LEGAL CONCERNS: WORLDWIDE COMPARATIVE APPROACH TO EUTHANASIA

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Abstract: The present study gives an account of the worldwide spread of euthanasia, focusing on its legal aspects. Although forbidden in most countries, a trend can be observed, and it is probable that in the near future, a permissive legal framework will come into existence beside those from The Netherlands, Belgium, Switzerland, Luxemburg (EU) and the states of Oregon, Washington, Montana and Vermont (US). Using the method of document analysis, we have compared the legislations existing in the states mentioned, discussing the British situation as well, where Lord Falconer's 2013 bill was repealed by the legislator. The Romanian Criminal Code, which has entered into force in February 2014, contains prohibitive provisions considered to be traditional that are no longer in line with altered societal needs, according to which the number of physicians and medical students who would support euthanasia is significant. The situation is also controversial because in one of its decisions from 2012, the European Court of Human Rights in Strasbourg voiced the position that the use of euthanasia is compatible with the protection of the sanctity of life, and may also be part of the right to individual self-determination. The phenomenon that only certain persons have access to the means for euthanasia (those who live in states where euthanasia has been legalized or who can afford to travel to such a state) is also of concern, even though everyone should be entitled to basic human rights in the same manner.

Keywords: euthanasia, trend, human rights, legal framework, protection of life.

Introduction

In the last decade, a worldwide breakthrough has taken place on the topic of euthanasia. In The Netherlands, Belgium, Switzerland, Luxemburg (EU) and the state of Oregon, Washington, Montana and Vermont (US), euthanasia has been legalized. Our study presents and compares existing legislations by using the method of document analysis, with a focus on the legal aspect. It also mentions a few research results from countries where euthanasia has been legalized that also give reasons for its acceptance. "Physician-assisted dying at the end of life has become a significant issue of public discussion" (Phillipa et al. 2014, p. 354). Euthanasia could be an alternative solution to the suffering of patients (Havill 2014). Voluntary active euthanasia by the request of the patient is the act of a physician who administers drugs or treatments with the intent of ending the patient's life. Passive euthanasia, also known as physician-assisted suicide, differs from active euthanasia in that the patient takes his or her own life, assisted by the physician. The lethal dose of drugs is prescribed by the physician (Benson 1999). According to some early views, there are no substantive differences between these two forms of mercy killings (Douglas 1976), although this position has nevertheless not become dominant neither in later scholarly literature nor in the eyes of the public, since both concepts have been used into the present day (Ostheimer 1980, Benson 1999, Anquinet et al., 2014, Phillipa et al. 2014, Willis et al. 2014).

In those countries where euthanasia has been legalized, it has not become an absolute right of the patient; practicing it depends on certain biological and spiritual conditions. "It is nuanced by depression, fear of being a burden, feelings of worthlessness, loss of awareness

and vulnerability to others. All of these must be ruled out before we can be sure that someone really wants to die" (Wright 2014. p. 27).

A worldwide review of the legal status of euthanasia

The topic of euthanasia is highly controversial because the views traditionally advocating the sanctity of life clash with the position of those who support artificially planned death (Oancea 2007, Perju et al. 2008 b, Pârvu et al. 2012, Buta and Buta 2012). The issue of euthanasia is still open from a moral point of view, but the debate has been settled from the legal standpoint, namely in favor of euthanasia: In Case no. 497/09 Koch vs. Germany, The European Court of Human Rights in Strasbourg has voiced conclusions that are universally valid.1 According to the Decision handed down in 2012, the right to privacy is a concept that should be interpreted broadly and that intrinsically contains the right to self-determination. The manner of ending his or her life should be the patients' option, considered as a part of the right to self-determination. The general legal framework is therefore a given for all countries, and they may treat the topic of euthanasia as they see fit. In the following, we will examine how the legislation of euthanasia has been put into practice in different countries.

In **the United Kingdom**, euthanasia is forbidden by the Suicide Act of 1961[2]. British jurisprudence considers the sanctity of life reflected in the right to life in Article 2 of the European Convention on Human Rights[3]. However, every person has the right to autonomy and dignity, and thus priority should be given to the sanctity of life (Jackson 2013). The Suicide Act of 1960 confers immunity from criminal proceedings for those who actually commit suicide. In the absence of a legal right, "it was impossible to impose on the state an obligation to allow others to assist" the patient practicing euthanasia (Jackson 2013, p. 471). By the Suicide Act of 1961, the British Parliament "expressly criminalized assisting a suicide. The court concluded that any common law defence was bound to fail because there is no fundamental right to commit suicide and 'the right to assist someone to do so cannot place the party providing assistance in a stronger position that the party committing suicide' the limits of the common law in this area have been reached and that any future development would be the responsibility of Parliament" (Jackson 2013, p. 472).

