Euthanasia and assisted suicide – current realities internationally

This is one of a series of articles on the topic of euthanasia and assisted suicide. It addresses the current realities of medically assisted termination of life in a range of countries around the world.

Other articles on the topic are:

Euthanasia and assisted suicide – historical perspectives
Euthanasia and assisted suicide – current realities internationally
Euthanasia and assisted suicide – UK experience
Euthanasia and assisted suicide – underlying social forces
Euthanasia and assisted suicide – the argument from autonomy
Euthanasia and assisted suicide – the argument from compassion
Risks of legalising assisted suicide
Euthanasia and assisted suicide – Christian responses and perspectives
Medical issues in the care of the dying person
Care of the dying – palliative care and legal frameworks

Current euthanasia practice in the Netherlands

The history of how euthanasia evolved in the Netherlands from the 1970s is discussed in the companion article *Euthanasia and assisted suicide – historical perspectives* which can be found on the website johnwyatt.com

In 2002 the Netherlands became the first country in the world to legalise both euthanasia and medically assisted suicide. The *Termination of Life on Request and Assisted Suicide (Review Procedures) Act* formalised the practice which had evolved over the preceding 20 years.

There has been a steady increase in the number of reported euthanasia and assisted suicide cases in the Netherlands rising from 1900 in 2006 to 6500 in 2017, a rate of 4-5 per 100 total deaths in the population. The commonest means of euthanasia is by lethal injection, usually with very large doses of barbiturate. Medically assisted suicide usually involves swallowing a lethal dose of barbiturates, prescribed and overseen by a doctor. In addition, many more die from the increasingly common practice of terminal or "palliative" sedation, deliberately rendering a patient unconscious and withholding fluids and nutrition until death occurs. This practice does not require official reporting but a report estimated that it accounted for about 8% of deaths in 2005, rising to about 12% in 2010. More recent figures

are not available. One Dutch parliamentarian, commenting on the rise in the practice of terminal sedation said, "Palliative sedation is easier for doctors. There is no control by the euthanasia committee, and it is emotionally easier, too." (There is further discussion of palliative sedation in the article *Euthanasia and assisted suicide - medical issues* available on the website johnwyatt.com)

Psychiatric illness in the Netherlands

In September 1991 a psychiatrist Dr Boudewijn Chabot, supplied his patient Ms B with lethal drugs. Ms B was a 50 year old with a prolonged psychiatric illness which had proved resistant to treatment. She had lost all desire to go on living and had made at least one previous suicide attempt. She consumed the lethal drugs in the presence of Chabot and died shortly thereafter. Chabot reported her death as a suicide which he had assisted. He was prosecuted and the case went ultimately to the Dutch Supreme Court. The Court concluded that unbearable suffering that was psychological in origin could provide justification for medical assistance with suicide, but criticised Chabot for failing to ensure that his patient was examined by an independent colleague. Following the court judgement there has been a small but significant number of patients with untreatable psychiatric illness who have received euthanasia in the Netherlands.

A 2013 interview with a Dutch psychiatrist Dr Paulan Stärcke, published on the NVVE website, illustrated the way in which professional attitudes are changing. She said that initially discussion about euthanasia in psychiatric patients was taboo but following the 2002 euthanasia legislation, things started to change. "According to the law a physician can carry out euthanasia and - as an institution - we could not say no to it anymore…" In 2009 the first serious discussion about assisted suicide took place, after a request from a 64-year old woman with depression and a serious compulsion disorder. Early in 2010 a demented woman asked for euthanasia. She was admitted to hospital because she was psychotic and she could not return home. Dr Starcke assisted her suicide with lethal drugs. She stated that many of her colleagues were anxious about euthanasia, so she decided to help out. Instead of just being the coach, she took over the euthanasia request if the psychiatrist was anxious.

