for the purpose of euthanasia.[59] In this case there were several important points which played big role in further development of the assisted suicide in the Netherlands. By not convicting the physician the Court opened the practice that in case of adhering of all requirements including reporting about the actions the physicians can perform acts which leading to person`s death (whether by euthanasia or by assisting in suicide). And second consequence is recognition of the necessity principle which can also be based on human dignity.

In this chapter I looked through the notion of the physician-assisted suicide as an intentional assisting of another person in his/ her dying (committing suicide) by prescribing the medication (lethal dose or lethal medicine). It should be done by the physician. Also I distinguished the notions of the euthanasia (as an act of intentional killing of another person with his/ her request) and physician-assisted suicide (which means suicide committed by the person himself with some kind of help/ assistance by another).

The issue of the physician-assisted suicide was questionable already in the ancient times, in some period of the history committing suicide was prohibiting, not talking about the physician-assisted or assisted by any other person. Throughout the history the notion of assisted suicide changed and developed. There were attempts to legalize it and regulate in certain periods of the history but the attempts were not successful until second half of the 20th century. Not always it moved forward, sometimes there were steps back, but all this brought us to the modern understanding of the issue.

[59] John Griffiths, Alex Bood and Helen Weyers, *Euthanasia and Law in the Netherlands*, (Amsterdam: Amsterdam University Press, 1998), 62-63

Chapter III: Legal regulation of the assisted suicide

In this chapter I would like to write about the regulation of the physician-assisted suicide in the State of Oregon and the Netherlands. I would like to see the main requirements which both of them provide. Also it should be good to see the basis on which legalization and the regulation lies.

I would like to develop the notion of the person who can request the physician-assisted suicide and to investigate the main safeguards (which also bring problematic issues) of the physician-assisted suicide regulation, whether they work, help to protect vulnerable group of the patients.

3.1. The legal basis

In the following subchapters I would like to look on the regulation of the physician-assisted suicide in the State of Oregon and the Netherlands to find out the requirements for this act, the basis of such regulation.

3.1.1. The State of Oregon

In 1994 the people of Oregon State voted for Measure 16, which legalized physician-assisted suicide with certain conditions and requirements. With that act Oregon became the first state in the U.S and first jurisdiction in the world to allow and regulate physician-assisted suicide. This act

was approved on November, 8th, 1994; the difference between votes for and against was very small: 51,3 % in favor of the act and 48,7 % against.[60]

This statute contained a lot of controversial provisions and thus was very discussed and challenged in the courts. In addition, people had fear, which was ungrounded, that people from all over the country would go to Oregon to use the possibility of the law - physician-assisted suicide. The Supreme Court held on this issue that the States by themself are allowed to decide whether to allow or not physician-assisted suicide, but it is not covered by any fundamental right, such as the right to liberty, for example (*Vacco v. Quill* and *Washington v. Glucksberg*). But it was not implemented till the 1997 when the Ninth Circuit Court of Appeal[61] stated that physician-assisted suicide can be an option for the terminally ill patients.

According to the Oregon Death with Dignity Act

> [a]n adult who is capable, is a resident of Oregon, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner in accordance with [the Oregon Death with Dignity Act].[62]

In such a way the Oregon legislator identified and narrowed the possible category of who can enjoy the right to physician-assisted suicide. Only in case of meeting all these requirements the patient can request the physician-assisted suicide, which also has very strict procedure, which includes seven main points:

[60] "Death with Dignity National Center" accessed on March 5, 2014 http://www.deathwithdignity.org/historyfacts/oregontimeline
[61] The State of Oregon as some other states of the U.S. belongs to this Court of Appeals
[62] The Oregon Death with Dignity Act, Oregon Revised Statute §§ 127.800 to 127.890, (1997), para.127.805 s.2.01

1) the patient should make an oral and a written request;

2) the oral request should be reiterated to the attending physician "no less than fifteen (15) days after making the initial oral request"[63];

3) the written request should be "witnessed by at least two individuals"[64], one of which is not a relative, is not entitled to any part of the estate of the person, does not have any relation to the health care facility which is in direct relation to the patient (either residency or treatment), is not an attending physician, an in certain cases such as "If the patient is a patient in a long term care facility at the time the written request is made, one of the witnesses shall be an individual designated by the facility and having the qualifications specified by the Oregon Health Authority by rule. "[65] All these requirements are made to ensure that the request was voluntary, not influenced and the person who are not interested, who can be impartial, can check it, see it and be witnesses.

