Physician-Assisted Suicide and Euthanasia: Contrasting the American and European Approaches

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Physician-Assisted Suicide is permitted in nine states in the United States. The American approach is closely regulated, and patients must be terminally ill with less than 6 months to live. Physicians are not directly allowed to end a patient's life as patients are required to ingest drugs by their own action. By contrast, a number of countries in Europe allow direct physician participation in ending a person's life. This article contrasts the American approach with the European approach.

INTRODUCTION

Nine states in the United States currently allow physicians to assist patients in ending their life in specific circumstances. Physician-assisted suicide is controversial and inspires both ardent supporters and fierce opponents. A January 2019 article in this journal, *Physician-Assisted Suicide---Homicide or Death with Dignity?* identifies the key arguments for and against the practice and reviews the development of assisted suicide laws in the United States.

The purpose of this article is to compare these requirements to laws and practices in European countries that permit assisted suicide. We begin by reviewing terminology and briefly exploring some of the issues debated by supporters and opponents of assisted suicide. Nest we summarize the most common features of U.S. laws in states that permit assisted suicide. We then consider the laws of seven European countries that allow some form of physician-assisted suicide or euthanasia. While most states in the United States do not permit assisted suicide, those that do have been fairly consistent in terms of the requirements and safeguards embedded into their laws. As in the United States, relatively few European countries have created legal options for patients seeking to end their lives with physician assistance. However, a handful of countries have adopted far more aggressive policies, including laws that allow minors to participate and physicians to take a more active role in ending patients' lives.

DEATH BY NATURAL CAUSES, ASSISTED SUICIDE AND EUTHANASIA

In layman's terms, opponents of assisted suicide or euthanasia might be expected to argue that the only acceptable end to human life is "death by natural causes." Adherence to this view may be motivated by religious principles, commitment to a secular code of ethics, or a specific concern such as protecting vulnerable patients from unscrupulous potential heirs. Likewise, supporters of assisted suicide and/or euthanasia can cite worthy motivations, including alleviating pain and suffering and respecting individual rights. Regardless of opinion or motivation, the crux of the issue is whether death results from a naturally occurring failure of the body's functioning, or whether an external force hastens or precipitates the end of life.

The United States Centers for Disease Control and Prevention (CDC) provides instructions for completing the cause-of-death section of a death certificate. Reviewing the CDC instructions and example brings this issue into clearer focus. The medical opinion reported on a death certificate includes both a **cause** and a **manner** of death. **Causes of death** include the chain of events—"diseases, injuries, or complications that directly caused the death." The CDC instructions provide dozens of medical possibilities. However, the section for reporting **manner of death** includes only six possibilities that are more legal than medical. The choices for manner of death include: Natural, Accident, Suicide, Homicide, Pending Investigation, and Could Not Be Determined.

Thus, a more careful description of the debate over assisted suicide and/or euthanasia requires focus on the manner in which a patient's life ends. The laws and practices described in the remainder of this article vary in terms of the extent to which a physician is involved in facilitating a patient's death. Most of the laws and practices discussed fall into three broad categories: *passive euthanasia*, *physician-assisted suicide,* and *euthanasia*.

The American Medical Association (AMA) Code of Medical Ethics provides a helpful frame of reference for considering the legal options discussed in subsequent sections of this article. The Code addresses these practices in Chapter 5: Caring for patients at the end of life.

Passive euthanasia is a term used to describe withholding or withdrawing life-sustaining treatment. AMA Code of Medical Ethics Opinion 5.3 suggests that physicians may ethically withhold or withdraw life-sustaining treatment subject to certain requirements. The Opinion includes a lengthy list of steps that physicians should follow to ensure that alternatives are explored and that the patient's wishes are followed. However, the Opinion clearly states that, "When an intervention no longer helps to achieve the patient's goals for care or desired quality of life, it is ethically appropriate for physicians to withdraw it." Individuals in the United States have used living wills since the 1980s whereby to direct the removal of life-sustaining treatments. In the United States, there is little opposition to passive euthanasia by withholding life support when a patient has no brain activity and has indicated previously in writing that they do not wish to prolong their life.