Due to the impact of international trends and the changing social attitudes, the topic of euthanasia has again come to the forefront of public attention. In 2013, Lord Falconer presented the Assisted Dying Bill in the House of Lords[4]. According to this document, assisted dying could only be considered for a patient of legal age, diagnosed with a progressive and irreversible disease and with a life expectancy shorter than six months. The legal framework included the provision that the prognosis must have been confirmed by a second physician. The major problem with this model was that survival times are based on past clinical experience, which in reality can vary from case to case (Frost et al. 2014). In the end, the proposed model did not pass the conservative British legislation.

In **Switzerland,** according to article 115 of the Swiss Criminal Code, euthanasia is not punishable under certain conditions: "Any person who for selfish motives incites or assists another to commit or attempt to commit suicide is, if that other person thereafter commits or attempts to commit suicide, liable to a custodial sentence not exceeding five years or to a

[1] http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-112282#{%22itemid%22:[%22001-112282%22]} Accessed: 29.08.2014.
[2] http://www.legislation.gov.uk/ukpga/Eliz2/9-10/60 Accessed: 29.08.2014.
[3] http://echr-online.com/ Accessed: 29.08.2014.
[4] http://www.dignityindying.org.uk/assisted-dying/lord-falconers-assisted-dying-bill/ Accessed: 29.08.2014.

monetary penalty."[5] Thus, based on the regulation, no criminal proceedings can be initiated against a person who is acting unselfishly, in the interest of the patient. Actual assisted suicide is not legal, but is not punishable unless a selfish motive is proven. At the same time, the person who assists in euthanasia does not necessarily have to be a doctor. The Swiss Criminal Code proposed in 1918 "did not intend to regulate assisted suicide from a medical perspective. Rather, lawmakers were concerned with suicides motivated by honour and romance. Today, assisted suicides in Switzerland involve volunteers working for 'right-to-die associations'. The role of physicians is restricted to assessing the decisional capacity of the person requesting assistance and to prescribing the lethal drug. Of note, the person requesting assistance does not need to have a terminal illness" (Steck et al. 2014, p.2).

The Swiss Law on Public Health (1985) was amended in 2012 by the introduction of Article 71 (b) with the following content: "Socio-medical Establishments in receipt of public subsidies must allow assistance for suicide to be provided in their establishments for any resident who makes a request to this effect to an association supporting the right to die with dignity or to the doctor responsible for his or her treatment."[6]

A study shows that it is not known whether a request is present or not in all assisted suicide cases in Switzerland. Although the membership of the right-to-die associations is voluntary, "there is no evidence that they solicit members to take up their services" (Lewis, Black 2013, p. 887).

Another recent study has been based on the analysis of "5,004,403 Swiss residents and 1301 assisted suicides (439 in the younger and 862 in the older group). In 1093 (84.0%) assisted suicides, an underlying cause was recorded; cancer was the most common cause (508, 46.5%). In both age groups, assisted suicide was more likely in women than in men, those living alone compared with those living with others and in those with no religious affiliation compared with Protestants or Catholics. The rate was also higher in more educated people, in urban compared with rural areas and in neighbourhoods of higher socio-economic position" (Steck et al. 2014, p. 1).

There is an important distinction between the Swiss model, where euthanasia is not punishable under certain conditions, and that of the **Netherlands and Belgium**, where euthanasia is considered to be medical treatment.

In the **Netherlands**, the Euthanasia Law adopted in 2001 and entered into force on the 1st of April 2002 permits euthanasia and assisted suicide if the physician acts "with due care".[7] According to Section 2 of the Dutch *Review procedures for the termination of life on request and assisted suicide and amendment of the Criminal Code and the Burial and Cremation Act*[8], this "due care" obligation means that the physician must be satisfied that the patient has made a voluntary and carefully considered request, the patient's suffering was unbearable, and that there was no prospect of improvement, the patient was informed about his situation and his prospects and the physician and the patient agreed that there is no reasonable alternative solution. Furthermore, the patient has been consulted by at least a second independent physician, who has given a written opinion on the due care criteria. Finally, the assistance provided and the act of euthanasia must be made with due medical care and attention. "The patient must have capacity to make the request, and the attending physician must consult a psychiatrist if he or she suspects the patient lacks capacity. The

[5] http://www.admin.ch/ch/e/rs/311_0/a115.html Accessed: 03.08.2014.
[6] http://www.patientsrightscouncil.org/site/switzerland/ Accessed: 03.08.2014.
[7] http://www.patientsrightscouncil.org/site/hollands-euthanasia-law/ Accessed: 07.08.2014.
[8] http://www.patientsrightscouncil.org/site/wp-content/uploads/2012/05/Dutch_law_04_12.pdf Accessed: 29.08.2014.

physician must also provide sufficient information to the patient to make his or her request well informed. The Act does not require that the request be made in writing, but it is established good practice to obtain a written request" (Lewis, Black 2013, p. 885).