4) the attending physician shall "[m]ake the initial determination of whether a patient has a terminal disease, is capable, and has made the request voluntarily"[66] and the consulting physician shall examine and confirm the information on the illness, treatment and the prognosis; also the examine the capability of the patient and verify if his/ her decision was voluntary;

[63] The Oregon Death with Dignity Act, Oregon Revised Statute §§ 127.800 to 127.890, para. 127.840 s.3.06.
[64] The Oregon Death with Dignity Act, Oregon Revised Statute §§ 127.800 to 127.890, para. 127.810 s.2.02. (1)
[65] The Oregon Death with Dignity Act, Oregon Revised Statute §§ 127.800 to 127.890, para.127.810 s.2.02. (4)
[66] The Oregon Death with Dignity Act, Oregon Revised Statute §§ 127.800 to 127.890, para. 127.815 s.3.01. (1) (a)

5) if there is possibilities or suspicion of impaired judgment of its own condition or the results of the physician-assisted suicide because of some psychiatric or psychological disorder attending or consulting physician shall " shall refer the patient for counselling."[67] Without the conclusion that there is no such disorder the further steps in assisting in suicide are impossible and prohibited.

6) the attending physician shall inform the patient about "[t]he feasible alternatives, including, but not limited to, comfort care, hospice care and pain control"[68] and he should be sure the patient understood the possibilities and takes it into account while deciding about terminate his/ her life;

7) physicians are obliged to inform the Oregon Health Services about the proscription of lethal medication.

3.1.2. The Netherlands

In 2001, euthanasia and physician-assisted suicide became legal in the Netherlands. The main point of the law was that "VAE [voluntary active euthanasia] must be performed in accordance with careful medical practice."[69] Requests must be voluntary, well considered, persistent, and emanate from patients who are experiencing unbearable suffering without hope of improvement, and the

[67] The Oregon Death with Dignity Act, Oregon Revised Statute §§ 127.800 to 127.890, para.127.825 s.3.03.
[68] The Oregon Death with Dignity Act, Oregon Revised Statute §§ 127.800 to 127.890, para. 127.815 s.3.01. (1)(c)(E)
[69] Carlos Gomez, *Regulating Death* (New York: Free Press, 1991), 32. cited in Chelsea Pietsch, Research Officer SCBI, *Development of Euthanasia and Physician-Assisted Suicide in the Netherlands*

doctor and the patient must agree that VAE is the only reasonable option. At least one physician must be consulted, who must see the patient and give a written opinion on the case."[70]

Physician-assisted suicide is still a crime under Dutch law: "a person who takes the life of another person at that other person`s express and earnest request"[71] is guilty in a serious crime. It differs from the usual murder as intentional killing of the person for any reason, but this provision of the Penal Code provides exactly for such situations punishment. What means that it is a crime in the Netherlands but there is an exception in the Penal Code according to which if physician follows some rules and requirements he will not be prosecuted.

According to the next article (Article 294) "a person who intentionally incites another to commit suicide, assists in the suicide of another, or procedures for that other person the means to commit suicide"[72] also will be claimed guilty in crime even though the suicide by itself is not a crime and not punishable.

The act which regulates euthanasia and physician-assisted suicide was discussed between 2000 and 2001 by the Parliament. The statute emphasizes the "transparency of euthanasia practice and legal certainty."[73] The aspect of self-determination does not appear in the statute as central or one of the values, not the personal autonomy or dignity. The main goal of the law is to provide the physicians with some guarantees if they comply with all requirements of due care which are necessary. The physician shall make a report about each case of physician-assisted suicide (and

[70] John Keown, *Euthanasia, Ethics and Public Policy: An Argument Against Legalisation* (Cambridge University Press, Cambridge, 2002), 88
[71] The Dutch Penal Code, art. 293 cited in John Griffiths, Heleen Weyrs, *Euthanasia and law in Europe.* Oxford : Hart, 2008, 29
[72] The Dutch Penal Code, art. 294 cited in John Griffiths, Heleen Weyrs, *Euthanasia and law in Europe.* Oxford : Hart, 2008, 30
[73] John Griffiths, Heleen Weyrs, *Euthanasia and law in Europe.* Oxford : Hart, 2008, 33

also euthanasia as in the Netherlands both are possible). After he had informed his actions will be examined by the special body – review committee – which after considerations decides whether to inform Public Prosecutor Office and Healthcare Inspectorate, if all the requirements were complied there will be no further actions.

The main requirements of due care put some obligations on the physician, such as:

> a. hold[ing] the conviction that the request by the patient was voluntary and well-considered,
>
> b. hold[ing] the conviction that the patient's suffering was lasting and unbearable,
>
> c. [informing] the patient about the situation he was in and about his prospects,
>
> d. and the patient hold the conviction that there was no other reasonable solution for the situation he was in,
>
> e. [consulting] at least one other, independent physician who has seen the patient and has given his written opinion on the requirements of due care, referred to in parts a - d.[74]

So, from here we can see that the approach to the act of physician-assisted suicide is quite based on the physician and not on the patient, or maybe patient-focus is hidden.

