Comparing the Law and Governance of Assisted Dying in Four European Nations

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Abstract

This article provides a comparative law and governance insight to assisted dying in England, France, Switzerland and the Netherlands, bringing together empirical studies of regulation and normative thinking about the role of the state. It follows the ‘new governance’ scholarly effort to challenge the conventional wisdom that regulation, especially in regard to controversial and sensitive public policy issues, must be determined by top-down, command and control rules. The question here is a straightforward, but fundamental one: to what extent do, and should, private actors contribute to the creation, application and enforcement of the law on assisted dying? Critical attention is paid to the differences that exist in the aforementioned nations and how they matter from a broader governance and policy-oriented perspective.

Keywords

euthanasia – assisted suicide – comparative law and governance – state politics

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Introduction

Three judicial decisions on June 25th 2014 breathed new life into the legal policy debate on assisted dying in Europe. First, the European Court of Human Rights suspended the French Conseil d'Etat's decision to withdraw nutrition and hydration to a tetraplegic patient in a permanent vegetative coma.\(^1\) Second, the English Supreme Court came within a whisker of declaring the English ban on assisted suicide as incompatible with human rights, and strongly suggested that Westminster review the current law.\(^2\) And third, a Cour d'Assise in Southwest France acquitted a physician of poisoning charges after helping seven terminally ill patients to die.\(^3\) It was a unique day of judgements, but the underlying issues raised have been reappearing in the public domain periodically across Europe for the past decade.\(^4\) Notwithstanding the vast scholarly attention afforded to assisted dying,\(^5\) the recent developments

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2. \(R\) \(\text{on the application of AM} \) \(\text{(AP)}\) \(\text{(Appellant)}\) \(v\) \(\text{Director of Public Prosecutors} \) \(\text{(Respondent)}\) \(\text{[2014]}\) \(\text{UKSC 38.}\)


4. Media and public discourse is most often initiated by high profile judgements: from the ECtHR's decisions in Pretty \(v\) \(\text{UK} \) (2002), Haas \(v\) \(\text{Switzerland} \) (2009), Gross \(v\) \(\text{Switzerland} \) (2013) to various national decisions (such as the 2003 'Humbert case' in France, the 2006 'Welby case' in Italy; the 2007 'Echevarría case' in Spain; the 2009 'Purdy case' in England, the 2014 'Fleming case' in Ireland).

demand an updated and alternative revision of the issue. It is important to note throughout this piece, the use of the single term ‘assisted dying’ refers to both voluntary active euthanasia (‘VAE’) and assisted suicide (‘AS’) where the distinction between the two is not relevant. The abbreviation ‘PAS’ is used when specifically referring to physician assisted suicide.

This article provides a comparative law and governance insight to assisted dying, bringing together empirical studies of regulation and normative thinking about the role of the state. It follows the ‘new governance’ scholarly effort to challenge the conventional wisdom that regulation, especially in regard to controversial public policy issues, must be determined by top-down, command and control rules. The question here is a straightforward, but fundamental one: to what extent do, and should, private actors contribute to the creation, application and enforcement of the law on assisted dying? Critical attention is paid to the differences that exist in the selected nations and how they matter from a broader governance and policy-oriented perspective.

6 Although both behaviours are distinct in practice, it is possible to discard the distinction between the two as far as their justifiability is concerned. This is the case in Dutch discourse, where despite their separate treatment in the Penal code (Art. 293 and Art. 294) the single term ‘euthanasia’ is frequently used for both VAE and AS. In the actual medical context and in cases of VAE or AS brought to trial in the Netherlands, no relevance had been attributed to the distinction. On this, see Cohen-Almagor, *Euthanasia in the Netherlands: The Policy and Practice of Mercy Killing* (Kluwer-Springer, 2004); K.M. Foley and H. Hendin (eds), *The Case against Assisted Suicide: For the Right to End-of-Life Care* (Baltimore MD, John Hopkins University Press, 2004); R. Magnusson, *Angels of Death: Exploring the Euthanasia Underground* (New Haven, CT: Yale University Press, 2002); J. McMahan *The Ethics of Killing: Problems at the Margins of Life* (Oxford: Oxford University Press, 2002); H. Watt, *Life and Death in Healthcare Ethics: A Short Introduction* (London: Routledge, 2000).

Each nation selected for analysis – England, France, Switzerland and the Netherlands - provides a distinct approach to the law on assisted dying. England represents a common law jurisdiction in which voluntary active euthanasia (VAE) and assisted suicide (AS) are formally prohibited. France represents a civil law jurisdiction in which only VAE is formally prohibited. Switzerland represents a civil law jurisdiction in which AS is lawful and openly practiced. Whilst the Netherlands represents a nation in which both VAE and AS have been regulated and legalised under certain conditions.8

Section 1 and 2 outline, respectively, the theoretical underpinnings and the definitions used throughout the article. Section 3 offers a descriptive analysis by looking at the law on assisted dying ‘in the books’ in the three above-mentioned nations. Section 4 comparatively identifies such law ‘in action’9 - focusing on empirical data and the application and enforcement of the law. Section 5 contains a critical comparative analysis of the law ‘in the books’ v the law ‘in action’. Section 6 identifies the actors and institutional architecture at play in the creation of the respective laws. This critical, and somewhat prescriptive, analysis is carried out in light of the theoretical underpinnings in Section 2 and findings in Section 5. Finally, brief conclusions will be made in Section 7.

1 A Law and Governance Perspective

Both ‘law’ and ‘governance’ are contested concepts whose meaning and inter-relationship cannot just be assumed or taken for granted.10 Hence, working definitions must be made from the outset.

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8 Note: a number of Dutch scholars are keen to clarify that VAE and AS are not formally ‘legalised’ but conditionally de-criminalised via a general statutory defence of force majeure (specifically accepted in the context of a doctor’s conflict of duties), which was codified in the 2002 Termination of Life on Request and Assisted Suicide (Review Procedures) Act [Wet Toetsing Levensbeeindiging op verzoek en hulp bij zelfdoding] along with an amendment of the Criminal Code [Wetboek van Strafrecht, Sr.] and the Burial and Cremation Act [Wet op de lijkbezorging]. See Kimsma and van Leeuwen, ‘Reviews After the Act - The Role and Work of Regional Euthanasia Review Committees’, in: Physician-Assisted Death in Perspective: Assessing the Dutch Experience (n 5) 192. Note also: due to the considerable process of legal change and the history of the discussion on assisted dying in the Netherlands, studying the Dutch approach provides ample material to draw from. For this reason it was selected for analysis over Belgium and Luxembourg as the representative nation that permits both VAE and AS.


This article amalgamates a combination of ‘governance’ definitions in contemporary political and social science literature. Governance is most broadly understood here as: decision making to steer and co-ordinate activity by formal or informal groups or institutions. Social groups, collective entities and human relationships are all subjects of governance. Command and control by public actors in the modern democratic state, namely by government, is only one form of governance. A governance perspective may not only examine the relevant actors and institutional architecture in decision-making, but also the nature of the instruments that thereby arise.

“Law” is conceptualised here in a broad functional sense as one means to mediate between conflicting interests. It must be differentiated from ‘other social norms’ as a specific instrument to regulate behaviour. In a highly abstract sense, law may be said to contain certain distinct characteristics: (1) some voluntary norms but also some categorical obligations, whereby it is not necessary to have obtained the agreement of those obligated as a necessary condition; (2) it has, unlike morality, only external sources – such as judging, ordering, agreeing, voting; and (3) although, it is marked by a certain formality, it does not necessitate that this formality may only be derived from the state. In other words, the requirement of formality also holds for non-state law, such as the law of religious communities, the law of customs, the emerging law.

11 For an overview of various definitions of ‘governance’ see Levi-Faur, ‘From Big Government to Big Governance?’ in: The Oxford Handbook of Governance (n 7) 3.


15 This is an unexceptional but solid point of departure. Legal commentators commonly support their descriptions of the law by references to the purposes and functions of the law, see J.W. Harris, Legal Philosophies (Oxford: Oxford University Press, 2004) 67.


of cyberspace etc. Regarding assisted dying, a wide range of ‘legal’ formants are relevant. These range from not only statutory law, case-law, and prosecution guidelines, but also to professional disciplinary rules, hospital standards, and decisions by ethics committees.

Accordingly, the scope of application of the ‘governance perspective’ (given above) may be narrowed down to instruments that only possess the characteristics of ‘law’. The focus is on policy and decision-making (actors and institutional architecture) in the creation, application, and enforcement of the law (categorically binding and formal instruments). Considering the recent working paper of Colombi Ciacchi and von der Pfordten, law and governance may be said to cover four highly abstract relations: the through-relation, the in-relation, the as relation, and the against-relation. Such characterisations support the NewGov theory whereby different modes of governance are dependent variable along a continuum of extremely formal to very informal.

‘Governance through the law’ is at the more formal end of the continuum. This entails decision-making predominately by central government institutions (parliaments, executive and bureaucracies), central political actors (political parties, politicians) and/or the judiciary in creating, applying and enforcing the law. ‘Governance in the law’ refers to the hybrid interaction between public and private actors embedded in the creation, application and/or enforcement of the law. It is important to note that this mode of governance still necessitates decision and policy making by central government institutions.

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20 An act of assisted dying may involve a host of legal consequences, ranging from criminal law, constitutional law, contract law, tort law, human rights law, and even European free movement law (as demonstrated in the forthcoming PhD Dissertation, A. McCann, Assisted Dying in the EU: A Comparative Law and Governance Analysis, University of Groningen 2015).
22 The through, in and against relationships are characterised by their ‘relativity’. The governance as law relationship is characterised by its ‘identity’. See ibid. Note that governance against the law – i.e. societal self-organisation in breach of the law will not be examined here.
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institutions, political actors and/or the judiciary, but to a lesser extent than above. We are now sliding down the continuum, whereby formal actors considerably rely upon informal actors (such as experts, stakeholders, NGOs), and vice versa. ‘Governance as law’ involves decision and policy-making predominantly by private actors that results in a type of non-state law. This governance is at the more informal end of the continuum, whereby private actors are mainly responsible for the creation, application and/or enforcement of the law. Examples of this are lex mercatoria or the ICANN system of control (management of internet domain names, regional internet registries etc.).

Attention will now be turned to four basic observations regarding the relationship between law and state politics that are pertinent to this study. First, the relationship between the two normative orders, and thus the type of governance dimension of the law, is dependent on the ‘policy sector of the society’. The legal policy on sensitive social issues requires a strong democratic process to take equal account of the citizens’ normative preferences. In such cases, central government institutions and political actors are dominant in the creation, application, and enforcement of the law (governance through the law).

Second, the ‘politicisation of the law’ at state level brings about indispensable benefits: it offers the opportunity of equal citizen participation in how to shape and pursue the polity’s aspirations, albeit abstracted through the development of political parties: this in turn provides a relatively robust legitimacy


25 The term ‘politics’ is commonly used to describe an array of activities in society whereby people strive to increase their power and to promote their interests. The phrase ‘it’s all politics’ can be heard in the descriptions of academic departments, football clubs, labour unions etc. ‘Politics’ here is addressed in a much narrower sense – in the form of state politics, especially by directly elected representatives in legislatures. For a detailed discussion of the various relationships between law and politics (casual, definitional, and normative), see M.D. Bayles, Principles of Legislation (Detroit: Wayne State University Press, 1978). See also M. Zamboni, Law and Politics: A Dilemma for Contemporary Legal Theory (Springer, 2008).


and accountability in the law, at least formally, via a consensus in the political community.29

Third, the ‘politicization of the law’ demands the constitutive ‘juridification of politics’:30 the law provides procedural rules on how to pass or generate political acts,31 content rules that contain political discretion and protect individual rights,32 enhanced judicial power33 and institutional rules granting one part of a political system exclusive competence.34 Depending on the policy sector, the degree of judicialisation (one form of juridification) of politics may vary.35 When divisive policy sectors arise, the separation of powers doctrine often lends support toward judicial restraint and a display of deference to parliament.36

And fourth, when the mediation of conflicting interest in regard to particularly controversial social and moral issues arise (such as LGBT rights, assisted reproduction, stem cell research, treatment of drug users or

re-offenders, etc.), it is difficult to ignore the potential negative effects of the over-politicisation of the law alongside the under-juridification of politics. Such negative effects are namely; the public exposure of post-materialistic interests to partisan and polarised ideologies, and the inflexibility of law because of status quo bias, no-clear-winner political situations, and rigid separation of power structures. When the dynamics between law and politics results in such disadvantages the situation arises whereby a commensurate change in the relationship is arguably justified.

Returning to the case at hand, the law on assisted dying is a highly polarising issue. Despite subtle differences in this respect, the vast majority of EU member states have answered the legal policy question the same. 25 of the 28 member states consider it worthy of a criminal blanket ban. It is equated with
almost exclusive state command and control, characterised by the decisive role of central government institutions and actors – legislators, public prosecution services and law enforcement officers. It provides a classic example of governance through the law. In light of the above observations, important questions thereby arise: to what degree are the respective laws on assisted dying politicised? What effect does the particular institutional architecture have on the balancing of the competing interests? And, would an alternative governance approach to said law be more, or less desirable?