According to AMA Code of Medical Ethics Opinion 5.7, "*Physician-assisted suicide* occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g., the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide). Although the practice is legal in a number of U.S. states and the European countries discussed in this article, AMA Opinion 5.7 deems physician-assisted suicide "fundamentally incompatible with the physician's role as a healer."

Opinion 5.8 of the AMA Code defines euthanasia as "…the administration of a lethal agent by another person to a patient for the purpose of relieving the patient's intolerable and incurable suffering." As is the case with physician-assisted suicide, euthanasia is deemed "fundamentally incompatible with the physician's role as a healer." The AMA Code clearly opposes both practices, citing societal risks that include applying this practice to incompetent or vulnerable patients. Nonetheless, as the next sections discuss, nine states and several European countries have enacted laws that allow physicians to assist patients in ending their lives under specific circumstances.

AN OVERVIEW OF PHYSICIAN-ASSISTED SUICIDE LAWS IN THE UNITED STATES

Currently, nine states and the District of Columbia allow assisted suicide. Eight of the nine states follow the general approach adopted by Oregon. The Oregon statute, passed in 1994, closely regulates the circumstances in which a physician can legally assist a patient in ending their life and has framed the approach followed in the United States. States that have passed legislation following Oregon's approach include Washington, Vermont, California, Colorado, Hawaii, New Jersey and Maine. The District of Columbia also allows physician-assisted suicides. Hawaii, New Jersey and Maine are the most recent states to pass legislation. Hawaii's statute took effect January 1, 2019, Maine's statute became effective on September 19, 2019 and New Jersey's statute became effective in August of 2019. The New Jersey statute is subject to pending litigation. Montana did not pass legislation, but its court system has decided a case allowing physicians to grant suicide assistance (Baxter v. Montana, 224 P.3d 1211 Montana 2009). It is worth noting that 37 states have specific legislation, which prohibits assisted suicide activities by physicians. Therefore, the vast majority of the states in the United States do not allow physician-assisted suicides and none permit active euthanasia.

Because all of the states that have passed physician-assisted suicide legislation have closely followed the Oregon approach, an understanding of the Oregon approach effectively portrays the dominant approach allowed in the United States. The Oregon Death with Dignity Act (Oregon Revised Statutes, Section 127.800 to 127.897) was passed in 1994. The first suicides under the Act occurred in 1998 after litigation and re-voting occurred.

The Oregon Act sets forth several requirements that must be present to allow a lawful assisted suicide. In order to invoke the Act, a person must first be diagnosed with a terminal illness with six months or less to live. A healthy person who is simply tired of living cannot invoke the provisions of the Oregon statute.

An adult, who has been determined to be suffering from a terminal illness, must first make an oral request of a physician for medication to end their life. Then, after waiting at least 15 days, the patient must make a second oral request. Then, the patient must make a written request for medications.

The attending physician must determine that the patient has a terminal illness that will result in death within six months. The patient must also be deemed capable of making and communicating health care decisions for himself. The physician must fully inform the patient of the diagnosis and prognosis and discuss alternatives to suicide including comfort care, hospice care, and pain control options.

A second physician must confirm the attending physician's diagnosis and must certify that the patient is mentally competent. If either of the doctors determines that the patient is mentally impaired, the patient must be referred for a psychological examination. The patient must be encouraged to notify their next of kin that they plan to end their life.

Prescribed medications are used to end the patient's life. The medications must be dispensed by the physician or a pharmacist. The medication is a lethal dose and it cannot be injected or administered by anyone else—it must be administered personally by the patient. The medication is typically a lethal dose of barbiturates. Only residents of Oregon can make use of the Death with Dignity statute. Oregon residency must be proven for a patient to obtain a lethal prescription. Under the express provisions of the statute, doctors and pharmacists who facilitate the suicide cannot be held legally liable either in a civil or criminal action. The statute clearly provides that doctors are not required to facilitate suicides under the act. Most physicians refuse to facilitate their patient's death even if allowed in the state where the physician resides.