3.2. Analysis of the State of Oregon and the Netherlands

Here I would like to see the main differences, similarities, contradictions in regulation of assisted suicide in Oregon and the Netherlands in order to compare and to try to find the weaknesses of each jurisdictions and the best ways to solve them probably with the help of the other jurisdiction.

[74] Termination of Life on Request and Assisted Suicide (Review Procedures) Act, art. 2(1)

3.2.1. Who can get access to physician-assisted suicide?

The physician-assisted suicide presupposes the fact that only terminally ill person can enjoy the right to choose to end their life by physician-assisted suicide. But how to include all the people who need it to grant this right without making exclusion of some category of people which might need it and not to put the vulnerable group under dangerousness.

According to the Oregon Death with Dignity Act the person who can request physician-assisted suicide should be adult what actually means that the patient shall be 18 years or older. In the Netherlands there are possibilities for the minors to request the physician-assisted suicide depending on age with the consent or the notification of the parents or the legal guardians.

Both the Netherlands and Oregon require the person to be capable while requesting the euthanasia. The Oregon Statute claims that capable:

> means that in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, psychiatrist or psychologist, a patient has 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.[75]

So, when person understands his/ her situation, what their decision means to them, they can take responsibility for it and can clearly express their opinion. Exactly that point can be a good challenge to the allowance of the physician-assisted suicide for the minors.

According to Oregon law and practice in the Netherlands the physician-assisted suicide can be enjoyed in each place only by residents of this state. So that non-residents could not just come and

[75] The Oregon Death with Dignity Act, Oregon Revised Statute §§ 127.800 to 127.890, para. 127.800 s.1.01. (3)

enjoy the right which is not granted under the laws of their state of origin. It can be seen as safeguard against abuses also in term that the patient and physician should be in some long relations in order to know all necessary circumstances for such a decision.

The person should be terminally ill under Oregon law and moreover their death should be within six months according to prognosis of the physicians (one attending and one more should be consulted). The Netherlands law and practice requires the conviction of the physician that the person has unbearable and lasting sufferings but according to the case law it should not be necessarily terminally illness. There were cases where the person was chronically ill, but the illness by itself did not lead to the death. The Court in *Schoonheim* case used the argument of dignity and accepted the assistance in suicide in case of necessity what makes the category of people who can enjoy the physician-assisted suicide broader and not so specific. The European Court of Human Rights in *Gross v. Switzerland* found the violation of the Convention because of the lack of guidelines in Switzerland on who can request the assistance in suicide, to which extends this right exists, which means that the European Court of Human Rights put itself on the position of clear defining of those who can request assistance.

3.2.2. The role of the physician in performing of physician-assisted suicide

While analysing the fact that the physician assists in dying (by any means) we should look what actually physician does and how it correlates with the medical practice, whether it contradicts main duties of the doctor as the person who should treat people and how does it relates to the Hippocratic Oath. In the Oregon physician`s main task is to prescribe medication which the patient takes after that by himself or surrounded by his relatives or whom he/ she wants to see. But the physician has

also other tasks such as: the physician should determine whether the patient is ill, whether he has terminal and incurable illness, make the prognosis, inform the patient about his illness, prognosis, and possible treatment; refer him to the consulting physician in order to check the diagnose and prognosis; make sure that the patient`s will is his own will and that the patient fully understands the consequences of his request; after all these steps physician contacts pharmacist in order to inform him on his prescription.[76] His last duty will be to sign death certificate in case patient will take the lethal medication and will not change his mind. So, from here we can see that the physician do not take part in the act of dying of the patient.

In the Netherland the physician except that he should comply with due care requirements are obliged to be present while the patient takes the prescribed medication. He is obliged to be present for several reasons such as: to control that the right person drank the medication and not the other by mistake or expressly; the second reason is to control the process and in case of necessity to take some required measures.

From both this cases (which are quite different in the matter of role of the physician) we can see that the physician plays important role in the assisting even if he does not directly takes part in the final act of the person. It can be argued that the physician does something what is contradicts the understanding of physician`s duties. But if we will come back to the intention of the physician while he prescribes the lethal medication or in some other way assists in dying we would see that his intention is directed towards relief of suffering of the ill person which totally matches with his duty as a physician.

[76] The Oregon Death with Dignity Act, Oregon Revised Statute §§ 127.800 to 127.890, (1997), para. 127.815 s.3.01.

3.3. The safeguards and its effectiveness (the Netherland and the USA)

The decision on physician-assisted suicide where it is legal should be voluntary, stable, well-considered. And so, voluntariness and written consent as a consequence are the first safeguard of this act. In Oregon Death with Dignity Act explicitly stays the requirement of written request which should even be witnessed. The Dutch Statute does not mention in which form the request should be, but according to the literature and case law the written form is preferable. The physicians are advised to take written request in order to have some document afterwards for future control. So, even though it does not explicitly regulated by both Acts, but in both practices the written form is preferably and common.