The above-mentioned Dutch law permits euthanasia of incompetent patients under certain conditions. Teenagers from 16 to 18 years old may request and receive euthanasia or assisted suicide if a parent or guardian has been involved in the decision process, but they need not agree or approve. Children from 12 to 16 years old may also request and receive euthanasia or assisted suicide if a parent or guardian agrees with the termination of life or the assisted suicide.[9] Physicians must report the cases of artificial death to the municipal pathologist. In cases of euthanasia, a regional review committee comprising a physician, an ethicist and a legal expert must also be notified in order to ensure greater transparency.

According to data collected between September 2002 and December 2007, after the legalization of euthanasia and assisted suicide in the Netherlands, the study "found the request criterion to have been met in all 10,319 reported cases. Similarly, in a study of reported cases from 2007 to 2009, the relevant Regional Review Committee (RRC) (the bodies delegated the evaluation of reported cases of euthanasia) found that the physician had met the criteria related to the request in all 7,487 cases" (Lewis, Black 2013, p. 887).

In **Belgium**, according to *The Belgian Act on Euthanasia of May 28, 2002,* the physician who performs euthanasia commits no criminal offence when he/she ensures that the patient has attained the age of majority or is an emancipated minor, and is legally competent and conscious at the moment of making the request. The request must be voluntary, well considered and repeated, and cannot be the result of any external pressure. The patient must also be in a medically futile condition of constant and unbearable physical or mental suffering that cannot be alleviated, resulting from a serious and incurable disorder.[10] The patient's request "must be in writing, and signed and dated by the patient, unless he or she is unable to write, in which case the request may be made by a nominated adult with no material interest in the patient's death (…) A request for euthanasia may be revoked at any time by any means" (Lewis, Black 2013, p. 886). Euthanasia was also legalized for children without any age limit in February 2014, but the parents must agree with the decision.[11]

A study about the situation on euthanasia in Belgium shows that "the frequency of reported euthanasia cases has increased every year since legalization. Euthanasia is most often chosen as a last resort at the end of life by younger patients, patients with cancer, and seldom by nonterminal patients" (Smets et al. 2010, p. 187).

About the legality of all 2,017 reported euthanasia cases, data shows that the request criterion was met until December 2007. Another study certifies that from 2007 on, the explicit request condition was also fulfilled in all studied cases in the Flanders region (Lewis, Black 2013, p.887).

In Belgium, according to a study from 2009, "the number of reported euthanasia cases increased every year from 0.23% of all deaths in 2002 to 0.49% in 2007. Compared with all deaths in the population, patients who died by euthanasia were more often younger", male and cancer patients. Unbearable physical pain (95.6%) and/or psychological suffering (68%) were reported in most of euthanasia cases, only a few cases (6.6%) concerned nonterminal patients (Smets et al. 2010, p. 187).

Euthanasia was legalized in the United States of America in the following States: **Oregon, Washington and Montana** (Steck et al. 2014, p.2). In 2013, **Vermont** became the

[9] http://www.patientsrightscouncil.org/site/hollands-euthanasia-law/ Accessed: 07.08.2014.
[10] http://www.ethical-perspectives.be/viewpic.php?LAN=E&TABLE=EP&ID=59 Accessed: 07.08.2014.
[11] http://www.patientsrightscouncil.org/site/belgium/ Accessed: 07.08.2014.

fourth State that legalized euthanasia. "In 1994, Oregon voters approved the *Death with Dignity Act* (DWDA) by a vote of 51% to 49%. It became effective in 1998, surviving court challenges and a repeal effort, to make Oregon the first state in the country to legalize physician-assisted suicide (…) The law allows physicians to prescribe life-ending drugs that are requested by terminally ill patients with six months or less to live. In the nine years since then, (…) records show that 455 people have requested lethal drugs from their physician and 292 people have died from using them. The yearly numbers continue to rise, beginning with 16 deaths in 1997, increasing to 38 in 2005, and reaching 46 deaths in 2006."[12]

From the data of Oregon Division of Public Health responsible for monitoring assisted deaths results that all 673 cases of prescriptions of lethal drugs causing death (from 1998 to 2012) fulfilled the request criteria and respected the mandatory waiting period of 15 days between the oral request and death (Lewis, Black 2013).