In the interview Stärcke was asked whether the act of euthanasia was not a heavy responsibility? "As a psychiatrist you always take heavy ethical decisions: forcible admission, separation. These are not easy decisions. I find assisting in suicide an act of mercy. We do not have much to offer to people with chronic psychiatric disease. And for some patients we can do nothing. In schizophrenia, personality disorders and bipolar disease you can fight the symptoms, reduce the suffering and teach patients to live with it, but there is no cure available. The medicines you prescribe do have unpleasant side effects. If someone says to me, 'This is unbearable', who am I to say 'Go on, it may become

tolerable'…. Patients with depression or anorexia nervosa receive euthanasia relatively more frequently than other patients. In those clinical situations it is clear which treatment to give and whether you have taken all the steps. Then you can say you have tried everything. Besides we know if the depression has lasted for a long time, it is very difficult to treat…"

This striking interview suggests that, at least in some of Holland's psychiatric institutions, there has been a move towards the acceptance of physician assisted suicide as a "therapeutic option". The annual number of reported cases of euthanasia in psychiatric illness in 2017 was 83, a sixfold rise compared with 14 in 2012. 169 people diagnosed with dementia received euthanasia in 2017.

Extension of euthanasia to other adult conditions

Currently in the Netherlands most cases of euthanasia are in patients with cancer. The practice seems widely accepted by the population as a whole and by doctors. Less than 10% of doctors refuse to participate in the process on the grounds of conscience. The main focus of debate in the Netherlands is on the availability of euthanasia for other conditions, particularly in patients with dementia, those with psychiatric conditions and older people who feel they have a 'completed life'.

In 2015 the KNMG, the Dutch national doctors association, published a position paper on whether euthanasia was justified in these controversial areas. The paper reflects the pressure that some physicians feel to perform euthanasia in elderly people with dementia and other chronic conditions to conform with public expectations.

It is clear that a significant number of Dutch doctors are modifying their clinical practice in response to strong public pressure to extend euthanasia to patients with dementia and those deemed to be suffering unbearably from psychiatric illness. But the KNMG is currently resolutely opposed to the medical practice of euthanasia where the only indication is an elderly person who is "tired of life".

I have quoted the KNMG document in detail in my book *Right to die?* because it seems highly significant in describing the pressures and conflicts that many doctors experience because of the availability of legalised euthanasia and increasing pressure from patients and relatives. A major survey of 1500 Dutch doctors published in February 2015 reported that 18% would consider "helping someone to die" even if they had no physical problems but were "tired of living".

In 2012 the NVVE (the Dutch Euthanasia Society) set up an independent End of Life Clinic for patients who had requested euthanasia but whose own doctors had refused. It was reported that the End of Life Clinic consisted of sixteen mobile teams (each consisting of a physician and a nurse) and a building in The Hague for the staff and telephone co-workers. The euthanasia or assisted suicide is carried out at the home of the one who asked for help. At the end of the first year of the clinic, the team reported 714 requests for help, mostly from people between 81 and 90 years. The total number of deaths in that period was unclear and a significant number were said to be "on the waiting list" for euthanasia.

Another striking trend in Holland is the increasing publicity about self-help methods for people who wish to kill themselves. In 2012 a film made by the psychiatrist Dr Chabot explained how someone can kill themselves using helium. Chabot has been involved in promoting "self-administered euthanasia" using methods such as slowly gathering together a lethal combination of medicines. However he then released a film showing how inhaled helium could be used to ensure rapid death from hypoxia.

To mark Euthanasia Week in 2012, the NVVE organised *The End*, publicised as the first ever film festival devoted to the subject of euthanasia. One film, *Medeleven [Sympathy]* showed a 91-year-old man travelling to pharmacies in Belgium to buy drugs for a lethal dose. His wife had died and he did not want to go on living, but he did not meet the criteria for legal euthanasia. The film showed the relief the man felt when he had finally obtained the suicide drugs: he had taken control. NVVE director Petra De Jong stated that she believed the taboo about death had diminished since the introduction of euthanasia legislation. "The subject has become a part of life. A result of this is that people really want to be in control. I increasingly see self-help methods being discussed."

Neonatal euthanasia in the Netherlands

In 1995 a Dutch gynaecologist Dr Henk Prins was accused of the murder of a three day old baby with severe spina bifida. The medical team responsible for the baby, in consultation with her parents, had earlier decided to cease further medical treatment and in particular not to operate on her spina bifida because such surgery was considered medically futile. The baby was said to be suffering unbearable pain and the doctors and the parents decided to give the baby a lethal injection. The gynaecologist claimed the legal defence of "necessity". As a compassionate doctor he had no choice but to put the baby out of her misery. The District Court held that active termination of life without an explicit request by the person concerned could be justifiable if certain requirements were met.