The patients in both cases should be well informed about their health condition, the prognosis and the possibilities of treatment. There should be no pressure on the patient in making such a request, the request should be voluntary and free from any external influence. And also the decision on the physician-assisted suicide should be impaired. The Oregon Statute provides here requirement of psychiatric consultation whereas the Dutch law also does not have such requirement in its body but due to the practice such consultation is also required in the Netherlands.

The next safeguard is requirement of reporting. Both jurisdictions require report to the special body but often this requirement is ignored by any reasons. There are nearly 20% of the cases which are not properly reported in the Netherlands, and this number can be even higher.[77] It is quite

[77] J. Pereira, Legalizing euthanasia or assisted suicide: the illusion of safeguards and controls, MBChB MSc, Curr Oncol. Apr 2011; 18(2): e38–e45. from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3070710/

tangible issue and the number of unreported cases is high, what can lead to abuses in the sphere of physician-assisted suicide.

The act of assisted suicide can be done only with assistance of the physician (which can include prescription of the drugs, administering of that drugs) and not any other person. This requirement is important because only physician knows all necessary factors. Here also comes the requirement of the consultation with one more physician which is not patient's attending physician for more impair judgment on the present and future situation. Also, as it was mentioned above in some cases it is important to consult not only the physician on the illness which became on stake in the question of assisted suicide, but also with the psychiatric worker which can tell whether the patient is compatible to take such decision or he is distressed and disordered by his suffering; probably psychiatrist can also tell if the person is under someone`s pressure or influence. This would help in protecting of the vulnerable groups of patients.

There are some similar points and some different points in regulating of the physician-assisted suicide in Oregon and in the Netherlands. The Dutch legislation regulates not only physician-assisted suicide but also the voluntary euthanasia, the Oregon statute states only for the physician-assisted suicide, but without explicitly mentioning that this is assisted suicide. In the Netherlands regulation is based on due care criteria, which basically means requirements for the physician in order to avoid the crime.

Both jurisdictions use the same safeguards to protect the patients and the physicians from the acts which cannot be performed in the society. To the safeguards belong the requirements for request

of the physician-assisted suicide, some time lapse (between two requests, between request and the act) during which the patient can rethink, change his mind on that issue. The consultation with the other physician (either on the merits of the illness or psychical condition) in order to avoid situation of impair, one-sided view on the situation.

Chapter IV: The physician-assisted suicide in practice

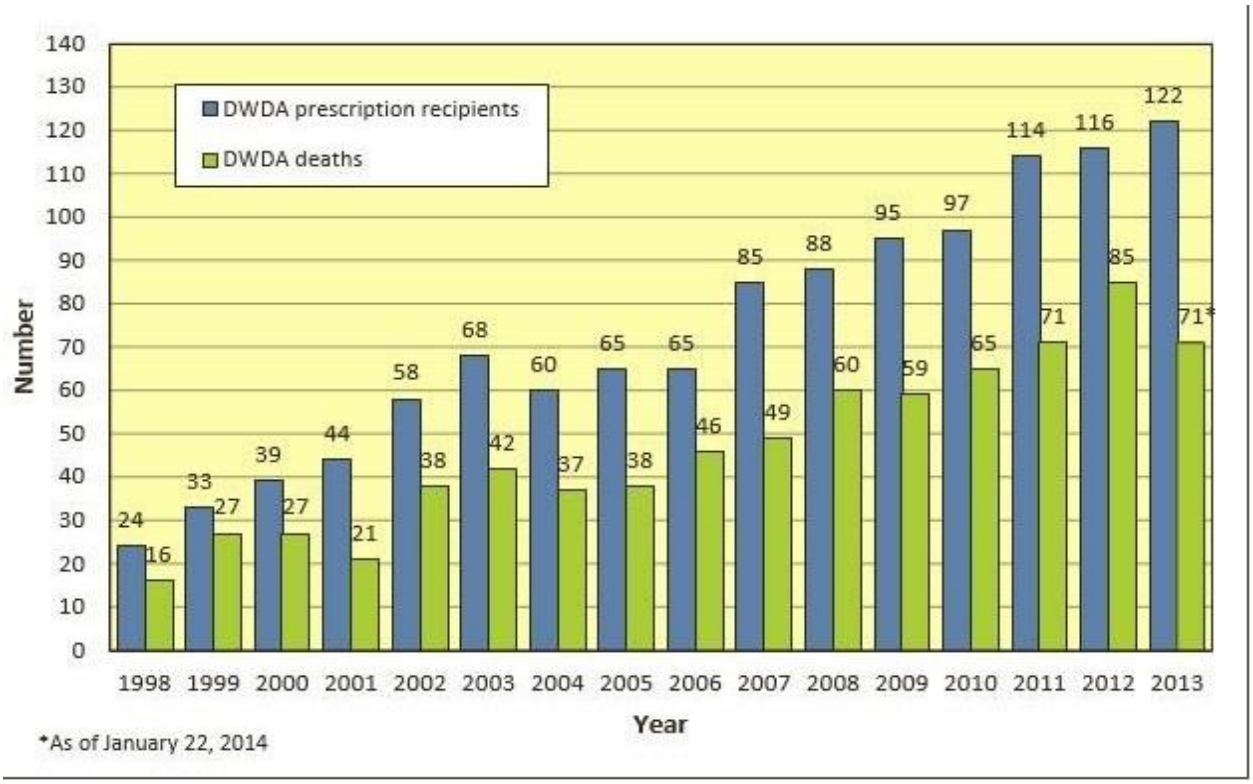
In this chapter I want to show the situation in physician-assisted suicide practice. In order to understand the processes, the influence of the time, how the public mind changed or not through this time (from 1990 in the Netherlands when the physician-assisted suicide was still regulated by the guidelines of the Court and from the 1997 in Oregon when the Statute came into force).