After three unsuccessful attempts to make euthanasia legal, *"*In 2008, assisted-suicide proponents targeted the state for a massive effort to make Washington only the second state to approve assisted suicide. With a voter initiative (…) they succeeded, by a vote of 57.91 to 42.09 percent, in making it legal for doctors to help their patients commit suicide. (…) The Washington law (RCW 70.245) went into effect in March 2009.*"*[13]

In the State of Montana in December 2009, the Supreme Court has changed the legal status of doctor-prescribed suicide by a ruling. **"**However, the court did not officially legalize assisted suicide but said that, if charged with assisting a suicide, a doctor could use the patient's request as a defense."[14]

Vermont is the fourth State which has legalized euthanasia in May 2013. Governor Peter Shumlin has signed Vermont's doctor-prescribed suicide bill called The Patient Choice and Control at End of Life Act[15], which has immediately entered to force. "According to the Vermont Health Commissioner, it is expected that health insurance will cover the process. (…) The law states: 'A health care facility may prohibit a physician from writing a prescription for a dose of medication intended to be lethal for a patient who is a resident of its facility and intends to use the medication on the facility's premises, provided that the facility has notified the physician in writing of its policy with regard to the prescriptions'."[16]

Therefore, Oregon, Washington and Vermont have legalized physician-assisted suicide via legislation, while Montana did so by court ruling.[17]

Evidence from the Netherlands, Belgium, Oregon and Switzerland suggests that "the legal criteria that apply to an individual's request for assisted dying are well respected: individuals who receive assisted dying do so on the basis of valid requests; third parties who assist individuals to die do not act unlawfully. However, further research on the elements that may undermine the validity of requests for assisted dying is warranted" (Lewis, Black 2013, p. 895).

In **Romania**, a Member State of the European Union located in Eastern Europe, several efforts have been made to adopt modern human rights and patient rights during the last decade. The reform process was part of the synchronization of national law with European law. The recently adopted Criminal Code still criminalizes any act of a person causing or facilitating suicide, the punishment being imprisonment.

[12] http://www.lifeissues.org/euthanasia/oregons_law.htm Accessed: 03.08.2014.
[13] http://www.patientsrightscouncil.org/site/washington/ Accessed: 03.08.2014.
[14] http://www.patientsrightscouncil.org/site/montana/ Accessed: 03.08.2014.
[15] http://healthvermont.gov/family/end_of_life_care/documents/Act39_faq.pdf Accessed: 29.08.2014.
[16] http://www.patientsrightscouncil.org/site/vermont/ Accessed: 03.08.2014.
[17] http://euthanasia.procon.org/view.resource.php?resourceID=000132 Accessed: 03.08.2014.

The new Criminal Code[18], which entered into force in February 2014, criminalizes any form of euthanasia: Article 191 penalizes any act of causing or facilitating suicide with imprisonment, if suicide took place. If the acts or aiding described above was followed by a suicide attempt, the penalty should be reduced by half. Suicide attempts committed without any intervention on the part of other persons is not incriminated.

In our view, this national regulation is a conservative legislative solution because it does not reflect the changed attitudes among the population. A Romanian research has shown that "in general, most physicians and approximately one half of the responding students said they agreed with euthanasia and its legalization" (Curcă 2008, p. 36). Romanian authors have also suggested the legalization of euthanasia under strict conditions in order to prevent any abuses (Pivniceru, Dăscălescu 2004, Curcă 2008). In our opinion a further review of Romanian criminal law should match the legislation with the societal needs.

At the same time, any **prohibition of the act of euthanasia can be avoided**: we would like to point out that under the existing bans, patients who are of means, mobile or who can be transported still have the option to resort to euthanasia, even if they aren't residents of the countries where the manner of death discussed has been legalized. "Euthanasia tourism" is an increasingly common phenomenon, and the above-mentioned patient category may resort to Swiss clinics under certain conditions (Steck et al. 2014, p. 3). This possibility can also be interpreted to be a privilege obtained by circumventing prohibitive norms. From a legal standpoint, since it has a bearing upon the basic right to self-determination, and is not accessible to everyone, it could cause serious concern.

Conclusions

The worldwide trend of euthanasia legalization can be established with certainty. At present, certain forms of euthanasia are permitted in certain countries: The Netherlands, Belgium, Switzerland, Luxemburg (EU) and the states of Oregon, Washington, Montana and Vermont (US). Furthermore, it also constitutes a topic for public debate in other countries, and is also dealt with in international scholarly literature.

Although forbidden in most countries, it seems that there is an ever-growing need for it in society. It is increasingly accepted not only among physicians, but among the populace as well, since the studies mentioned recount a growing number of euthanasia cases. The phenomenon of *euthanasia tourism* has also appeared, i.e., foreign patients travel to permissive countries in the hopes that they would receive planned death.

Even if the need for euthanasia is not necessarily a majority one when taken in the context of total population, we believe that traditional, rigid viewpoints and arguments should be rethought, and the opportunity to decide, under strictly regulated conditions, what manner of death they wish for themselves should be afforded for incurable and suffering patients. Everyone should be entitled to an opportunity to leave life without humiliation and suffering, since at present, it is available only to patients who can afford the costs of travel and of the currently functioning medical establishments.

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