2 Definitions

For the purpose of this article, voluntary active euthanasia (VAE) is understood as when a person terminates the life of another person at the latter’s explicit request. Assisted suicide (AS) refers to the voluntary termination of one’s own life by self-administering drugs with the assistance of another person. Both of these definitions presuppose the existence of valid informed consent. Both VAE and AS should be clearly distinguished from other medical behaviour that shortens life (MBSL), which are often attributed to the word ‘euthanasia’: passive euthanasia (refusal of treatment, or withholding/withdrawing treatment due to ‘medical futility’) and indirect euthanasia (medical treatment to alleviate pain, which has life shortening effects). These latter end-of-life decisions are largely considered, under certain circumstances, as permissible medical practice and are not covered by the term ‘assisted dying’ in this article.

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41 Usually, but not exclusively, by administering a lethal injection.
42 According to one of the most prominent and widely consulted medical textbooks in the English language (“Goldman’s Cecil Medicine”), there are four requirements for valid informed consent: (i) mental capacity, (ii) disclosure, (iii) understanding, and (iv) voluntariness. See E.J. Emanuel, ‘Bioethics in the Practice of Medicine’, in: L. Goldman and A.I. Schafer (eds), Goldman’s Cecil Medicine (24th edn, Elsevier-Saunders, 2012) 7.
43 These distinctions/subcategories of ‘euthanasia’ are largely thought of as outdated and problematic, and will not be used in this article. As stated above, the single term ‘assisted dying’ is used exclusively herein to mean both VAE and AS where the distinction between the two is not relevant.
44 See for an overview of definitions regarding end-of-life behaviour, Emanuel, ‘Bioethics in the Practice of Medicine’ (n 42) 8.
45 ‘Permissible’ here does not necessarily mean such behaviour is subject to tight control. In a number of European nations studied, it means that a resulting death can be reported as
3.1 *England*

VAE is an act of homicide under English law. Depending on the circumstances, it may fall under the defence of diminished responsibility and be regarded as voluntary manslaughter. A physician who performs VAE would also face disciplinary charges by the General Medical Council (GMC), which requires its members ‘to act within the boundaries of the law’.

Any person who assists in (or encourages) a suicide or an attempted suicide of another person commits an offence under Section 2 of the Suicide Act 1961. It carries a maximum penalty of 14 years imprisonment. Here the Director of Public Prosecutions (DPP) must apply a two-stage test when deciding to prosecute: it must first be ascertained if sufficient evidence exists, and if so, whether a trial would be in the ‘public interest’.

Following a High Court decision in 2009, the DPP was ordered to issue a policy of factors for and against prosecution in the ‘public interest’. This states that prosecution is less likely provided the suspect was motivated by compassion, the assistance was only minor, the suspect sought to dissuade the victim and the suspect was reluctant in the face of a voluntary, clear, settled and informed decision on the part of the victim to commit suicide. There are 16 factors in favour of prosecution, such as: the suspect was acting in his or her capacity as a medical doctor or nurse and the victim was in his or her care; the suspect gave assistance to more than one
victim who were not known to each other; or the suspect stood to gain or was paid.

3.2 **France**

VAE is an act of homicide under French law. Specifically, the administration of a poisonous substance that causes death (such as benzodiazepines) carries a maximum sentence of 30 years imprisonment. According to professional medical codes of conduct, a doctor would also face disciplinary charges for performing VAE.

As suicide is not a criminal offence, complicity or assistance in suicide is subsequently considered lawful. However, the prosecution of a person present at the time of the suicide is possible on the ground of the ‘duty to rescue’. Prosecution under this offence is rare and subject to the discretion of the public prosecutor. If a suicide involves only the prescription of drugs and not the presence of the doctor at the moment the drugs are actually administered, the only sanction under French law would be disciplinary.

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54 Art. 38, *Code de la santé publique* [Code of Public Health].

55 Art. 223–6, *Code Pénal*.

3.3 **Switzerland**

VAE (recognised as ‘compassionate murder upon request by the victim’) is a specific crime under Article 114 of the Swiss Penal Code. It is treated as a less reprehensible form of homicide. The maximum sentence is three years imprisonment.

According to Art. 115 of the Penal Code, assisted suicide is not a crime provided it is performed without any self-interest. It is not necessary that the assistor is a doctor or that there is a medical precondition. Nor is it necessary that the recipient is a Swiss national. Any involvement of a doctor in terms of prescribing a lethal drug for the purpose of suicide is subject to Art. 11 of the Narcotics Law and thus to established rules of medical practice. The 2013 professional guidelines by the Swiss Academy of Medical Science (SAMS) state that a doctor’s decision to provide as ‘must be respected’. The medic must check for a number of preconditions: namely, that the patient is nearing the end of life; alternative possibilities have been discussed and offered; the patient has full capacity; and the final action leading to death is taken by the patient him/herself.

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58 Art. 114 *Strafgesetzbuch* [Penal Code]. Available in English at <www.admin.ch/ch/e/rs/311_0/>. 

59 This raises an interesting EU free movement law issue: see McCann, _Assisted Dying in the EU - A Comparative Law and Governance Analysis_ (n 20).

60 *Betäubungsmittelgesetz* [Narcotics Law], _BetmG_, SR 812.121.

A number of Court decisions have also refined the role of doctors in performing AS:\(^{62}\) there is an obligation to ascertain the patient’s competence to make such a decision, the prescribing doctor must examine the patient in person, and identify ‘a condition indisputably leading to death.’ It was further held that a patient suffering with an incurable, permanent and serious mental health disorder may also qualify for assisted suicide, subject to a report by an expert in psychiatry that the patient’s judgment is still rational.\(^{63}\)

There are four main ‘right to die’\(^{64}\) (RTD) organizations that provide (almost all instances of) assisted suicide in Switzerland. Each is subject to their own ‘internal guidelines’. Exit Deutsche Schweiz and Exit ADMD require a person seeking assistance to be permanently resident in Switzerland or to have Swiss citizenship. Dignitas and Exit International offer assistance to persons not resident and persons without Swiss citizenship. All four place greater conditions – often referred to as ‘self-imposed restrictions’ - than those set out in Art.115 of the Penal Code. The person seeking assistance must be terminally ill, suffering from a disease with hopeless prognoses, or with unbearable symptoms, or with unacceptable disabilities.\(^{65}\) A number of procedural steps/diligence rules must be satisfied (submission of medical diagnosis, personal interview, discussion about alternatives, the role of the assistant in preparing the drug, notifying police services, ‘legal inspection’).\(^{66}\)

There is no federal or cantonal rule specifically dealing with assisted suicide in hospitals or nursing homes. In such case, recourse is had to their own criteria. Not all hospitals and nursing homes permit AS. Most hospitals in the French speaking region do allow Exit ADMD to provide assistance to their residents.\(^{67}\) Some permit right to die societies on to the premises only for those

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\(^{63}\) Schweizerisches Bundesgericht [Federal Supreme Court of Switzerland], Entscheid 2A.4812006, 2006.

\(^{64}\) These are non-profit organisations consisting of volunteers who are mostly clergymen, social workers or nurses. See S. Ziegler and G. Bosshard, ‘Role of Non-governmental Organisations in Physician Assisted Suicide’, BMJ 334(7588) (2007) 295–298.

\(^{65}\) See the conditions as set out by Dignitas (available at: <www.dignitas.ch/index .php?option=com_content&view=article&id=20&Itemid=60&lang=en>), by Exit Deutsche (available at: <www.exit.ch/freitodbegleitung/bedingungen/>), and by Exit ADMD (available at: <www.exit-geneve.ch/conditions.htm>).

\(^{66}\) Ibid. See Ziegler, ‘Collaborated Death: An Exploration of the Swiss Model of Assisted Suicide for Its Potential to Enhance Oversight and Demedicalize the Dying Process’ (n 57).

who are terminally ill and unable to travel (Lausanne University Hospital and Geneva University Hospital). While some hospitals in German speaking Switzerland have adopted a ‘neutral’ approach (like in Zurich Cantonal University Hospital), whereby no medic of the hospital should provide assistance in suicide, but the patient may seek it elsewhere, and if necessary be transported in order to receive the assistance.

3.4 The Netherlands68

In 2002, the Termination of Life on Request and Assisted Suicide Act (hereafter referred to as the ‘2002 Act’ or ‘the Wtl’) came into effect. This only allows a physician to perform vae and as, provided s/he complies with the due care criteria and notifies the municipal pathologist of this act. Both vae and as remain criminal offences69 if not performed by a physician, or if performed by a physician but not in accordance with the ‘2002 Act’. The conditions in order to lawfully perform vae or pas stipulate:70

- the patient’s request was voluntary and carefully considered
- the patient’s suffering was unbearable, and there was no prospect of improvement
- the doctor informed the patient concerning his situation and his prospects
- the doctor and the patient were convinced that there was no reasonable alternative in light of the patient’s situation
- the doctor consulted at least one other independent physician who must have seen the patient and given a written opinion on the due care criteria [i.e. the preceding four items]
- the doctor terminated the patient’s life or provided assistance with suicide with due medical care and attention
- the doctor reported the case to the municipal pathologist

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69 Article 293 and 294, Wetboek van Strafrecht, Sr. [Penal Code], respectively.

70 See Sec. 2(1) Wet Toetsing Levensbweekbeding op verzoek en hulp bij zelfdoding (Wtl) [the Termination of Life on Request and Assisted Suicide (Review Procedures) Act].
The patient’s request as referred to above may be in the form of a present oral request. It may also be in the form of a written declaration of intention (advanced directive - *wilsverklaring*) by a patient who is no longer capable of oral communication. A request for *vaer* or *as* may be made by a mentally competent patient who is a minor. For patients aged between twelve and sixteen, the consent of the parent(s) and/or the legal guardian is required. For those aged seventeen or eighteen, the parent(s) and/or guardian must be involved in the decision process.

It is also important to note that no physician is ever obligated to grant a request for *vaer* or *as*. In case the physician should refrain, he/she can refer a patient to a colleague. However, there is no duty to directly refer to another physician who is willing to comply with the request. Also, the often-supposed requirement that the patient must be in the ‘terminal phase’ or that the illness is ‘terminal’ is not included in the statute. Nor is there any restriction to suffering of a purely ‘somatic’ origin. Although the test for ‘unbearable suffering’ is subjective to the patient’s perspective, it is also subject to the qualification by the more objective requirement that this must be “understandable” (*involgbaar*) to a doctor (i.e. medically classifiable) to an independent consultant, and also *ex-post* to the Regional Review Committee (*rrc*), explained below. The requirements that the patient’s condition must have ‘no prospect of improvement’ and ‘no reasonable alternative form of treatment’, is a matter of objective medical opinion.

The ‘2002 Act’ also established a ‘notification procedure’, whereby the physician is obligated to notify the municipal medical coroner of every instance of assisted dying based on a pre-defined ‘reasoned report’ containing all circumstances of the case at hand. The pathologist does not turn the report over to the Public Prosecutors Office, but to the relevant ‘non-criminal’ Regional Review Committee (*rrc*). These Committees determine, on examination of

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71 This is conditional upon proof that the patient was aged sixteen or over when he drew up the declaration and was still mentally competent in doing so. See Section 2(2) of the *Wtl*.
72 See Section 2(4) *Wtl*.
73 See Section 2(3) *Wtl*.
74 Note: it is of course still required that the patient is decisionally competent.
75 Section 7(2) *Wet op de lijkbezorging* [the Burial and Cremation Act].
76 There are five *rrc*s in the Netherlands, which serve five judicial regions. They consist of three members (and three substitutes): a lawyer (who is the chair), a physician, and an ethicist. Before contacting the relevant *rrc*, the coroner makes an on-site visit, checks the facts of the physician’s report, gathers the relevant medical info, and contacts the prosecution services to receive allowance for burial or cremation. A model report has been made available pursuant to a general administrative order [*algemene maatregel van
the report, if the applicable criteria of due care have been satisfied. The RRC notifies the Public Prosecution Service and the Health Care Inspectorate only if they consider the due care criteria have not been fulfilled.

4 The ‘Law in Action’

In examining the governance dimension of a particular law, it is not enough to look at what the rules are (Section 3, above), but it is also essential to account for what happens to them ‘in action’. This part briefly outlines in the respective jurisdictions: (i) the limited empirical evidence of assisted dying, and (ii) the application and enforcement of the law on assisted dying.

4.1 Empirical Evidence of Assisted Dying

Agreement is had here with van der Heide regarding the role of empirical data: ‘observational studies on the characteristics of practice cannot be used to prove that [those] who engage in practices that hasten death were right or wrong.’ Instead, empirical data plays a more modest yet important supportive role in critiquing any given regulatory approach.

4.1.1 England

The leading statistical research on end of life decisions in England, dating from the early 1990’s, 2006 and 2009 comes from Professor Clive Seale. In his latest representative survey, 3,733 medical practitioners working throughout the UK responded to an anonymous questionnaire.