Also, here will be good to see the slippery slope argument which always comes into the mind when talking about the physician-assisted suicide. This argument is usually used to show the dangerousness of legalization of such practice, claiming that it can lead to abuses. I wanted to see what slippery slope argument is and whether it is really such a strong argument against legalization.

4.1. How the assisted suicide works in practice: statistics and main concerns

Here I am going to see the actual statistics and reports on the issue of physician-assisted suicide.

The practice of some act (physician-assisted suicide in our case) can show a lot of information on how the Statute works, what is done and which steps can be taken to make the physician-assisted suicide work better. In Oregon physician-assisted suicide is legal from 1997, so already the results for 16 years can be observed and from such a period it is possible to make some conclusions.



(Figure 4.1.1. Oregon Death with Dignity Act (DWDA) prescription recipients and deaths in 1998-2013[78])

From figure 4.1.1. we can see the progression of the people who used the right to physician-assisted suicide from the time the Death with Dignity Act came into force (1997, but the information is available from the 1998) till the present time. Since that time there were 1173 people who received prescription for the medicine according to the Death with Dignity Act, and 752 patients who died because of these medicine.

[78] Report on Oregon`s Death with Dignity Act - 2013 http://public.health.oregon.gov/ProviderPartnerResources/Evaluationresearch/deathwithdignityact/Pages/index.aspx

There are also some cases when the patients received the prescription but did not take it for some reason but died from other causes, for example there were 28 of such cases during 2013.[79]

> Of the 71 DWDA deaths during 2013, most (69.0%) were aged 65 years or older; the median age was 71 years (42 years – 96 years). As in previous years, most were white (94.4%), well-educated (53.5% had a least a baccalaureate degree), and had cancer (64.8%). In 2013, fewer patients had cancer (64.8%) compared to previous years (80.4%), and more patients had chronic lower respiratory disease (9.9%), and other underlying illnesses (16.9%). [80]

From this we can see that mostly elderly people who has terminal illness (such as cancer) enjoy the right for assisted suicide, more than half have higher education what can show that people have understanding what they are going for. Also, according to this information it can be said that from year to year more people choosing the right to make their own choice.

There are "three most frequently mentioned end-of-life concerns …: loss of autonomy (93.0 %), decreasing ability to participate in activities that made life enjoyable (88.7 %), and loss of dignity (73.2)."[81] So, it can be clear that people pay a big attention to their own autonomy, dignity and enjoyable life.

Very important fact that during 2013 year there were no cases known by "Oregon Medical Board [of] failure to comply with [Death with Dignity Act] requirements."[82]

[79] Report on Oregon`s Death with Dignity Act - 2013 http://public.health.oregon.gov/ProviderPartnerResources/Evaluationresearch/deathwithdignityact/Pages/index.aspx

[80] Report on Oregon`s Death with Dignity Act - 2013 http://public.health.oregon.gov/ProviderPartnerResources/Evaluationresearch/deathwithdignityact/Pages/index.aspx

[81] Report on Oregon`s Death with Dignity Act - 2013 http://public.health.oregon.gov/ProviderPartnerResources/Evaluationresearch/deathwithdignityact/Pages/index.aspx

[82] Report on Oregon`s Death with Dignity Act - 2013 http://public.health.oregon.gov/ProviderPartnerResources/Evaluationresearch/deathwithdignityact/Pages/index.aspx

The procedure of physician-assisted suicide usually takes very differently: from 5 minutes to 5.6 hours.[83]

Proportionally the practice in the Netherlands does not differ much from such in Oregon. From the figure 4.1.2. (it can be seen below) we have the number of cases where intent to hasten death took place in the Netherlands as on year 2010 we can see the total number of death in that year taking into account different causes (illnesses) for death, also we can see total number of cases of death which occurred by different means of death hastening and the number of cases of assisted suicide among all intentional termination of life.