It is important to note that the Oregon statute permits assisted suicide, not active euthanasia. As previously discussed, an assisted suicide means that a physician issues a prescription for medication that will end a patient's life. The suicidal patient must ingest the medication through his or her own actions. This practice differs from active euthanasia where a physician intentionally ends a patient's life by personally administering a deadly medication.

In summary, nine states allow physician-assisted suicide in the United States. Physician-assisted suicide statutes commonly incorporate multiple conditions and safeguards, including requirements for residency, terminal illness, physician certifications of medical condition and patient competence. All states allow a physician to withdraw life support if the patient is brain dead and has executed a living will. No states allow a physician to directly administer a deadly dose of medications to end a patient's life.

END OF LIFE ALTENATIVES IN EUROPEAN COUNTRIES

As in the United States, most countries in Europe do not allow physician-assisted suicide or any form of euthanasia. Germany, Finland and Austria do allow passive euthanasia through withholding life-sustaining assistance in an end of life situation. However, several European countries have adopted laws that impose fewer restrictions on patients seeking to end their lives with physician support. Switzerland allows both passive euthanasia and physician-assisted suicide. Three other countries—Belgium, the Netherlands and Luxembourg—allow active euthanasia, in which a physician can directly end the life of their patient. Shockingly, Belgium and the Netherlands allow physicians to directly end the life of a minor, and three minor children have died with the assistance of physicians in Belgium. This aggressive approach in a few European countries is alarming to many and contrasts sharply with the prevailing perspective in the United States.

ASSISTED SUICIDE IN SWITZERLAND

Switzerland has a relatively large number of individuals who lawfully end their life with the assistance of physicians. The most interesting aspect of the Swiss approach is that the Swiss Code permits the assistance of suicide for non-resident foreigners. (Swiss Criminal Code of 1937, Article 115.) Many individuals who live in countries that prohibit assisted suicide travel to Switzerland to end their life. Because most countries in Europe do not allow assisted suicide, Switzerland has become a death destination for many European citizens. The practice has become so common that it has been referred to as "suicide tourism".

A number of nonprofit organizations in Switzerland provide assistance in ending a life. Nonprofit organizations rent a number of apartments in Zurich where participants can stay to prepare to end their life. The costs to end life in Switzerland range from 4,000 to 7,000 francs. The Swiss Criminal Code imposes no requirement that the person ending their life must be diagnosed with a life-threatening illness. This approach contrasts sharply with requirements in the United States where there must be a diagnosis of a terminal illness with an expectation of only six months (or less) left to live. The only requirement in Switzerland is that the patient must give due consideration to their situation and be sure that they wish to die. Patients must end their life themselves, with no assistance from another person. Physicians who issue the medication prescription are protected from liability under the law. The Swiss Code specifically prohibits assistance to suicide if there are selfish motives by another person influencing the suicide decision.

MORE OPTIONS IN LUXEMBOURG, THE NETHERLANDS AND BELGIUM

In contrast to Switzerland, the countries of Luxembourg, the Netherlands and Belgium allow physicians to take an active role in the death of patients. In 2009, Luxembourg passed a law which allows a patient to direct a physician to end their life if their suffering is considered to be unbearable. (Law of 16 March 2009 on Euthanasia and Assisted Suicide, Articles 1 to 16.) The statute anticipates that this option will be used by persons who are terminally ill or suffering painful illnesses. Citizens of Luxembourg can choose to take medications authorized by a physician, or a physician can personally administer the medications directly. Citizens are allowed to choose how their life will end and the doctors who assist in the patient's death are protected from prosecution.

Physicians are required to conduct interviews with the patient and the patient must be an adult with full legal capacity. The decision to end life must be made without any outside pressure and the patient must have an incurable medical condition with no prospect of improvement. The patient must be under constant and unbearable physical and /or mental suffering. Minors are specifically precluded from using this legislation and parents are also prohibited from making a death request on behalf of their children. Critics of the law suggested that thousands of patients would have irresponsible access to ending their life, but in the first eight years of the legislation only 20 individuals ended their life under the Luxembourg legislation.