Out of the total number of deaths attended by the respondents, 0.21 per cent involved the ‘termination of life with an explicit request from the patient’, in other words VAE. Taking into account the annual deaths attended by the responding doctors, this survey estimates approximately 151 deaths were due to VAE.\textsuperscript{79} Extrapolating this to the annual population of total UK deaths,\textsuperscript{80} approximately 1,070 deaths may be a result of VAE per year. There were no reported cases (in the survey) of actual physician assisted suicide. In response to further questions in the survey, it is relevant to point out that 2 per cent (approx. 1,440 of the 72,071) of the reported deaths were a result of pain alleviating treatment, which was ‘partly intended to end life’, while another 15.1 per cent (approx. 10,880 of the 72,071) with the knowledge of ‘probable or certain hastening of end of life’.

Acknowledging the inherent difficulties in such questionnaires regarding accuracy, they do provide some degree of indication that VAE is occurring in secret.\textsuperscript{81} Furthermore, it is demonstrated that a high number of deaths resulted from pain alleviation in the knowledge of probable or certain hastening of life. The data ‘did not suggest higher levels of life shortening actions, or higher levels of sedation for the very elderly or for those recorded as having dementia.’\textsuperscript{82}

It is also relevant to take into account instances that did not involve medical professionals, i.e. the occurrence of ‘mercy killings’ (typically by a family member). Again it is difficult to obtain a holistic picture via empirical data (given the obvious illegal nature of the behaviour), but Home Office records show that from 1990/91 to 2004/05 there were a total of 57 homicide cases that can be described as ‘mercy killing’. Regarding as, 91 cases have been brought to the attention of the DPP between April 2009 and February 2014.\textsuperscript{83} A large number of these cases involved what has become known as ‘suicide tourism’. This occurs when a patient travels abroad to a jurisdiction were s/he is legally permitted to commit suicide in the presence of family/friends and an experienced end of life care-giver. The most popular choice of jurisdiction is Switzerland.

\textsuperscript{79} Note the confidence interval (c1) level of these estimates is 95%.
\textsuperscript{80} According to the Office for National Statistics, there were 509,090 deaths registered in England and Wales that year.
\textsuperscript{81} Furthermore, such surveys indicated the large number of MBSL occurring; of which VAE is only a small part.
\textsuperscript{83} Cases of assisted suicide are recorded centrally by Crown Prosecution Services, and are available at: <www.cps.gov.uk/publications/prosecution/assisted_suicide.html>.
Dignitas, one of the best known and most criticised right-to-die organisations, recorded (at the time of writing) 893 members from the UK alone.\(^\text{84}\) From 1998 to December 2013, a total of 244 Britons have availed of assistance in dying at said clinic.\(^\text{85}\)

### 4.1.2 France

A 2010 anonymous survey,\(^\text{86}\) funded by the Ministry of Health, provides an indication of the number of physician performed VAE occurring in France. The results are based on a representative\(^\text{87}\) sample of 4,891 deaths. Accordingly, 0.2 per cent of these deaths were preceded by the use of a drug to deliberately end life at that patient’s request. Considering there are approximately 500,000 deaths a year, this survey indicates that around 1,000 of these deaths are a result of VAE (physician performed).

Furthermore, 28.1 per cent of deaths in the survey involved the intensification of treatment to alleviate pain, knowing that the decision may or will hasten death (0.8 per cent with the intention of hastening death and 27.3 per cent with ‘the knowledge that the decision may hasten death’). 18.8 per cent of the deaths involved the withholding or withdrawing of life prolonging treatment (1.5 per cent with the intention of hastening death and 17.3 per cent with ‘the knowledge that the decision may hasten death’). No physician-assisted suicides were recorded. Also it must be noted that from 1998–2013, a total of 159 patients have travelled from France to Dignitas in Switzerland to commit suicide.\(^\text{88}\)

Aside from this survey (notably the first and only one of its kind in France to offer any data on end-of-life decision making), a Parliamentary working committee explicitly acknowledged the practice of clandestine VAE.\(^\text{89}\)

### 4.1.3 Switzerland

There have been a number of empirical studies carried out regarding end of life practices in Switzerland. According to a European (EURELD) study based...
on an anonymous questionnaire method sent out to physicians (resulting in 3,355 studied deaths), 0.27 per cent of all deaths attended by the respondents were understood as VAE. In 92 per cent of these cases, a ‘right-to-die’ organisation was also involved. While for the majority of Swiss patients (61 per cent), the assistance takes place in their own home. In 54 per cent of PAS cases, life was estimated to be shortened by one week to one month.

In context with other end of life medical behaviour, the same study shows that 22% of deaths involved the administration of pain relief with ‘possible life shortening effect’ and 28 per cent involved ‘non-treatment decisions’, such as withholding or withdrawing life prolonging treatment. However, another EURELd study estimated that 41 per cent of all deaths attended by the respondents were preceded by a ‘non-treatment’ decision. In both surveys the incidence of such behaviour in Switzerland was the highest in Europe.

Further empirical data comes from the ‘right to die’ organizations. The German speaking organisation EXIT Deutsche Schweiz has 73,000 members and receives more than 2,000 requests for AS annually. According to its website, it has approved 600 requests and physicians performed approximately 450 cases of assistance. According to a study by the Institute of Social and Preventative Medicine, there were 927 deaths assisted by non-physician volunteers in Exit Deutsche Schweiz during the years 2003 to 2008. Its French speaking counter-part, Exit ADMD (Association pour le Droit de Mourir dans la Dignité), has 20,196 members and has assisted in 330 deaths during the years 2003 to 2008. Dignitas, known for providing assistance to non-resident and/or non-Swiss nationals, has assisted in 1,701 deaths during the years 1998 to 2013.

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91 See S. Fischer et al., ‘Suicide assisted by two Swiss “right to die” organisations’, Journal of Medical Ethics 34 (2008) 812.
92 EURELd (n 90) In 17 per cent of cases, the estimated life shortening effect was less than 1 week, while in 29 per cent of cases it was estimated to be more than one month or unknown.
93 Ibid.
95 See <www.exit.ch/en/exit-at-a-glance/>.
The ‘Bosshard study’ in 2003 found that 78.9 per cent of the assisted suicides involved patients suffering from fatal diseases (such as cancer, or cardiovascular disease). Another study analysed reported cases of AS by RTD organisations in the city of Zurich (between 2001 and 2014) in order to identify the physician’s reason (ph) for prescribing the drug and the patient’s reason (p) for wanting AS. The most often cited reasons were to relieve pain (ph: 56 per cent, p: 58 per cent), concerns for long term care (ph: 37 per cent, p: 39 per cent), neurological symptoms (ph: 35 per cent, p: 32 per cent), immobility (ph: 23 per cent, p: 30 per cent), control of circumstances over death (ph: 12 per cent, p: 39 per cent), loss of dignity (ph: 6 per cent, p: 38 per cent), weakness (ph: 13 per cent, p: 26 per cent), inability to engage in activities that make life enjoyable (ph: 6 per cent, p: 18 per cent), and insomnia and loss of concentration (ph: 4 per cent, p: 13 per cent).

4.1.4 The Netherlands

The Netherlands is one of the few Member States where relatively reliable data on the incidence of assisted dying is available. Empirical data from 1990 to 2013 has been obtained via interviews, questionnaires, nation-wide surveys and annual reports of the RRCs. However desirable, it will not be possible to go into this data in great detail. Instead a brief outline will be given.

97 21.1 per cent involved a non-fatal diagnosis (such as rheumatoid arthritis or osteoporosis). See G. Bosshard, E. Ulrich and W. Bär, ‘747 Cases of Suicide Assisted by a Swiss Right-to-die organisation’ Swiss Medical Weekly 133 (2003) 310–317.
100 Annual Reports from 2002–2013 are available at <www.euthanasiecommissie.nl/archief-jaarverslagen.asp>.
There has been a steady increase of assisted dying cases in the Netherlands. According to the 2013 Annual Report, the RRCS received 4,829 reports of assisted dying. This is an increase in cases by 15 per cent compared to 2012. Of these cases, the frequency of VAE has been consistently higher than that of AS. In 2013, VAE accounted for 93.2 per cent of reported cases, 5.92 per cent of cases were AS, while 0.86 per cent of cases involved a combination of both. It is difficult to accurately identify the percentage these reported cases represent the actual number of euthanasia cases being performed. Research stated in 1990 that only 19 per cent of all cases were being reported. This figure subsequently rose to 41 per cent in 1995, 54 per cent in 2001, 80 per cent in 2005, and decreased slightly to 77 per cent in 2010.

Since the introduction of the RRCS (in 1998) and the 2002 Act, the reporting rate has increased somewhat. One hypothesis attempts to explain the reasoning behind the unreported cases as a lack of ‘cognitive solidarity.’

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101 Regionale Toetsingscommissies Euthanasie, Jaarverslag [Regional Euthanasia Review Committees, Annual Report] (2013). Note according to the 2012 Annual Report of the RRCS, there were 4,188 reports of euthanasia. This is an increase of 13 per cent compared to 2011. See Regionale Toetsingscommissies Euthanasie, Jaarverslag (2012). Total number of VAE and AS reports: in 2011 = 3,695 cases; in 2010 = 3,136 cases; and in 2009 = 2,636 cases.

102 See the 2013 RRC Annual Report. Data consistently suggests that if patients are given the choice, they prefer to have their doctors do the procedure, see C. Gamondi, G.D. Borasio, C. Limoni, N. Preston and S. Payne, ‘Legalisation of assisted suicide: a safeguard to euthanasia?’, The Lancet 384(9938) (2004).

103 Note, another analysis came to the conclusion that this reporting rate was about 70%: see M. Rurup et al, ‘Trends in gebruikte geneesmiddelen bij euthanasie en samenhang met het aantal meldingen’ Nederlands Tijdschrift voor Geneeskunde 150: 618–24 (2006).


105 Prior to 1998, physicians were required to report cases of VAE or AS directly to the public prosecutors. Certain Dutch scholars speculate that placing the criminal prosecution services at a greater distance, and the RRCS jurisprudence may have encouraged physicians to report more frequently. See Onwuteaka-Philipsen, ‘The Unreported Cases’, in: Physician-Assisted Death in Perspective (n 5) 127.


107 See Griffiths, Weyers and Adams, Euthanasia and Law in Europe (n 5) 203.
In other words, there is a disconnect between those measuring/controlling what doctors do and what doctors perceive as necessary to report. Data suggests uncertainty in the physician’s mind about whether the administration of high dose opioids (rather than the drugs recommended for euthanasia\footnote{108} constituted euthanasia or pain relief with life shortening effect\footnote{109} According to an alternative analysis whereby the opioid cases are subtracted from the empirical studies, the 54 per cent reporting rate in 2001 rises to 90 per cent; the 80 per cent reporting rate in 2005 rises to 99 per cent; and the 77 per cent reporting rate in 2010 raises to 92 per cent.\footnote{110} Furthermore, data consistently identifies that the majority of patient requests for assisted dying are not performed.\footnote{111} Valuable information may also be obtained by examining the characteristics of deaths due to assisted dying. In 2010, it was reported that in 21 per cent of actually performed cases, the estimated life shortening effect was one month or more, this was slightly higher than in previous years (approx 8 to 16 per cent).\footnote{112} The majority of cases appear to shorten life by less than one month.\footnote{113} According to the 2013 RRC Annual Report, 74.3 per cent of reported

\footnote{108} The Royal Dutch Society for the Advancement of Pharmacy (KNMP) recommends the use of specific drugs for VAE and AS: the administration of a barbiturate to induce a coma, followed by a muscle relaxant that causes the death of the patient. If the patient is suffering so badly, it may be required to administer the barbiturate before the administration of the muscle relaxant. See Koninklijke Nederlandse Maatschappij ter bevordering der Pharmacie (KNMP), Toepassing en bereiding van euthanatica ['Application and preparation of drugs for euthanasia'] (The Hague: KNMP, 1998).

\footnote{109} ‘[B]y far the largest difference between reported and unreported cases lies in the drugs used, in combination with the designation given by the physician’ See B.D. Onwuteaka-Philipsen, ‘The Unreported Cases’, in: Physician-Assisted Death in Perspective (n 5) 135.

\footnote{110} See van der Heide et al., Tweede Evaluatie Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding (n 104) 232.

\footnote{111} The results of a 2005 (death certificate and physician questionnaire) study stated: ‘In about two thirds [of cases], the request did not lead to euthanasia or physician assisted suicide being performed, in 39 per cent because the patient dies before the request could be granted and in 38 per cent because the physician thought the criteria for due care were not met’, see B.D. Onwuteaka, M.L Rurup, H.R. Pasman, A. van der Heide, ‘The last phase of life: who requests and who receives euthanasia or physician-assisted suicide?’, Medical Care 48(7) (2010) 596–603. See also H, Roeline and W. Pasman, ‘When Requests Do Not Result in Euthanasia or Assisted Suicide’, in: Physician-Assisted Death in Perspective (n 5) 147–158.