We can find out that in 2010 only 3.2% of all deaths were caused by the means of hastening the death (totally there were 136058 deaths events, number of death with intention to hasten the end - 4360), and among the number of all who terminate their life intentionally 4.4% were caused by assisted suicide (out of 4360 intentional termination of life cases, number of people who used the assisted suicide was 192). Even though the biggest number of deaths in 2010 happened within the group who is 80 years or more, but if we are looking on relation of total number of deaths within the group and number of deaths because of some incurable illness (such as malignant neoplasm or cancer in more habitual terms, for example) we would see that the percentage of people is much higher in the group of people who are 17 to 65 years old (there are 50,3% (12102 out of 24066 persons) of people who died because of cancer within this age group).

[83] Report on Oregon`s Death with Dignity Act - 2013 http://public.health.oregon.gov/ProviderPartnerResources/Evaluationresearch/deathwithdignityact/Pages/index.aspx

Age	Periods	Subjects			Cause of death	Total causes of death	Congenital anomalies (age zero)	Other/unknown causes of death (age zero)	Malignant neoplasms (>0 years)	Diseases circulatory syst.excl.CVA (>0..	Diseases respiratory system (>0 years)	Diseases nervous syst.incl.CVA (>0 yrs)	Suicide (>0 years)	Other/unknown causes of death (>0 years)
Total age	2010	Total deaths			*number*	136 058	202	493	42 346	30 158	13 012	13 504	1 600	34 744
		With end-of-life decision	Explicit intention of hastening death	Total explicit intention of hastening ..		4 360	5	5	3 321	153	232	239	-	406
				Assisted suicide		192	-	-	100	7	49	25	-	11
0 years	2010	Total deaths				695	202	493						
		With end-of-life decision	Explicit intention of hastening death	Total explicit intention of hastening ..		9	5	5						
				Assisted suicide		-	-	-						
1 to 17 years	2010	Total deaths				363			61	11	17	28	12	233
		With end-of-life decision	Explicit intention of hastening death	Total explicit intention of hastening ..		-			-	-	-	-	-	-
				Assisted suicide		-			-	-	-	-	-	-
17 to 65 years	2010	Total deaths				24 066			12 102	3 564	1 006	1 774	1 301	4 320
		With end-of-life decision	Explicit intention of hastening death	Total explicit intention of hastening ..		1 468			1 257	7	22	115	-	67
				Assisted suicide		91			61	-	10	20	-	-
65 to 80 years	2010	Total deaths				41 731			17 651	8 825	4 094	3 799	206	7 157
		With end-of-life decision	Explicit intention of hastening death	Total explicit intention of hastening ..		1 771			1 337	105	110	77	-	141
				Assisted suicide		64			14	-	39	-	-	11
80 years or older	2010	Total deaths				69 203			12 532	17 759	7 895	7 902	82	23 033
		With end-of-life decision	Explicit intention of hastening death	Total explicit intention of hastening ..		1 112			728	41	100	46	-	197
				Assisted suicide		36			24	7	-	5	-	-

(Figure 4.1.2. Deaths by medical end-of-life decision; age, cause of death[84])

Also within the same age group (17-65 years old people) is the highest percent of the people who asks for hastening their death, and namely there are 10,4% (1257 person out of 12102) of people with cancer who died due to any means of hastening death, and among them 4,9% (61 out of 1257) used physician-assisted suicide. From this example we can see that the usage of any means to

[84] Statistics Netherlands - Deaths by medical end-of-life decision; age, cause of death
http://statline.cbs.nl/StatWeb/publication/?VW=T&DM=SLen&PA=81655ENG&LA=en

hasten the death among most vulnerable groups of people who can be dependent on others (young children or elderly) is not as popular as among young people and so the fears are not so justified.

There exist also concern whether the legalization of assisted suicide in one states while in other it is still prohibited will open the window for "death tourism". But this fear also seems to be unjustified because according to the Oregon Death with Dignity Act the person who requests assisted suicide should be a resident of Oregon.[85] So, there is very small possibility that somebody would fulfil the requirements to become a resident of the State in order to receive assistance in suicide especially when taking into account the fact that other requirement is that the person should be terminally ill and according to prognosis should live no more than six month.