The Netherlands has adopted an extremely aggressive approach to assisted death and active euthanasia. (Termination of Life on Request and Assisted Suicide (Review Procedures Act, 2001.)) Similar to Luxembourg, individuals in the Netherlands do not have to be suffering a terminal illness to end their life. The Netherlands passed legislation allowing physician-assisted suicide and active euthanasia that took effect in 2002. Under the legislation, several conditions must be met for a physician to end the life of a patient. The patient must be suffering from unbearable pain without the prospect of improvement. The patient must voluntarily request euthanasia and be free from the influence of others. The patient must be cognizant of their condition and medical options. A second independent doctor is needed to confirm that all of these requirements are present. The physician who has verified the conditions must be present at the termination of life event. Finally, the patient must be at least 12 years old and parental consent must be obtained if the patient is between the ages of 12 and 16. Inexplicably, a minor between the ages of 16 and 18 is not required to have parental consent to end their life.

A common criticism of the Dutch approach is that a person can seek an end to life even though the patient is not facing a terminal illness. A person suffering from depression and suffering a non-life-threatening situation may seek euthanasia by insisting that their pain is unbearable. In recent years, four percent of all deaths in the Netherlands have been through life-ending measures.

Belgium is the most aggressive end of life country in the world. Belgium legalized active euthanasia in 2002. (Doc. 50 1488/005 of Belgium's Chamber of Representatives of March 1, 2002, Bill on Euthanasia.) The terms of the initial legislation protected physicians from liability for intentionally ending the life of an individual who requested assistance in ending their life. The patient had to be an adult or an emancipated minor capable and conscious and thus competent to express his/her free will. The doctor was expected to verify that the patent made the end of life request voluntarily and persistently without outside pressure. The legislation required that the patient have a hopeless medical condition and be experiencing constant and unbearable physical or mental suffering caused by a serious or incurable injury or pathological condition. A second physician opinion was required. Interestingly, if the patient was not in a terminal stage of illness, a third opinion was required.

In 2014, additional legislation allowed for minors of any age to end their life. A minor must suffer a hopeless medical condition with unbearable physical suffering as well as a short life expectancy. A psychologist must evaluate the situation and the parents must give written consent. A 9-year-old, an 11-year-old and a 17 year-old-child have been euthanized in Belgium.

There are increasing numbers of Belgian citizens who are seeking euthanasia (without a terminal illness) for mental illness and behavioral disorders including depression, dementia and Alzheimer's. In a recent year, almost 100 persons elected to end their life while suffering from psychiatric issues only with no terminal health concerns. Since its legalization in 2002, the number of deaths by euthanasia has increased every year. Belgium is often criticized for its liberal policies regarding end of life activities.

CONCLUSION

While only a minority of U.S. states allow physicians to assist in suicides, the trend appears to be toward the practice gradually becoming more widely accepted. In Europe, as well, only a minority of countries allow physicians to assist patients seeking to end their lives. However, the range of options permitted in a few countries is much greater than in the United States. Allowing patients who are not terminally ill to seek suicide assistance, allowing physicians to participate in active euthanasia, and

extending end of life options to minors are potentially alarming developments for both proponents and opponents of assisted suicide. Aggressive euthanasia practices in Luxembourg, the Netherlands and Belgium are now deeply entrenched, and it seems very unlikely this practice will be reversed in those countries.

While other countries may not adopt this aggressive approach, it is clearly possible that more U.S. states and European countries could adopt the more conservative physician-assisted suicides allowed under the Oregon approach. Spain is currently exploring legislation permitting end of life choices for its citizens. Portugal has passed legislation allowing physician-assisted suicide, but it has not been signed into law. Expansion of physician-assisted suicides in more states in the United States appears inevitable. Five of the nine states that allow assisted suicides have passed enabling legislation in the past five years. These controversial practices will certainly continue to generate passionate debate among those who view assisted suicide and euthanasia as cruel and gruesome and those who frame these practices as an inherent right to end life through a personal decision.