\footnote{112} van der Heide et al., Tweede Evaluatie Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding (n 104) 233.

\footnote{113} See van der Heide et al., Evaluatie Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding, (n 104) 103, 113, 117, 120.
cases involved a patient suffering from cancer.\textsuperscript{114} More controversially, 2 per cent (97 reports) of cases in the same year involved patients suffering from dementia\textsuperscript{115} and 0.9 per cent (42 reports) of cases involved patients suffering from a psychiatric condition.\textsuperscript{116} A General Practitioner performed 88.6 per cent of all cases reported in 2013,\textsuperscript{117} while 78.6 per cent of cases were carried out in the patient’s home.\textsuperscript{118} Since March 2012, a controversial End-of-life Clinic [\textit{Levenseindekliniek}] came into operation. Described in the 2012 RRC Annual Report as a ‘peripatetic euthanasia team’, it is an initiative by the Dutch Association for Voluntary Euthanasia (NVVE) to help patients who cannot find a physician willing to otherwise help. The number of cases reported by the End-of-life Clinic totalled 32, while in 2013 this figure increased to 107 – all of which were considered by the RRC to have meet the criteria of due diligence.

Statistics regarding the type of patients receiving VAE and AS shed some (albeit reasonably limited) light on the risk legalisation incurs for vulnerable members of society and the potential ‘slippery slope’ to an increase in non-voluntary termination of life. The frequency of ending of life without explicit request has appeared to decrease since VAE and AS have been legalized (from 0.8 per cent of all deaths in 1990 to 0.2 per cent in 2010).\textsuperscript{119} Also, there appears no clear evidence for a higher frequency of VAE and AS among the elderly, people with low educational status, the poor, the physically disabled or chronically ill, minors or racial or ethnic minorities, compared with background populations.\textsuperscript{120} As for guidelines and practices in hospitals and nursing care

\begin{footnotesize}
\begin{enumerate}
\item Condition and number of reported cases of assisted dying in 2013: cancer = 3,588; cardiovascular disease = 223; disorders of the nervous system = 294; lung disease = 174; Dementia = 97; Psychiatric = 42; multiple aging complaints = 251.
\item This is an increase in cases compared to 2012 (42 reports). See 2012 RRC Annual Review.
\item This is an increase in cases compared to 2012 (14 reports). See 2012 RRC Annual Review.
\item Reporting doctors in 2013: general practitioner = 4,281; medical specialist in hospital = 213; specialist in geriatric medicine = 193; trainee medical specialists = 13; doctor with different background.
\item See the 2013 RRC Annual Report. In 2011, reported ‘dementia’ cases = 49, and reported psychiatric cases = 13. In 2012, these figures were 42 and 14, respectively.
\item In a 1990 study, 0.8 per cent of deaths studied were a result of ending of life without an explicit request. In 1995 and 2001 it was 0.7 per cent, in 2005 it was 0.4 per cent, and in 2010 it was 0.2 per cent. In all the studies, the most common reason given by physicians for not discussing the decision with the patient was due to the fact that patient was comatized or unconscious (31-48 per cent). Less common reasons were that the patient had been a neonate (5-21 per cent); and incompetent due to dementia (1-16 per cent).
\item M.P Battin et al., ‘Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in “vulnerable” groups; Journal of Medical Ethics, 33(10) (2007) 591–7. See also N. Steck, et al., ‘Euthanasia and Assisted Suicide in Selected
\end{enumerate}
\end{footnotesize}
homes, data suggests that information with regard to advanced VAE directives and due care criteria is not optimal. Other studies report the (illegal) involvement of nurses in the direct performance of VAE and AS.

In 1998, a body of independent specially trained VAE and AS consultants for doctors (known as SCEN) was established. These consultants provide

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European Countries and US States: Systematic Literature Review’, Medical Care 52(10) (2013) 938–944. The last mentioned study identified some common characteristics between legal systems that conditionally allow assisted dying (namely the Netherlands, Belgium, Luxembourg, Switzerland, and Oregon): ‘the typical person who dies with assistance was a well-educated male cancer patient’. In the Netherlands, the highest percentage (3.5–5.6 per cent) was seen among deaths in individuals under 64 years of age, while in Oregon PAS was most common in those aged 25-34 years (140.8 per 10,000 deaths), see ibid, 941.

See the conclusions of B.A.M. Hesselink et al., ‘Do guidelines on euthanasia and physician-assisted suicide in Dutch hospitals and nursing homes reflect the law? A content analysis’, Journal of Medical Ethics 38 (2012). According to other studies, the majority of Dutch physicians and medical students in the Netherlands did not know that advanced euthanasia directives were legal (under certain circumstances). See van der Heide et al., Evaluatie: Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding (n 108); B.A. Hesselink et al., ‘Education on end-of-life care in the medical curriculum: students’ opinions and knowledge’, Journal of Palliative Medicine 13 (2010).

A questionnaire (sent in 2003) responded to by 532 nurses revealed: in 45.1 per cent of cases, the nurse was the first with whom patients discussed their request for assisted dying; in 78 per cent of cases, consultation between physicians and nurses took place. In 15.4 per cent of cases nurses themselves administered the euthanatics with or without a physician. See G.G. van Bruchem-van de Scheur, A.J. van der Arend, H. Huijer Abu-Saad et al., ‘Euthanasia and assisted suicide in Dutch hospitals: the role of nurses’, Journal of Clinical Nurses 17 (2008) 1138–44. See also for a study of nurses in Flanders carried out in 1998 (the Dutch speaking part of Belgium): J.J. Bilsen, R.H. Vander Stichele, F. Mortier et al., ‘Involvement of nurses in physician-assisted dying’, Journal of Advanced Nursing 47(6) (2004) 583–91.

before-the-fact assessments regarding the nature of the patient’s voluntary request and suffering. From a 2012 national study, 74 per cent of assisted dying cases involved a SCEN consultant.124

Out of the 38,768 cases of assisted dying reported to the RRCs from 1999 to 2013, a total of 74 of the physicians (0.19 per cent of cases) were deemed not to have acted in accordance with the due care criteria.125 To date, there have been no prosecutions of reported cases and only 2 physicians have been sanctioned in medical proceedings. From 2007–2011, 27 cases of ‘not careful’ resulted in an unconditional discharge and 6 cases resulted in a conditional discharge126 (i.e. where the doctor is warned that he could be prosecuted for his misstep if he acts in a similar way again).127 The majority of cases which did not satisfy the due care criteria related to the independence of the consulted doctor and careful medical execution, a smaller number regarded the voluntary nature of the request, and the presence of alternative treatment.128 Furthermore, a total of 11 people have travelled from the Netherlands to Dignitas in Switzerland for assisted suicide since 1998.

4.2 Application and Enforcement of the Law

4.2.1 England

Due to the absolute criminal nature of assisted dying in England, it is natural that top-down command-and-control ensues (i.e. governance through the law). The only actors involved in the application and enforcement of the law are public129 – namely, members of the judiciary, public prosecutors, and law enforcement officers.

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124 See A. van der Heide et al., ‘Tweede Evaluatie Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding’ (n 104) 193.
126 van der Heide et al., ‘Tweede Evaluatie Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding’ (n 104) 217.
129 Arguably, one unique exception to this arises when private actors are required to act as jurors in trials before the Crown Court and Criminal Circuit Court.
One of the first court cases to deal with vae in England was the 1957 case of R v Adams.\textsuperscript{130} The physician administered large doses of morphine and heroi-ne in order to ease the suffering of a terminally ill elderly patient who died as a result. The Court applied the doctrine of ‘double effect’ and acquitted the physician of murder. This doctrine states (in this context) that a physician who prescribes pain relief that he knows will hasten the patient’s death, will not be guilty of murder unless his primary purpose was to cause the patient’s death. The reluctance to criminally charge a physician acting out of compassion was evident again in the R v Lodwig case.\textsuperscript{131} Dr. Lodwig gave his patient, who was in the terminal stages of cancer, a mixture of potassium chloride and lignocaine. This was ‘to treat uncontrollable pain’. The patient died a few minutes after the administration. Despite initially prosecuting Dr. Lodwig, the prosecutor offered no evidence against him during the proceedings, resulting in a not guilty verdict. Notwithstanding the certain foreseeability of fatality given the dosage administered, it was held that he did not intend the death (i.e. the Court applied the doctrine of ‘double effect’).

Two years later in R v Cox,\textsuperscript{132} a rare occasion occurred whereby the court convicted the accused physician. The deceased had rheumatoid arthritis and was suffering greatly. There was also evidence of a persistent request from the deceased for help in ending her life. Regardless, the doctor was found guilty of attempted murder\textsuperscript{133} due ‘to the most clear and compelling evidence’ from his own records that he did not just foresee, but in fact intended to cause her death. Justice Ognall proclaimed that Cox had betrayed his unequivocal professional duty, and required as a matter of principle, to be handed down a term of imprisonment. He was given a 12-month prison sentence, ‘but in recognition of the fact that the public interest would not be served immediately’ it was suspended. Furthermore, the General Medical Council (GMC) did not erase his name from the medical register and merely censored his conduct while he underwent re-training. Mention must also be made of the Dr Martin trial. The physician in question had been accused of accelerating the death of three patients. Despite, being acquitted of the criminal charges by the Teeside Crown Court, the GMC (in disciplinary hearings) found that in two of those instances the administration of drugs “more than minimally or trivially contributed to the deaths” of the patients, and that the injections given by Dr Martin “were

\textsuperscript{131} See The Times (16 March 1990).
\textsuperscript{133} Dr. Cox was charged with attempted murder because the deceased’s corpse had been cremated before the police investigation could prove actual causation.
not clinically justified". He was accordingly struck off the Medical Registrar. In relation to assisted dying not involving a medic, one particular high profile court decision must be noted. In the 2010 Gilderdale decision, a 12 person jury in Lewes Crown Court found a mother not guilty of the attempted murder of her daughter. The deceased was suffering from a severe irreversible form of ME. Over the 21 years she suffered from this condition, she repeatedly requested assisted suicide. Despite the accused's guilty plea to assisted suicide, the DPP chose to file for the charge of attempted murder. Upon a verdict of not-guilty, the judge paid tribute to the jury for showing 'decency' and 'humanity'.

Regarding the 91 investigations of assisted suicide brought to the attention of authorities, 65 were not proceeded with by the DPP, 13 cases were withdrawn by the police and 1 resulted in prosecution. There are (at the time of writing) 8 on-going investigations. A number of investigations involved 'suicide tourism', whereby sufficient evidence existed to prosecute but having weighed up the factors, the DPP decided against sanctioning such behaviour in the 'public interest'. Furthermore, some well known individual claims have come before the High Court, the Court of Appeal and the Supreme Court, seeking a

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134 N. Bunyan, 2010. 'GP Howard Martin accused of ending the life of more patients' The Telegraph, 30 July; See also 2013. 'Dr. Howard Martin: timeline of investigation in patient deaths' The Telegraph, 14 March.

135 See also the 2010 Criminal Court of Appeal decision in Inglis [2010] All ER (D) 140; where the defendant was convicted of murder. In this instance of 'mercy killing', the deceased was in a severe coma and unable to make a voluntary request.


137 She did attempt to commit suicide on her own a number of times but due to her disability had failed, causing further injury and suffering.


139 The following data on such cases is from the Crown Prosecution Central records (n 83).

140 This was quite an exceptional case in light of the others: the accused had supplied the victim, whom he knew was suicidal, with the means (a lighter and petrol) to set himself a light.

141 In these cases, the DPP has the choice to prosecute family members and/or doctors who assist in helping a person travel to Switzerland for assisted suicide.
declaration that the current law on VAE and AS is incompatible with the Human Rights Act 1998 (namely the right to private life).\(^{142}\) Recently a claim was also made to permit the defence of necessity should a doctor perform VAE as the only means to end suffering. Both of these claims were rejected. The claim to extend the defence of necessity was refused, as it would effectively create a new law – arguably beyond the power of the Court.\(^{143}\) As for the human rights claim, it was consistently held, prior to the Supreme Court decision in 2014, that it would be inappropriate for the Courts to declare the current law incompatible with human rights.\(^{144}\) However in said decision, Lady Hale and Lord Kerr did argue (contrary to the other seven trial judges) that the current ban on assisted suicide is incompatible with Article 8 of the Human Rights Act (HRA) 1998. Also in the same decision, Lord Neuberger, Lord Mance, and Lord Wilson, although refusing to declare the law incompatible with the HRA in this instance, did not rule out the possibility of a declaration of incompatibility being made in the future once the parliament has been given time to assess the issue.\(^{145}\) In any case, it was made clear from the case-law that any reform of the law on this matter is preferably an issue for Parliament.