In the Netherlands there is no regulation on that issue, no prohibition for non-citizens to get access to the physician-assisted suicide, but by the authorities was noted that it is impossible for the person from other country to seek euthanasia or physician-assisted suicide in the Netherlands

> given the need for a close doctor-patient relationship. The legal procedure for the notification and assessment of each individual case of euthanasia requires the patient to have made a voluntary, well-considered request and to be suffering unbearably without any prospect of improvement. In order to be able to assess whether this is indeed the case, the doctor must know the patient well. This implies that the doctor has treated the patient for some time.[86]

From written above we can see that even though there is no legal prohibition for citizens from other countries to get access to the physician-assisted suicide but the patient and physician should be in a long relations in order physician could evaluate the condition of the person who requests

[85] The Oregon Death with Dignity Act, Oregon Revised Statute §§ 127.800 to 127.890, (1997), para.127.805 s.2.01

[86] *The Termination of Life on Request and Assisted Suicide (Review Procedures) Act in practice* FAQ EUTHANASIA 2010, Publication of the Netherlands Ministry of Foreign Affairs http://www.patientsrightscouncil.org/site/wp-content/uploads/2012/03/Netherlands_Ministry_of_Justice_FAQ_Euthanasia_2010.pdf

physician-assisted suicide. Probably it is more in the Dutch medical culture that it would not be enough to meet once in order to make such a decision, the relationship between patient and physician should last longer.[87] But the possibility for death tourism exists since it is not prohibited even though it is claimed about its impossibility by the State authorities. Though this fear is not justified because there is no such information that this practice becomes widespread, if it is exists.

4.2. The slippery slope argument

The slippery slope argument is a concept which "asserts that one exception to a law is followed by more exceptions until a point is reached that would initially have been unacceptable."[88] Legalizing physician-assisted suicide, if concluding that it is morally permissible, can lead to legalizing voluntary euthanasia which can lead to such results which cannot be morally permissible, such as euthanasia without request of the person or euthanasia against the will of the person.

In the jurisdictions I am looking at the physician-assisted suicide is legal for the patients who are competent to take such decisions, but now it is likely to extend to the patients who are not able to take such decisions, who lack such capacity. So that its important to look through such dangerousness and the ways to prevent such an extension.

[87] Alexander R. Safyan. *A call for international regulation of the thriving "industry" of death tourism* Loyola of Los Angeles International and Comparative Law Review (33 LYLAICLR 287), Winter 2011 from http://international.westlaw.com/

[88] J. Pereira *Legalizing euthanasia or assisted suicide: the illusion of safeguards and controls*, MBChB MSc, Curr Oncol. Apr 2011; 18(2): e38–e45. from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3070710/

The Hippocratic Oath which expressly prohibits physician-assisted suicide was written at the time when the medicine had much less power in curing the patients, but at the same time it was totally incompatible with the profession of the physician to assist somebody in his/ her dying. This fact can show that nowadays public has another understanding of the role of the medicine and its moral limits. It can also mean that the public does not know all possibilities of palliative treatment.[89]

Here there are a lot of problems which appear from the facts that became a barrier to palliative care and thus to improvement of patients condition such as lack of education as of the people and so of the medical staff, "inadequate pain assessment, inadequate use of palliative medications, fear of regulatory or legal action if opioid medications are used, and difficulty in establishing a terminal prognosis."[90] All this leads to wrong impression about one`s own illness, present and future possibilities and perspectives, which can lead to wrong understanding of the situation and according to this understanding desire to terminate life. Very often stress, not understanding of future and lack attention to these factors lead to request (or increase the possibility of such request) of physician-assisted suicide. So, there is possibility that better state of knowledge about palliative care can lead to reduction of number of requests that will be made.

On the other hand, even if palliative care would be on the highest possible level there still will be possibilities of the physician-assisted suicide discussions on the matter of personal autonomy. People will claim that it should be matter of their own choice to choose the time, place, way of their death the same as deciding on the special circumstances of their life. Even though great number of people will be satisfied and agreed on palliative care and they even will not think on

[89] *Physician-Assisted Suicide: The Legal Slippery Slope* Cancer Control, Journal of the Moffitt Cancer Center 2001;8(1) from http://www.medscape.com/viewarticle/409026 p.3
[90] Physician-Assisted Suicide: The Legal Slippery Slope Cancer Control: Journal of the Moffitt Cancer Center 2001;8(1) from http://www.medscape.com/viewarticle/409026 p.3

requesting of physician-assisted suicide, but there always will be some other category of people which will prefer to have choice of whether to end the life or not. Here comes the question whether the physician should and is able to take over the patient`s life in such an issue; whether the courts should change their mind on the topic of allowing suicide.

Physician-assisted suicide is very closely linked to active voluntary euthanasia. It is also a slippery slope argument against legalization of physician-assisted suicide, because it will lead to discussions on legalizing euthanasia (which is intentional killing of the terminally ill person) which can in some circumstances go beyond it.

The physician-assisted suicide depends much on choice of the person which should be voluntary and rational and "in order to ensure that physician-assisted death is voluntary, which is the inviolable cornerstone of this policy, only adults with decision-making capacity should be eligible for physician-assisted death."[91] So, the close adherence could be a strong guarantee against moving to voluntary euthanasia which can be followed by non-voluntary (which takes place without patient`s choice) or all the more so to involuntary (which is against person`s will) euthanasia.