In 2005 the prestigious New England Journal of Medicine published the "Groningen protocol", a procedure for regularising the euthanasia of newborns in the Netherlands. The protocol described three groups of infants in whom deliberate life-ending procedures could

be taken; those with no chance of survival, those with a poor prognosis who are dependent on intensive care, and those with a "hopeless prognosis who experience what parents and medical experts deem to be unbearable suffering." The paper described 22 reported cases between 1997 and 2004; nearly all cases were babies with severe spina bifida.

A national survey in the Netherlands suggested that euthanasia was being carried out in 15 to 20 newborns each year, but the number of reported cases was much lower. The publication of the Groningen protocol aroused considerable controversy around the world, but it has received strong support from a number of medical ethicists.

Ethical issues surrounding neonatal care are addressed in my article *Neonatal care – ethical issues* available on the website johnwyatt.com

Assisted suicide in Oregon

It is striking that the way in which medically assisted suicide developed in the US state of Oregon was fundamentally different from the Netherlands. In Oregon the conceptual framework is not centred on the duty of the doctor to treat unbearable suffering, but rather the right of every patient to die in a way that they themselves perceive as dignified. According to one campaigner, "The greatest human freedom is to live, and die, according to one's own desires and beliefs."

The Death with Dignity Act became law in the state of Oregon in 1997. The law allows a "capable" adult patient who is a resident of Oregon, and has less than six months to live, to request a prescription for a lethal dose of drugs. The patient must take the drugs by themselves and cannot be physically assisted by the physician. Physicians are encouraged to report cases but the system is based entirely on trust. There is no specific regulatory authority, no resources are made available to ensure compliance with the law and there are no penalties for doctors who fail to report assisted suicide deaths. When concerns were raised about a patient who woke up 3 days after taking the supposedly lethal medication, the State Department of Human Services said it had no authority to investigate individual death-with-dignity cases.

It should be noticed that whereas "hopeless and unbearable suffering" is an essential feature before euthanasia or assisted suicide can be considered in the Netherlands, in Oregon there is no requirement for the patient to be suffering at all.

In the official report for 2014 from Oregon, the reasons given for requesting assisted suicide were as follows:

"Losing autonomy" 91%

"Less able to engage in activities making life enjoyable" 86%
"Loss of dignity" 75%
"Losing control of bodily functions" 49%
"Burden on family, friends/caregivers" 40%
"Inadequate pain control or concern about it" 31%

One Oregon doctor commented "They are not using assisted suicide because they need it for the usual medical kinds of reasons, they are using it because they tend to be people who have always controlled the circumstances of their lives and they prefer to control their death in the same way".

Only 3 out of 105 patients who died by assisted suicide in 2014 had been referred for psychiatric evaluation. Since the law was passed in 1997, a total of 1,327 people have had lethal prescriptions written and 859 patients have died from taking lethal medications prescribed under the Death with Dignity Act. A steady increase in the rate of assisted suicide has been observed over the last decade, rising steadily from 16 in 1998 to 143 in 2017, but the total number remains small at approximately 4 per 1000 deaths in Oregon.

The standard method for assisted suicide in Oregon involves the oral ingestion of a massive overdose of barbiturates – sometimes as many as 90 tablets. Not surprisingly there are case reports in which the suicide attempt has been unsuccessful because of vomiting. In fact the Oregon approach has been opposed by Dutch euthanasia specialists. "Taking 90 barbiturate tablets is not a harmless procedure: it causes vomiting; it tastes awful; it is painful. If you are going to have a quick and easy death from some kind of euthanasia or assisted suicide you have to have lethal injection…"

In Oregon, any appointed person such as a family member or a volunteer from Compassion and Choices may pick up the lethal medication from the pharmacy and deliver it to the patient's home. The medication could then remain in the patient's home for a year or more; no safeguards are in place to ensure that the medication is stored safely and returned to the pharmacy if unused. Similar legislation to Oregon has been passed in Washington State, New Mexico, Montana, Vermont and California. In California it was reported that 374 people died as a result of medically assisted suicide in 2017.

Canada

In February 2015 the Canadian Supreme Court ruled that the Canadian provinces could not legally prohibit physician assisted suicide provided that the patient suffered from a "grievous and irremediable medical condition". There was no requirement for the patient to be terminally ill. In June 2016, the Parliament of Canada passed federal legislation that allows eligible Canadian adults to request "medical assistance in dying".