4.2.2 France

Similar to England, the blanket ban nature of assisted dying in France means it remains in the stronghold of governance through the criminal law. Here the only actors involved in the application and enforcement of the law are the judiciary, public prosecutors and law enforcement officers.\(^{146}\)

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142 See Pretty v Director of Public Prosecutions [2001] EWHC Admin 788 (QB); Pretty v DPP [2002] 1 AC 800 (HL); R (on the application of Purdy) v Director of Public Prosecutions [2009] UKHL 45; Nicklinson v Ministry Of Justice [2012] EWHC 2381 (Admin); Nicklinson and Lamb v Ministry of Justice [2013] EWCA Civ 961; R (on the application of Nicklinson and another) (Appellants) v Ministry of Justice (Respondent); R (on the application of AM) (AP) (Respondent) v Director of Public Prosecutors (Appellant); R (on the application of AM) (AP) (Appellant) v Director of Public Prosecutors (Respondent) [2014] UKSC 38.

143 See in particular the decision: Nicklinson v Ministry Of Justice [2012] EWHC 2381 (Admin).

144 For example: See Nicklinson and Lamb [2013] EWCA Civ 961, per Lord Justice Elias at para. 155: ‘Parliament represents the conscience of the nation. Judges, however eminent, do not; [...] we cannot suspend or dispense with primary legislation'; Nicklinson v Ministry of Justice [2012] EWHC 2381 (Admin), per Lord Justice Toulson: ‘Some will say the Judges must step in to change the law. Some may be sorely tempted to do so. But to do so here would be to usurp the function of Parliament in this classically sensitive area.’


146 Arguably, one unique exception to this arises when private actors are required to act as jurors in trials before the Cour d’Assise.
In the Duffau\textsuperscript{147} case, a doctor instantly ended the life of a 92 year-old patient who was ‘suffering unbearably’ upon the patient’s request.\textsuperscript{148} In disciplinary proceedings before the Regional Medical Board, the doctor was found guilty of intentionally causing his patient’s death. This finding was upheld by the \textit{Conseil d’État}. Despite being aware of the disciplinary decision, the prosecution authorities refused to open a criminal investigation or initiate any criminal charges. In 2003, the highly publicised Humbert\textsuperscript{149} case fuelled numerous government discussions, public opinion surveys and media reports. A 22 year old had been left mute, blind and paralyzed from a car accident. He unequivocally expressed his desire for assistance in ending his life.\textsuperscript{150} His mother injected him with barbiturates before his physician injected him with potassium chloride, resulting in death. Both faced criminal charges. However, the court followed the DPP’s request to dismiss the trial, ‘given the particular moral circumstances’. The judge held that both of the accused acted out ‘of love’ and ‘compassion’ and in light of the public reaction; an order of \textit{non-lieu} must be issued. Both were exonerated of the charges.

In the 2007 Tramois case, a doctor and nurse were prosecuted\textsuperscript{151} for providing a lethal injection to a cancer patient in the terminal phase, upon her request. According to the case report, she was suffering greatly despite massive doses of morphine. The \textit{Cour d’Assize} finally acquitted the nurse. The doctor, however, was found guilty of murder and sentenced to a symbolic one-year suspended jail sentence. It was not recorded on her criminal record and both medics eventually returned to work (having also served disciplinary suspensions from the Medical Council). In June 2014, the \textit{Cour d’Assize} in Pau acquitted Dr Bonnemaison of administering poison to hasten the death of seven patients. Despite the fact that the accused doctor had used a ‘banned poison’, the jurors held that ‘it had not be proven’ that by administering the sedatives that he intended to kill his patients.\textsuperscript{152} It was accepted that he had taken

\begin{itemize}
\item \textsuperscript{147} See \textit{Conseil D’État}, 29 December 2000, no. No. 2128\textsuperscript{13}. For an online version of this decision go to: \texttt{http://basedaj.aphp.fr/daj/public/index/display/id_theme/403/id_fiche/9389}.
\item \textsuperscript{148} Evidenced by the doctor in question and the attending medical staff.
\item \textsuperscript{149} See \textit{Le Monde} (26 September 2003); See also Chapter 9 ‘Studying Bioethics in France’, in: R.C. Fox and J.P. Swazey, \textit{Observing Bioethics} (Oxford: Oxford University Press, 2008).
\item \textsuperscript{150} Recorded via functional lines of communication (hearing and right thumb) in a letter to then president Jacques Chirac.
\item \textsuperscript{151} The son of the deceased, who like his father refused to bring civil charges, declared he was “sad and disgusted” by the decision to bring the two women before a court “as criminals”.
\end{itemize}
‘medically justified’ steps to end the agony of patients who only had a short period of life expectancy left. An appeal to overturn the decision has been made, however at the time of writing a trial date has not yet been decided.

As in England, the French judiciary\(^{153}\) has also faced individual claims seeking for the prohibition on euthanasia to be overturned. In 2008 a Dijon court\(^{154}\) rejected a claim to permit euthanasia with a lethal dose of barbiturates provided the patient’s suffering was untreatable and unbearable. This rejection was, according to the Court, based on the clear prohibition in the criminal code and the inability to usurp the legislators’ preference. It was made clear that French judicial decisions are limited to a narrow interpretation of the criminal code and may not set precedent for the future, effectively creating new law.\(^{155}\)

4.2.3 Switzerland
Unlike the English and French approach, the Swiss approach to assisted dying cannot be easily categorised. On the one hand, the application and enforcement of the law on VAE is dominated by public actors (police officers, prosecution services, courts) – it is a case of governance through the criminal law. On the other hand, the application and enforcement of the law on AS is initially in the hands of private actors (RTD organisations\(^{156}\) and professional medical councils), with public actors (police and prosecutors) playing a secondary role. Compared to England and France, this is more a case of ‘governance in the law’.

Most notably, RTD organisations are responsible for drafting and complying with their own internal guidelines when performing AS.\(^{157}\) Some common procedural and substantive steps may be identified in this respect.\(^{158}\) All relevant

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153 Rather exceptionally, both former Presidents Jacques Chirac and Nicolas Sarkozy also received direct individual pleas to allow for VAE – from Humbert and Sebiré.
156 These private associations play a more central role than physicians in facilitating an AS since they continually provide information to the public, screen members, acquire the prescription, assess decisional capacity and then contact the police and other relevant authorities after the performance of an AS. See Ziegler, ‘Collaborated Death: An Exploration of the Swiss Model of Assisted Suicide for Its Potential to Enhance Oversight and Demedicalize the Dying Process’ (n 57) 324; Ziegler and Bosshard, ‘Role of Non-governmental Organisations in Physician Assisted Suicide’ (n 57).
157 Ziegler, ‘Collaborated Death: An Exploration of the Swiss Model of Assisted Suicide for Its Potential to Enhance Oversight and Demedicalize the Dying Process’, (n 57) 323.
158 See the conditions of each RTD as laid out on their websites (n 65).
medical reports, including a certificate confirming faculty of judgement, must be obtained and reviewed. An in-person interview is arranged where questions and alternatives are discussed. Upon the patient's reconfirmation for AS, the organisation will request a physician (be it a general practitioner, the attending physician, or a consultant doctor working at the association) to prescribe a lethal drug. On the agreed date of suicide, the patient must be able to take the final step on their own. Once the suicide has occurred, the local police service should be informed of an ‘extraordinary death’. This results in a standard ‘legal inspection’ whereby the police arrive at the scene, normally with a medical officer of the state health department, to clarify that everything fell within the scope of the law. It is not uncommon for the volunteer to have recorded the suicide for practical evidential purposes.

There have been a small number of trials and very few criminal convictions or medical disciplinary charges for assisted dying. In 1990, an Exit volunteer was convicted for killing two people who had expressed their desire to die. He suffocated them with a plastic bag after their attempted suicide had failed. He was handed a suspended six month sentence. In 2004, the Zurich Administrative Court revoked a doctor's licence to prescribe controlled substances. He had prescribed, more than once, a lethal substance to be used in a suicide without making a personal assessment of the recipient. In the same year, the Aargau Administrative Court revoked a doctor's licence for failing to make a careful medical diagnosis. In this case the doctor had also failed to write a medical report. In 2007, the Basel Criminal Court sentenced a psychiatrist to three years in prison (two years probation) for failing to take proper care in his own RTD organisation. The doctor had failed to assess competency and, due to broadcast a number of assisted suicides on TV, was deemed to be acting out of a selfish motive for self-publicity.

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159 Ziegler, ‘Collaborated Death: An Exploration of the Swiss Model of Assisted Suicide for Its Potential to Enhance Oversight and Demedicalize the Dying Process’, (n 57) 323–325.
160 Ibid.
161 Lewry, Assisted Dying in Europe and America: Four Regimes and their Lessons (n 67) 88–109.
Just as in England and France, individual attempts to challenge the law have been made before the highest Swiss courts. Moreover, two rather recent rights-based challenges to Swiss law were brought before the ECtHR. In Haas v Switzerland,165 it was decided that the rule upheld by the Swiss court requiring a prescription for a lethal drug (sodium pentobarbital) to be based on a psychiatric assessment had a legitimate aim, and was not a violation of the applicant’s rights under Art. 8 ECHR. In Gross v Switzerland,166 the Chamber of the Court held that there had been a violation of Article 8 due to the unclear nature of Swiss law as to when AS is permitted or not. The case was referred to the Grand Chamber at the request of the Swiss government. Here it was held that the Chamber judgment was not legally valid as the applicant was found to have abused the right of individual application by misleading the Court.167

4.2.4 The Netherlands
In comparison to England and France, the approach to permit assisted dying under certain conditions in the Netherlands has meant that the application and enforcement of the current law mandates public-private actor interdependence. In comparison to Switzerland where only AS is permitted, this interdependence takes a very different form. The Dutch prosecutors and courts may of course still be called upon to act in the final instance. Nonetheless, the role of doctors in self-reporting, ex ante control by expert consultants and ex post assessments by non-criminal regional review bodies precedes (and determines) any involvement of police officers, prosecution authorities and court action. Attention to the application and enforcement of the law in the Netherlands prior to the 2002 law will be given in Section Six below, which looks at how formal legal change was effected. Here, attention is paid to the application of the control system in practice post the 2002 Act.

The annual reports of the Regional Review Committees (RRCS) provide a decent overview of the process of decision making and evaluation.168

165 Haas v. Switzerland, no.31322/0, ECHR 2011.
166 Gross v. Switzerland, no. 67810/10, ECHR 2013.
167 Gross v. Switzerland [GC], no. 67810/10, ECHR 2013. The patient had in fact died before the first hearing at the ECHR. The Grand Chamber found that the applicant had ‘intended to mislead the Court on a matter concerning the very core of her complaint. In particular, she had taken precautions to prevent information about her death from being disclosed to her counsel, and thus to the Court, in order to prevent the latter from discontinuing the proceedings in her case.’
168 There are well over a hundred (anonymised) cases involving particularly complex, new or borderline situations that are available in the reports. These are made available deliberately for the purpose of providing guidance and clarity for physicians in similar future situations.
The publication of particularly complex cases therein has helped to develop a type of RRC 'jurisprudence'. This fills in the regulatory gap between practice, diverse situations and what is permitted within the exception to the criminal law. Most of the cases are relatively straightforward and clear to assess – the information is largely deemed adequate and the legal norms (based on the test of reasonableness)\textsuperscript{169} are often understood as fulfilled.\textsuperscript{170} This is despite the inevitable abstraction of notions such as 'unbearable suffering' and 'voluntary, well considered request'.\textsuperscript{171} Two of the more controversial talking points with regard to the RRCs decisions will be described here: (i) reports submitted by physician's working for End-of-Life clinics; and (ii) cases whereby patients suffered from dementia or psychiatric conditions.

As for the former, the End-of-Life clinic (described above in Section 4.1.4) has received both professional\textsuperscript{172} and academic\textsuperscript{173} criticism. Opponents of the clinic restate a position generally assumed as valid before the enactment of the 2002 law: the attending/treating doctor must be the same doctor who performs the VAE or AS.\textsuperscript{174} In short, the End-of-Life Clinic raises doubts and concerns over the doctor-patient relationship (or rather the potential lack thereof). The

\textsuperscript{169} The physician must make it plausible that he could 'reasonably conclude' that the statutory due care requirements were complied with – see RRC Annual Report 2010, 7.

\textsuperscript{170} It is clear that the increasing role of SCEN is helping to standardise and improve the quality of the reports. The Regional Review Committees, the Medical Inspectorate, the Royal Dutch Medical Association (RDMA), the prosecutorial authorities, and the Government actively encourage the use of accurate due care policies and SCEN consultation.

\textsuperscript{171} These material conditions are somewhat intentionally open. The flexibility and freedom to develop new interpretation was explicitly encouraged during the political debate in the Dutch Parliament. See Kimsma and van Leeuwen, 'Reviews After the Act: The Role and Work of Regional Euthanasia Review Committees', in: Physician-Assisted Death in Perspective: Assessing the Dutch Experience (n 5) 198–199.