There are some shields which can protect against moving to euthanasia such as: "adhering to traditional physician morality that stands against it and keeping the issue of voluntary euthanasia legally framed as homicide."[92] So, if the voluntary euthanasia will be kept as a crime (whether homicide or some other crime case) than the possibility to be legalized is not big, but in case it will be seen as a matter of choice, then there is possibility of moving from physician-assisted suicide

[91] Miller FG, Quill TE, Brody H, et al. *Regulating physician-assisted death*. N Engl J Med. 1994;331:119-123 cited in Physician-Assisted Suicide: The Legal Slippery Slope Cancer Control: Journal of the Moffitt Cancer Center 2001;8(1) from http://www.medscape.com/viewarticle/409026_4 p.4

[92] Physician-Assisted Suicide: The Legal Slippery Slope Cancer Control: Journal of the Moffitt Cancer Center 2001;8(1) from http://www.medscape.com/viewarticle/409026_4 p.4

to voluntary euthanasia which can be extended to the cases when the patient is not capable of making such a decision.

In the State of Oregon the Statute does not contain definition of physician-assisted suicide, it only describes the relations between the patient and physician in order to perform such an act, but it clearly does not state that this act is actually physician-assisted suicide.

In a case of physician-assisted suicide it can be told that the person who is not possible at the moment to make competent decision by any reason does not enjoy equal rights with the person who can do it, and so it violates principle of equality. But it can be also seen as a safeguard for the slippery slope argument.

There is also the phenomenon of "social slippery slope" which was described by Keown. This phenomenon means increasing tolerance of physician-assisted suicide in society, and so changing of social and moral values. This leads to the physician`s desire rather to help the person die than to treat a terminally ill person who has no hope of recovering. In order to avoid such consequences the regulation of physician-assisted should be as precise as possible. Also from the side of the patient, who knowing the possibility of ending his life would be influenced by this knowledge and will feel obliged to relieve the doctor of his duties, the relatives from the unnecessary (as he/ she can think) care. To avoid such understanding of the case, physicians should more carefully explain the possibilities of palliative care which can make the suffering much less unbearable, the medicine which can help reduce the undignified condition in the last days of the patient`s life.

I looked on the statistics of the physician-assisted suicide in the Netherlands and the State of Oregon. This information showed me that the fears that the most vulnerable group of people will be abused by the assisted suicide are not confirmed by the statistics date. Of course there should be safeguards and control over that act but the opposing opinion that the physician-assisted suicide should not be legalized or should not be decriminalized on the grounds that there will be violation of this right has no grounds according to the practice which exists nowadays.

Furthermore, I looked on the slippery slope argument and its influence on the practice. The slippery slope usually is understood as sliding from one which can be morally right to something else which cannot be accepted by the society, accepting one fact which can be extended wider, which will lead to negative consequences. But in my opinion taking everything into account the slippery slope argument is not a big deal if all the safeguards will be and requirements will be duly regulated and enforced.

Conclusion

In my work I looked through the different aspects of legalization and regulation of physician-assisted suicide as an act performing by the physician in order to help the patient to die (assist in suicide) in dignified manner, to relief the person from suffering when there is no hope for recovery.

As the right to die and the right to physician-assisted suicide does not exist under any law in any jurisdiction this right is derived from other rights such as right to dignity as the patients claim they live in degrading manner and the death is expected to be undignified. The claim for the dignity while dying sounds very often, the idea that the person`s life lacks its quality makes the people think of dying and of having possibility to choose between life and death, to choose the time to finish their suffering, to have feeling of controlling the situation. The idea of having choice comes near to the right for personal autonomy, self-determination and so the right to respect for private life which can include any possibility to control one`s own life, life choices and also integrity of the body. Exactly on these grounds the European Court of Human Rights in *Gross v. Switzerland* opened the possibility to claim the right to make the choice on the issue of physician-assisted suicide without even invoking the right to die question.

After some investigation I found out that the right to life cannot be extended to the right to die, the scope of this right concerns more on protection of life rather on the quality of life or life ending issues.

I looked on the regulation of the physician-assisted suicide and namely in the State of Oregon and the Netherlands. Both jurisdictions regulate on the issue of physician-assisted suicide very carefully.

I found also that most fears that people have concerning the legalization of the practice of assisted suicide do not have any grounds or confirmation if we will look careful on the data that we receive from the statistics. Of course, control and monitoring over the practice should always take place, but while carefully regulating there is no place to abuse the vulnerable groups of people or to violate other rights which are currently under protection of constitutions and international treaties and conventions.

So, the physician-assisted suicide is a quite important issue in the modern world and needs further development in order to become a right to receive assistance in suicide and to relief person`s suffering.

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