Official guidelines state, "*To be considered as having a grievous and irremediable medical condition, you must meet all of the following criteria. You must:*
- have a serious illness, disease or disability
- be in an advanced state of decline that cannot be reversed
- experience unbearable physical or mental suffering from your illness, disease, disability or state of decline that cannot be relieved under conditions that you consider acceptable
- be at a point where your natural death has become reasonably foreseeable,
this takes into account all of your medical circumstances and does not require a specific prognosis as to how long you have left to live. You do not need to have a fatal or terminal condition to be eligible for medical assistance in dying.

An official report in 2017 stated that a total of 3714 people had received "medical aid in dying since legislation was passed in December 2015 with 1525 deaths occurring in the last 6 months of 2017. In virtually all cases medication was given by physicians or nurses, mainly, it seems, by lethal injection.

Euthanasia in Belgium

In September 2002 an act legalising euthanasia in Belgium came into effect. The wording was very similar to the Dutch legislation. However the act explicitly included mental suffering as an indication for euthanasia, stating, "…. *the patient should be in a medically hopeless condition of constant and unbearable physical or mental suffering, which cannot be cured and which is a consequence of a severe and incurable disorder caused by accident or disease."*

In 2014 Belgian legislation was passed which would allow euthanasia in children of any age, though parents would have a role in their child's decision to die. "We want to provide freedom of choice also to minors who are able to make up their own mind," said one of the bill's backers. "The legislation will give a merciful way out for young people suffering from debilitating conditions and legalise a practice that is already going on in secret."

Switzerland

Switzerland has a unique legal approach to suicide. Assisted suicide has been legal since 1941, if performed by a non-physician without a vested interest in that individual's death. The law prohibits doctors, spouses, children, or other such related parties from directly participating in the suicide of another. Hence whereas in the Netherlands and many USA states only a physician may authorise the legal suicide of another, in Switzerland a physician is prohibited from directly assisting such an act; only a lay person may directly participate in a suicide.

The Dignitas clinic in Zurich was set up in 1988 and according to its website it has “helped more than 1,700 people to end their lives gently, safely, without risk and usually in the presence of family members and/or friends.” Following medical assessment, clients are prescribed a very large dose of an oral barbiturate (40-50 times the therapeutic dose) together with an anti-sickness medication. The medication is taken under the supervision of a volunteer but a physician cannot be present. Over 80% of those who commit suicide with the help of Dignitas come from outside Switzerland, with the largest group coming from Germany followed by the UK.

Although there has been controversy about some of Dignitas’ procedures and about the reality of “suicide tourism” in Switzerland, the practice was supported in a referendum of the local population. The basis on which clients are assessed for suitability for suicide is not clear, and there has been controversy about clients who were clearly not terminally ill. Ludwig Minelli the Dignitas director agrees that some of those who receive assisted suicide are people who are just tired of life. "If you accept the idea of personal autonomy, you can't make conditions that only terminally ill people should have this right….With life expectancy growing and medical sophistication improving, people are increasingly worried about whether they will be condemned to linger on, forced to end their lives in an institution. Our members say: with our pets, when they are old and in pain, we help them. Why am I not entitled to go to the vet? Why haven't I such an opportunity? We hear this often."

Minelli's vision goes beyond helping the infirm to shorten a painful end. He believes the right to choose to die is a fundamental human right and, in theory, he is willing to help anyone. However Swiss medical regulations prohibit doctors from assisting the suicide of healthy people, and they restrict assisted suicide for the mentally ill – making it practically impossible for Dignitas to help people who are profoundly depressed to kill themselves. This is a prohibition that Minelli is fighting.

Dignitas staff argue that once a client has been assessed as suitable for assisted suicide the possibility is enough to “relieve people burdened by disease and suffering because it acts as a kind of escape valve. The individual is no longer the helpless and indiscriminate victim of fate, but rather sees a new opportunity to take control of his or her own destiny. Thanks to this option, many people then decide to await their uncertain future. They do this because they know that they have the possibility later on to definitely end their lives themselves with Dignitas, should their situation become too difficult. Along the way, they realise that they are actually stronger than they thought. In addition, suitable palliative care is often helpful in maintaining an acceptable quality of life for them.” Approximately 25 people travel from the UK to the Dignitas clinic every year for assisted suicide.

This material is adapted from *Right to Die? Euthanasia, assisted suicide and end of life care,* by John Wyatt, published by IVP.

For further articles on the topic of euthanasia and assisted suicide visit the website johnwyatt.com