\textsuperscript{172} The RDMA expressed its apprehension regarding the clinic at an early stage of its formation: 'it is only in such a long-term treatment relationship that a bond of trust between patient and physician can develop. [...] The End-of-Life Clinic's mobile teams assess the request for euthanasia in isolation from other care requirements and the patient’s medical history. The RDMA considers this to be undesirable.' J. Legemaate and I. Bolt, ‘The Dutch Euthanasia Act: Recent Legal Developments’ European Journal of Health Law 20 (2013) 451–470. The RDMA statement is available at: <knmg.artsennet.nl/Nieuws/Nieuwsarchief/Nieuwsbericht-1/knmg-huiverig-voor-Levenseindekliniek-1.htm>.

\textsuperscript{173} For example Den Hartogh raises some interesting questions regarding the legality of the association, see G.A. den Hartogh, ‘Levenseindekliniek binnen de grenzen van de wet?’, Tijdschrift voor Gezondheidsrecht 35 (2011) 212–216.

\textsuperscript{174} See Weyers, ‘Physician Assisted Death in Western Europe: the legal and empirical situation’, in: Palliative Care and Ethics (n 5) 290.
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RRCs, along with the Minister of Health, Welfare and Sport, concluded that the 2002 law does not require that termination of life on request should only be carried out by the physician who is treating the patient. In all reported cases involving the clinic, the due care criteria were understood as fulfilled. According to the RRC reports, a cautious procedure for both the outpatient phase (intake and assessment) and implementing phase (when termination of life actually occurs) presented no reasonable ground to find a case of ‘not careful’.

As for the second point, the Supreme Court held in 2002 that the suffering of a patient should have a basis in some ‘medically classifiable’ somatic or psychiatric disease in order to justify a physician’s involvement. The RRCs have received a marked increase in dementia and psychiatric cases, as the initial reluctance to consider such cases appears to be waning. All of the cases concerning patients with psychiatric problems were deemed ‘careful’, with the RRC stressing the need for the physician’s response to be ‘considered especially

175 In a letter to the House of Representatives in February 2011, said Minister reasoned that no de jure obstacle existed prohibiting such clinics. Any question of compatibility is dependent on whether the physician’s activities fall within the boundaries of the law. Also, the Minister did not exclude the exceptional performance of assisted dying in such a clinic on patients suffering from dementia or psychotic disorders. See Parliamentary Documents II 2010–2011, 32647, No. 1, 2; Parliamentary Documents II 2011–2012, 32647, No. 4, 25.

176 In response to a patient’s request for assisted termination of life, a written questionnaire is requested, as is access to medical data in order to compile a record. A trained nurse and doctor then examine the record, meetings are arranged with the patient to assess the nature of the suffering and the request. Attempted contact is made (most often successfully) with the patient’s treating doctor – a consultant is then contacted and consulted, before the case is presented to internal multidisciplinary consult group and reviewed entirely once again before any performance of assisted dying takes place. See 2012 RRC Annual Report, 6.

177 The ‘Brongersma case’, Nederlandse Jurisprudentie 2003, no 167. Here the physician assisted a patient who was reported to be ‘tired of life’. As no medically classifiable disorder was present, this was deemed to fall outside the scope of his professional competence. The physician was found guilty, but no sentence was imposed. The RRCs stress that the concept ‘weary/tired of life’ [levensmoe] as presented in a number of reports is distinct from the meaning attributed to the term in popular debate. In the RRC case-law, it is held that any weariness of life must be predominantly due to a medically classifiable illness or condition. See RRC 2010 Annual Report, 6–7. A combination of old age afflictions, the experiences of pathological grief or clinical depression were deemed to be capable of falling within the scope of what is unbearable suffering ‘in a medical context’. See 2009 RRC Annual Report, 22–23 (Case 9); 2011 Annual Report, 28–29 (cases 10 and 11); 2011 Annual Report, 33–34 (Case 13); 2012 Annual Report, 19–20 (Case 8).

178 See the ‘Foreword’ of the 2012 RRC Annual Report.
carefully.\(^{179}\) To assess the voluntary and well considered nature of the request, the RCC consider it ‘important to consult not only an independent physician but also one or more experts, including a psychiatrist.'\(^{180}\)

As for the dementia cases, there are two issues to take account of depending on the development of the illness. In early-stage dementia, the main concern is the fulfilment of ‘unbearable suffering’. The RRCs were satisfied in all reported cases that the patient could competently assess their prognosis and had reasonable insight into their future (expected loss of orientation and personality). This was deemed as a real and painful combination that may be medically classifiable as ‘unbearable’. In 2012, one case was however considered ‘not careful’ due to concerns over the independent assessment.\(^{181}\) No prosecution was initiated after further inquiries into the case. In late-stage dementia (less common in the reported cases than early-stage dementia), the main concern is the acceptability of an advanced written request. The RRCs acknowledge that in such cases decisional competence is less likely to be present and that ‘it is essential there is a record of the patient expressing the wish for euthanasia in the past, namely a clear advance directive written by the patient when still decisionally competent, which incontrovertibly applies to the situation at hand’\(^{182}\) One case regarding an advanced written request was deemed ‘not careful’ (the second dementia case to be deemed so in 2012). The concern in this case was a lack of proof regarding the repeated discussions. Again, no prosecution charges were deemed necessary in light of further investigation.

There have been a small number of prosecutions and medical disciplinary proceedings for doctors\(^{183}\) who did not report, as well as convictions of lay persons for assisting suicide.\(^{184}\) Rather recently, Gerard Schellekens, the

\(^{179}\) 2012 Annual Report, 12.
\(^{180}\) Ibid., 11.
\(^{182}\) Ibid.
\(^{183}\) Most notably the conviction of Dr Sutorius (in the Brongersma case mentioned above). See also the convictions in the Van Oijen case, Hoge Raad, 9 November 2004; Nederlandse Jurisprudentie 2005 no 217 and the Vencken case, LJN: AU0211, Court of Appeal, ’s-Hertogenbosch, 20-000303-05.
\(^{184}\) A number of cases involved lay persons (sometimes known as ‘suicide-consultants’) who work voluntarily for organisations that give advice and support for people contemplating suicide. In one case, a ‘consultant’ was sentenced to twelve months imprisonment of which eight were conditional: LJN: AR 8225, Supreme Court, 01853/04. In another case, a ‘consultant’ was also handed a twelve months, of which eight were conditional: LNJ: AX7270, Court of Appeals Amsterdam, 23-006489-05. See S. Ost and A. Mullock, ‘Pushing the Boundaries of Lawful Assisted Dying in the Netherlands? Existential Suffering and Lay assistance’, European Journal of Health Law 18(2) (2011) 163–189.
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ex-chairman of SVL (Voluntary Life Foundation) was found guilty of knowingly violating the 2002 Act. Although not a doctor, Schellekens aided an 80-year-old woman end her own life who had been suffering from Parkinson's disease for 15 years. The Court emphasised that the Dutch legislation evidenced the legislature's intention that as should only be lawful under medical supervision and where a doctor's decision would be scrutinised afterwards. He was sentenced to a one year suspended prison sentence. In October 2013, Albert Heringa was found guilty for assisting in the suicide of his 99 year old mother. Heringa, a non-medic, had assisted his elderly mother because she had persistently claimed to be tired of old age, and could not find a willing physician to help fulfil her request. Despite a guilty verdict, no punishment was handed down as the Court was satisfied that Heringa had acted out of love.

5 Critical Analysis of ‘The Law in the Books’ v ‘The Law in Action’

Having looked descriptively at ‘the law in the books’ and ‘the law in action’, it is now important to comparatively critique any discrepancies between the two. First, England and France will be looked at together due to the commonalities identified in both jurisdictions. Switzerland and the Netherlands will then be addressed in turn.

In the few VAE cases that came before the courts in England and France, one can identify discrepancies - particularly in the punishment of offenders. The courts rely on techniques such as the doctrine of double effect or jury nullification to find the accused not guilty. Although the result sought (not to criminally sentence a compassionate physician) is commendable, such legal techniques as a means of doing so are questionable. In both jurisdictions, VAE is deemed an act of murder. This requires the proof of an intention to kill. In England, it is a well-established principle of criminal law that intent is inferred from the reasonable/certain foreseeable consequences of your actions. A desire (or primary purpose) to kill is irrelevant once it is established that the

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185 Hof Arnhem 17 februari 2012, LJN BV6139.
186 Rechtbank Gelderland, 06/950537-10. This is a well known case, known as the ‘Moek’ case. The accused recorded the suicide and his assistance therein. It was broadcast on a Dutch television network in Feb 2010.
187 This is when the jury is given the option to acquit on compassionate grounds, even if the accused has no defence in law.
result was foreseeable. Under French law, proof of ‘special intention’ is required for a charge of murder. Here, ‘intent’ is based on the desire to commit the wrongful act, not a desire to achieve the exact result of that act. It is irrelevant if the accused had either the cruel desire to end life or a compassionate desire to end suffering, once it is established that he/she had a desire to commit the act that caused death. However as evident in Section 4.2.1 and 4.2.2 respectively, the courts in both countries have frequently discarded this fundamental point of law. Instead, a unique subjective understanding of ‘intent’ in criminal law has been frequently made to find the doctors not guilty. A doctor who intends to bring about the death of a patient (his primary purpose/desire) by injecting a large dose of morphine is guilty of murder. However, a doctor who intends to relieve the patient’s pain (this being his primary purpose/desire) with that same dosage of morphine, and who foresaw death as a reasonable/certain consequence, is not guilty. The making of such a distinction creates a doctrinal tension in both jurisdictions between the established objective meaning of intent in criminal law and the subjective concept of intent to resolve cases of VAE.

If this distinction is workable, one may ask what is the intent (primary purpose/desire) of the doctor in the Netherlands who performs VAE? Given that the patient’s suffering must be unbearable and irrepresible (required by law to be verified by an independent consultant), any subsequent termination of life is performed on the prerequisite of relieving unbearable pain. Thus, the doctor’s primary intention/desire (although certainly ending life in the process) must be the alleviation of the patient’s pain. The doctrine of double effect appears to have little legal benefit in such cases. Arguably, the defence of medical necessity provides a more coherent explanation for exempting physicians from criminal liability, applying – objectively - to situations where the doctor is faced with the choice of leaving the patient without adequate relief, or administering what is likely to be a fatal dose as the only means to relieve severe untreatable pain.

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190 In England, see the Dr. Adams, Dr. Lodwig and Dr. Martin decisions (Section 4.2.1, above); whereby the respective doctors were found not guilty despite the fact that they administered morphine and potassium, respectively, with fatal (certainly foreseen) consequences. In France, see the Humbert decision (Section 4.2.2, above); whereby the accused was acquitted of murder charges due to the overwhelming compassion to alleviate suffering and ‘moral aspects of the situation’ despite the foreseeability of a resulting death.
Whilst in the majority of cases in England and France doctors have escaped criminal liability, there have also been a few, very similar, cases in which convictions (and disciplinary sanctions) have ensued. Thus, the techniques described above to circumvent the apparent harshness of the law are not always applied. In France, public authorities have, on occasion, been made aware that a doctor or lay person had performed VAE but refused to initiate any criminal prosecution. However when Dr. Tramois performed VAE in circumstances akin to those that went unnoticed, she was criminally prosecuted and handed a one year suspended jail sentence. Similarly in England, the Dr. Cox case was a rare instance where the Court did not avoid imposing a criminal sentence (albeit, a 12-month suspended sentence).

Another concern becomes apparent here. Qualifying VAE as an act of murder, by definition makes it a ‘serious offence’. Yet on the rare occasions when a guilty verdict of murder is reached, the sentence is minimal given the ‘public interest’ not to seriously sanction such behaviour (at most a suspended jail sentence). This suggests a disconnect between the law on the one hand and common views of reprehensibility on the other. Essentially, VAE remains an illegal and covert practice (somewhat empirically evident) but occasionally permitted on unconvincing legal grounds. Upon such reflections, one may question if the blanket ban on VAE in England and France may be deemed suitable, necessary or effective in ‘the public interest’.

As for the English and French approach to AS, a number of problems also arise. First, there is a greater disdain for close professional medical assistance than for other forms of assistance. In England, the DPP policy states that prosecution is more likely if the suspect was acting as a healthcare professional and the patient was in his/her care. In France, if a doctor prescribes drugs to a patient for the purpose of that patient’s suicide he or she may face disciplinary sanctions. Second, AS may be permitted regardless of the patient’s condition (treatable or not). No regard is given to the patient’s degree of suffering, provided the assistor acted ‘compassionately’ (in England) or did not incite the suicide (France). And third, it appears that by prohibiting professional assistance, the English and French legal systems rely on the ‘Swiss option’ or ‘suicide tourism’ to fill in the gap. As recognized above, 182 English patients and 137 French patients (at the time of writing) have travelled to Dignitas in Switzerland for assisted suicide over the past ten years. This is hardly a satisfactory alternative. This option is limited to patients who can afford the costs, and to those

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191 As particularly evident in the Daffau case (Section 4.2.2, above) – whereby, the doctor was found guilty of intentionally ending the life of his patient in disciplinary proceedings before the French Medical Council, yet not criminally investigated.
who are physically capable of travelling (able bodied patients). Such a law arguably accommodates a discriminatory undertone. Also, evidence has been given that some patients who fear due to their progressive illness that they may not be able to physically travel in a few months, feel compelled to travel and thus end their life far earlier than otherwise desired.\footnote{See Final Report by Commission on Assisted Dying, (Demos, 2012) 101. Available at: <www.demos.co.uk/files/476_CoAD_FinalReport_158x240_I_web_single-NEW_.pdf?1328113363>.}

Moving on to the Swiss approach itself, a number of critical remarks may also be made about ‘the law in the books’ and ‘the law in action’. As alluded to above there is no federal-level regulation of AS. ‘The law in the books’ comes from a variety of sources. Nonetheless, it appears that the reporting rate of AS is quite good when right-to-die (RTD) organisations are involved.\footnote{See in regard to Dignitas and Exit: the rate of reported AS corresponds with the empirical data carried out by Eureld on the occurrence of AS in Switzerland. See Bosshard, ‘Switzerland’, in: Griffiths, Weyers and Adams, Euthanasia and Law in Europe (n 5) 479.}
The internal guidelines and policies are well respected. This may be true, but there are also a number of problems which arise in practice from such a fragmented delegation of responsibility.

Leaving aside the public criticism and disputes with public authorities,\footnote{Dignitas has been at the centre of much criticism. For example, the organisation has had an injunction granted against it from working next to a busy brothel, see M. Leidig, 2008. ‘Suicide ‘factory’ reopens – next to a brothel’ The Guardian, 16th March. It has also been on the end of numerous allegations by ex-employees. One accused the organisation of being a ‘production line of death concerned only with profits’, see P. Sawer 2009. ‘Dignitas founder accused of profiting from assisted suicides’, The Telegraph, 10 January.}

there are concerns over the transparency of Swiss RTD organisations. Although the actual act of assistance is recorded and certain documents are reviewed by police, the events preceding the act or potential act raise a host of questions. Such as how do volunteers (or internal ethics committees) decide especially difficult cases? What training and supervision of the assistors is provided? What relationship does the prescribing doctor have with the voluntary association? What is the financial breakdown of these ‘non profit’ organisations?

This last question raises another specific point. The general understanding by the Swiss prosecutors, courts and legislators of ‘selfish motives’ as stated in Art 115 of the Penal Code is questionable. It is generally understood that benefiting materially from a person’s suicide is a selfish motive. The Swiss judiciary also deemed certain non-material benefits sufficiently selfish to act in breach of the law, such as the desire for fame (i.e. where the AS is televised or
broadcasted somehow). Nonetheless, the reality is that right-to-die societies, although formally ‘non-profit organisations’ consisting of volunteers, do charge quite hefty medical and legal fees. Dignitas may cost anywhere in the region of €4,000 for preparation and suicide assistance, up to €7,000 in case of taking over duties such as funerals, medical costs and official fees. With no public access to the financing of such organisations, one may legitimately ask two questions: why are the standard fees so high for a non-profit organisation? And, given the amounts involved (i.e. that the costs are above mere expenses for drugs or standard consultation time), is it reasonable to maintain that certain individuals are not materially benefiting?

Another issue with the Swiss approach is that of substantive equality. The Swiss Federal Supreme Court recognised the underlying idea behind the Swiss law on assisted dying is that autonomous individuals have the right to decide the time and manner of their own death. However the current system limits this right to only those who have a certain physical capability (i.e. persons who can take the final act themselves). Although, the right to die organizations have fully utilized modern technology in order to minimize this group of persons (i.e. by availing of various methods that only require a small amount of physical capability to administer the lethal drug), the reality remains that certain individuals, regardless of their terminal or unbearable suffering cannot avail of the right to assisted dying by simple fact of their physical capacity. In this sense, the law maintains an indirectly discriminatory practice.

Recognizing the risks of ‘transplanting’ the Dutch experience of euthanasia into jurisdictions of different socio-political traditions, we can still learn from the identified commonalities or differences in how Dutch law is applied and enforced. It must be stated that legal control is not perfect in the Netherlands. A number of specific shortcomings and inherent difficulties regarding the practice may be identified.

First, data (albeit limited) suggests that guidelines in hospitals and nursing homes regarding advanced directives for VAE and the due care criteria do not

See Spoendlin, Suizidhelfer muss hinter Gitter. Neue Gesetzesauslegung in der Schweiz (n 164); Bosshard, ‘Die Tätigkeit der Sterbehilfsorganisationen und die Rolle des Arztes’ (n 164).


See Schweizerisches Bundesgericht [Federal Supreme Court of Switzerland], Entscheid 2A.4812006, 2006. The Court based its decision not only on the Swiss Constitution, but also on the European Convention of Human Rights.

reflect the complete picture. A number of institutional guidelines are stricter than the 2002 law – namely, in 79 per cent of guidelines a written advanced directive is always necessary and in 19 per cent consideration must be had to ‘life expectancy’. The stricter guidelines are either a deliberate choice by the institutions, or the result of under-awareness of the legal boundaries. To protect the substantive freedom to choose a different healthcare institution, patients and physicians should be made explicitly aware (preferably in the relevant guidelines) that the internal rules go beyond the requirements of the law. Better dissemination of the 2002 law and more clarity on what distinguishes VAE from pain relief with life shortening effect is also required amongst health care professionals. The latter would be particularly useful to help improve the accuracy of the reporting rate.

Second, close attention needs to be paid to the role of the nurse in institutional practice guidelines. The majority of hospitals and nursing homes recognise the role of the nurse in the consultation and decision making process, but research also identifies that less than half of the guidelines actually describe the role of the nurse in the performance of assisted dying. Given that certain empirical evidence suggests the direct performance of assisted dying by nurses (however minimal or not) this seems a reasonable concern.

199 Hesselink et al., ‘Do guidelines on euthanasia and physician-assisted suicide in Dutch hospitals and nursing homes reflect the law? A content analysis’ (n 121) 35–42.

200 By no means is it considered against the law for a medical institution to issue stricter or more restrictive guidelines. Furthermore under Dutch law, no doctor in the Netherlands may face a legal duty to perform VAE or AS. See also the European Resolution 1763, 2010 (1), adopted by the Parliamentary Assembly of the Council of Europe, ‘The right to conscientious objection in lawful medical care’. This states: ‘no person, hospital or institution shall be coerced, held liable or discriminated against in any manner because of a refusal to perform, accommodate, assist or submit to (among other things) euthanasia.’

201 Some guidelines categorically excluded certain types of patients: 30 per cent of nursing homes were estimated to exclude cases of dementia and 25 per cent also excluded incompetent patients. See Hesselink et al., ‘Do guidelines on euthanasia and physician-assisted suicide in Dutch hospitals and nursing homes reflect the law? A content analysis’ (n 121).

202 Certain data indicates that a substantial number of physicians and medical students are unaware of the permissibility of assisted dying by an advanced written directive. See Ibid., and also Hesselink et al., ‘Education on end-of-life care in the medical curriculum: students’ opinions and knowledge’ (n 121).

203 Hesselink et al., ‘Do guidelines on euthanasia and physician-assisted suicide in Dutch hospitals and nursing homes reflect the law? A content analysis’ (n 121).
Third, there is an inherent difficulty in realising a fundamental criterion of the law: the determination of what is ‘unbearable suffering’. The RRCs recognise that suffering is a subjective experience, originating in bodily symptoms (e.g. pain, itching, nausea) or functional losses (e.g. sight, balance, memory, digestion). Although the RRCs insist that in assessing ‘suffering’ the physician must adopt the patient’s point of view – they equally maintain a degree of objectification must be possible. Leaving aside this contested standpoint and notwithstanding the validity of Cassell’s seminal definition of suffering as physically and/or psychologically-based, extreme caution must be taken in borderline cases. This is particularly so in cases involving advanced written directives. Careful attention should be had to the warning expressed by Hertogh that severe dementia inevitably weakens the existence of reciprocity in decision-making and may unveil a discrepancy between the current legislation and actual practice. Further research is needed not only from the requesting patient’s perspective but how the health care professionals (physicians, psychiatrists and involved nurses) experience the patient’s suffering (i.e. inferences related to socio-economic and cultural backgrounds, patient

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204 See H. Wijsbek, ‘The Subjectivity of Suffering and the Normativity of Unbearableness’ in: Physician-Assisted Death in Perspective: Assessing the Dutch Experience (n 5) 319. The RRC quite succinctly summed up the difficulty in determining what suffering actually is: ‘Suffering is a complex experience, like pain, love hope or despair. It is a fundamental part of human life, and can often be recognized as such more readily than it can be put into words.’ See Annual Report 2007, 16ff.

205 See also the position of the RDMA (Royal Dutch Medical Association) Standpunt Hoofdbestuur (Position paper of the Board) (1995): whereby the physician is obliged to objectively assess the suffering, and via careful communication turn it into an intersubjective agreement with the patient.


207 As ‘a state of distress induced by a threat of the loss of intactness or the disintegration of a person from whatever cause’. E. Cassell, The Nature of Suffering and the Goals of Medicine (New York: OUP, 1991).

208 It has, according to Hertogh, great potential to undermine the mutuality and intersubjectivity legally required in a conviction that assisted death is the only way left. See C.M.P.M. Hertogh, ‘Unbearable Suffering and Advanced Dementia: The Moral Problems of Advanced Directives for Euthanasia’ in: Physician-Assisted Death in Perspective: Assessing the Dutch Experience (n 5) 221.
ethnicity, patient diagnosis, gender or the medic’s age, martial status, experience or speciality).209

Fourth, more information and transparency is required in regard to the ‘not-careful’ decisions made by the RRC. Of course certain information must remain withheld from the case report (such as names and locations), but it is argued here that a systematic database detailing the follow up procedure and the reasoning for a finding of unconditional/conditional discharge by the prosecution services should be made easily available.

Clearly, the relationship between the law in the books and the law in action is not perfect in the Netherlands. Agreement is had with Stephen Smith however that the Dutch system, like the English, French, Swiss or every other regulatory system, cannot be expected to achieve the ‘illusionary goal’ of perfect obedience.210 The approach in the Netherlands, notwithstanding its very real shortcomings, appears ‘better than in other countries for which information is available, and it has been getting more encompassing and more refined’211 A number of points may be made here.

First, one of the main criticisms of the Dutch approach is based on an apparently alarming rise of non-voluntary assisted dying cases. From the limited data available, there appears a modest decline in such behaviour. Of the few European studies on the frequency of end of life behaviour (Eureld studies), the termination of life without a request is not higher in the Netherlands than in other countries where assisted dying remains illegal.

Second, by refusing to allow assisted dying to remain an amateur activity, the Netherlands has acquired a system of control (albeit imperfect) over the requirements of due care. Doctors in the Netherlands are ‘exposed to greater regulatory pressure and concrete social control.’212 Systems for the transmission of legal information are in place, such as medical journals, local protocols and the SCN programme of trained advisors and consultants. The latter programme in particular has proven to be an efficient ex ante system of control.

Third, by removing the immediate threat of criminal prosecution and placing a ‘buffer’ (i.e. the Regional Review Committee) between the physician and the prosecution services, Dutch law has witnessed an increase in the reporting

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210 Smith, End-of-Life Decisions in Medical Care (n 5) 10.

211 Griffiths, Weyers and Adams, Euthanasia and Law In Europe (n 5) 520.

212 Ibid., 516.
procedure. The data does not support claims that the unreported cases of assisted dying are out-of-control. Fourth, no evidence exists of a slippery slope towards the victimisation of the vulnerable. Empirical evidence shows the current safeguards are utilised quite well to protect patients in quite extreme circumstances (the majority of instances involving terminal cancer patients suffering in the final phase). As regards the rise in the number of assisted dying cases, this in itself says nothing regarding the effectiveness or suitability of the system of control.

Finally, one may look at the lack of prosecutions for assisted dying in the Netherlands (despite RRC findings of ‘not careful’) and reason that it is a control system with no bite. However, agreement is had here with Dan Hartogh that if one is looking for convictions as a sign of efficient control, then they have misunderstood the rationale behind the Dutch system. It is based on the co-operation and willingness of reporting physicians – it is not a system designed ‘to catch crooks’. The primary form of control is prospective; the physician submits a report that s/he knows will be examined and accepts that s/he may face further (non-criminal) questioning.

Having said all this, close attention is still required to ensure that the number of unreported cases of assisted dying remains low, and that sufficient attention and resources are given to palliative care and curative care. In sum, it appears the Dutch approach although not perfect (the shortcomings in the preceding paragraphs should not be ignored), has provided patients with more legal certainty and proportionate safeguards than the approach adopted in England, France, and Switzerland.

6 Comparative Critique of Legal Reform

The above comparative analysis has so far focused on the ‘law in the books’ v the ‘law in action’; however, in order to complete a law and governance perspective, attention must now be given to the actors and institutions responsible for the creation of the respective laws. This allows one to make more than just descriptive remarks (Section 3 and 4) and critical remarks (Section 5), but also prescriptive ones.


6.1 Governance through the Law – England and France

As is evident from the above, the dominant actors and institutions involved in the application and enforcement of the law on assisted dying in England and France are public and hierarchical in nature. The same holds largely true in the creation of said law. Interest groups and medical associations have played a limited role in developing the law or effecting legal change. Central political actors (public prosecutors, parliament) and the judiciary are again the main players.

Over the last 15 years in England, four individual bills proposing rules very similar to those in the Dutch 2002 Act were put before the House of Lords (indirectly elected upper house of parliament). All of these proposals failed. No bill to legalise assisted dying has ever been proposed/debated in the House of Commons (directly elected lower house of parliament). In 2012, the lower house did debate the suitability of the DPP policy on AS, and the motion in favour of maintaining the current DPP policy was passed without a vote. At the time of writing, there is a new ‘Assisted Dying Bill 2014’ being debated in the House of Lords. This bill is only to help those who are terminally ill, and will only provide AS – therefore persons such as Tony Nicklinson with locked in syndrome could not avail of the assistance in dying according to this Bill.

In France, since 2008 a number of bills to legalize VAE and AS have been proposed by individual Members of Parliament without success. In January 2009, a select committee on Social Affairs in the Senate (indirectly elected upper house) approved such a bill, however the full Senate rejected the proposal later that year by a vote of 170 to 142. A very similar bill was presented before the National Assembly (directly elected lower house) in 2009, but was rejected by a vote of 326 to 202. A number of comparable observations may be


215 The patient must be suffering unbearably and with no prospect of improvement; subject to voluntary request; performed only by a physician; requires independent consultation; report filed before a Review Committee.

216 Note that of the 763 seats, 26 are reserved for Lords Spiritual (Bishops) and 92 members sit in the house by hereditary peerage.

217 The Bill is sponsored by Lord Falconer of Thoroton. It is, at the time of writing, waiting to be debated at the Committee Stage of the House of Lords.

218 One of the applicants at the heart of the recent Supreme Court decision that insisted Parliament debate the law on assisted dying. See Nicklinson (n 147).

219 Also containing safeguards and conditions very similar to those in place in the Netherlands.
made from studying the political debates and processes in England and France.220

First, it may be argued that the debates were not sufficiently contextualized – by both the legislators and the judiciaries. Neither sufficiently defined VAE and as as part of a wider, complex phenomenon of medical behaviour that shortens life (MBSL). This, intentionally or not, widens the vacuum for partisan and polarised ideologies to fill.221 Second, there was often a confusion between practical concerns of a slippery slope in legal change (empirical argument) and more ethical concerns about a slippery slope in moral standards. Such ideological argumentation resulted in a disregard for (i) the similar dangers inherent in permitting (although not regulating) ‘morally legitimate’ forms of MBSL, and (ii) the problematic discrepancies in the status quo (i.e. the current ban on assisted dying) and its application in reality (see Section 5, above). Instead the majority opposed legal reform similar to that in the Netherlands based upon unfounded evidence of the inherent potential for abuse and lack of possible safeguards.

Third, the fact that the actual legality of assisted dying has been debated only once in the directly elected house in France and never in the English equivalent reflects something in itself. Despite the seemingly strong public support for legal reform in both nations,222 there is political reluctance to put euthanasia on the legislative agenda. As Giandomenico Majone points out,
'most political scientists can safely assume that the main goal of elected politicians is to maximize their probability of being re-elected'.223 Accordingly, they prefer to support distributive policies serving special/influential interest groups. In the case of assisted dying, it may be argued that English and French politicians have a 'get out of jail card' with their electorate. They can justify their legislative inaction by not only relying on the polarized nature of the debate, but by also relying on the lack of mobilized and influential interests groups224 and, in particular, the formal unwillingness of the medical profession to support legal reform.225 Weyers convincingly illustrates that legal change does not require a formal positive stance from the medical association (see in the case of Belgium) but it may be assumed that where they ‘are vigorously opposed, legalization is less likely, even if values of the general public seem to point to legal change’.226 Furthermore, one may question if the formal opposition by medical associations to legal reform truly reflects the views of the respective members.227 It is no secret that medical associations are generally opposed to stringent legal obligations and constraints on their members' actions. For example, see the reaction of the French Medical Association to the 2002 Patients’ Right Bill, where the basic right for patients to obtain medical


224 Indeed interest groups do exist, but they have failed to meaningfully cultivate good relations with existing political parties and government bodies. Note in contrast, that prior to World War II and the negative connotations subsequently attached to the term ‘euthanasia’, the English right to die society known as the Voluntary Euthanasia Society (now known as Dignity in Dying) ‘enjoyed the support of many of Britain's most distinguished doctors, public figures and clergy men' and had proposed a bill for legislation before the House of Lords in 1936. Today, the leading right-to-die associations in France (l’association pour le Droit de Mourir dans la Dignité) and England (Dignity in Dying) have approximately 50,000 and 25,000 members respectively. This may be compared with the leading right-to-die association in the Netherlands (NVVE), which has 105,000 members.

225 In England, the General Medical Council refuses to take a position on VAE or PAS, ‘neutral or otherwise’ – it merely insists that its members follow the law. However, the British Medical Association (trade union for doctors) is officially opposed to the legalization of VAE and PAS. In France, the Académie Nationale de Médecine formally opposed the Bill before the National Assembly to allow for assisted dying under similar conditions to the Dutch 2002 Act, also the National Medical Ethics Council rejected both VAE and PAS, but approve of other MBIs.

226 See Griffiths, Weyers and Adams, Euthanasia and Law in Europe (n 5) 525.

227 In England, see the organisation of Healthcare Professionals for Assisted Dying. Note that during the Tramois trial in France, 2,000 doctors signed a petition to allow for euthanasia.
information prior to any form of treatment was contested as overly complicated and counter-productive.  

Fourth, the importance of one particular institutional structural parameter becomes apparent - the separation of powers. Both the English and French courts have made it clear that lawfully permitting assisted dying is a matter for parliament only. They are resigned to pass any power to effect legal change into the hands of the respective parliamentarians. In return, parliamentary inaction on the issue has left the prosecution authorities and members of the judiciary to deal with criminal accusations and individual challenges to the blanket ban. To avoid punishing benevolent physicians and usurping the parliament's role, the prosecutors and judiciary subsequently rely upon problematic techniques not to impose the full, if any, force of the law (see Section 5, above). This creates a regulatory paradox: the law on assisted dying is unlikely to be consistently enforced and unlikely to be adequately reviewed.

It may be said that the law on assisted dying in England and France is hampered by the effects of over-politicisation (mentioned in Section 2): individual rights are weakened by partisan ideology and the law is largely inflexible because of no-clear-winner political situations and rigid power structures. An alternative law and governance approach may be of fundamental value.

6.2 Governance through and in the Law – Switzerland

Switzerland is a peculiar case. From the creation of the Penal Code in the late 19th century up to its enactment in 1942, vae was understood as a lesser form of homicide, but as was deemed permissible. In terms of private actors effecting legal change, there is little to be said for the former phenomenon (vae) and a substantial amount to be said for the latter (as). Since the mid-1980’s, the legal norms surrounding as were ‘filled in’ by right-to-die societies, ethical guidelines, cantonal medical standards, prosecution standards, and a number

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229 See Section 4.2.1 and 4.2.2, above.
230 Although it must be said that the recent English Supreme Court decision in Nicklinson (n 142) is a peculiar example of a highest national court giving a type of ‘heads up’ to the elected officials to debate the impugned law on assisted dying or face judicial intervention in the future. The fact of the matter still remains that the English Supreme Court, for all its doubts about the compatibility of the current law, refused the relatively mild legal effects of declaring the law as incompatible with the hra – which, does not result in the law becoming null and void, but merely formally requires the Parliament to review the issue in a timely manner.
of court decisions. Thus the law on AS is the result of a certain degree of public–private actor interaction (i.e. governance in the law), yet no political consensus on how to regulate the behaviour has been achieved. Meanwhile, the 1942 prohibition on VAE has also been subject to Federal-level legislative proposals, but none have succeeded. It remains, unlike AS, in the grip of central government institutions and political actor control (i.e. governance through the criminal law).

A number of observations may be made here. First, the Swiss politicians have expressed their preference for maintaining the status quo on a number of occasions. In 1994, an individual member of the lower house of parliament (Nationalrat) proposed the decriminalisation of VAE with safeguards akin to those in the Netherlands. It was approved after a two year process in which the motion had been changed to a postulate - a nonbinding resolution that called for an expert report. A multi-disciplinary working group established by the Swiss Federal Council in 1999, (consisting of experts in law, medicine and ethics) recommended legally regulating AS and VAE in a manner similar to the Dutch approach. However, the Parliament opted to reject these findings as presented in the ‘Cavalli Initiative’, which proposed to put the working group’s findings into law. In the same session, a motion to restrict the practice of RTD organisations was also rejected (known as the ‘Vallender Initiative’). In 2005, the Swiss National Advisory Commission on Biomedical Ethics recommended that the State supervise or apply greater control over RTD organisations. However, since then three different political attempts to do act upon this recommendation have failed. First, the Canton of Zurich rejected a proposal to subject right to die societies to registration and licensing, and to prohibit ‘suicide tourism’ in general. Then the Swiss Federal Department of Justice and Police stated its position that both assisted suicide and suicide tourism are sufficiently regulated by the existing legal framework. While in 2011, the Swiss Federal Council after consultation with the cantons and political parties decided not to initiate a legislative proposal to specifically regulate AS. This is despite the general agreement that the federal law should define specific duties of care within the context of assisted suicide. This has resulted in criticism from the national medical association (SAMS) and the national bio-ethics committee (SNACBE) that central government institutions and political actors are ‘shirking’ their responsibilities.

Second, there is also an interesting separation of powers dimension. The Federal Supreme Court has been given the liberty to limit the open-ended
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nature of Art. 115, and to define the right to assisted suicide as a ‘negative right’. Furthermore, in July 2010, the same Court declared the agreement made by the General Public Prosecutor of the canton of Zurich and the RTD organisation Exit to be invalid. The agreement had planned to achieve financial transparency, including a ban on profit, a small maximum payment (416 Euro) for expenses, and the obligation to have Exit’s financial statement monitored by a recognized auditor. It also limited assistance to those ‘with sever suffering as a result of a disease’. The Federal Court concluded that the agreement was not valid as it lacked a legal basis and was not in accordance with domestic law.

Third, the national medical association (SAMS) has taken a ‘neutral’ stance on the legality of AS, and has rejected the permissibility of VAE. As alluded to in regard to the situation in England and France, without a formal positive stance from the medical association the chances of any legal reform (via the judiciary or legislators) is reduced. It would be more accurate to say that SAMS has gradually acquiesced what has been legally condoned – for example it had to change its stance that AS ‘is not a part of a doctor’s activity’ to a decision to provide assistance to commit suicide by a doctor ‘must be respected’.

Thus, it may be said that law on VAE and AS in Switzerland, like in England and France, is hampered by over-politicization: directly elected officials remain responsible yet indifferent towards the problem of maintaining the status quo, while judicial reluctance to become quasi-legislators and to formulate specific regulations means that patients and doctors are left subjected to uncertain professional guidelines. Although private actors (i.e. professional medical ethics committees and RTD organisations) are substantially more involved in the creation of the law on AS than in England and France, problematic issues seem to still arise.

6.3 Governance in the Law – the Netherlands

In the Netherlands, the legal norms finally codified in 2002 were not formulated in a simple hierarchical manner or solely dependent on public actors. The law is a result of significant interaction between the medical profession (individual doctors and the Royal Medical Association), interest groups

232 BGE 136 II 415.
234 Interchangeably referred to as the ‘KNMG’.
(in particular the Association for Voluntary Euthanasia – NVVE), the Executive, the Parliament, the Health Council, the State Commission on Euthanasia, the Remmelink Commission (appointed by to carry out empirical research concerning euthanasia and related practices), academics, the judiciary, the prosecutorial authorities, the medical disciplinary tribunals, the Medical Inspectorate, and the ‘public’.235 A detailed account of Dutch legal reform on euthanasia is beyond the scope of this chapter,236 instead some key moments will be highlighted.

In the 1970’s and early 1980’s, Dutch cultural change237 and advances in medical technology brought the topic of ‘euthanasia’ into the public spotlight.238 Media attention increased and special interest groups239 mobilised rapidly. Importantly, a number of criminal prosecutions240 for euthanasia encouraged the highest prosecutorial authority – under guidance of the Ministry of Justice – to develop a policy on such cases.241 In deciding to prosecute or not, certain ill-defined criteria were agreed upon; the presence of a well considered request, independent medical consultations, and unbearable and hopeless suffering. In the following decade a unique course of legal development and period of conceptual clarification occurred.

A number of reporting and investigating procedures were established by local prosecutors designed to encourage doctors to report if they had performed euthanasia.242 In response to reports of doctors performing VAE or AS, the prosecution authorities initiated criminal proceedings to clarify the procedural and substantive grounds on which such behaviour may be justified. During that same time, the Executive Board of the KNMG recognised243 that

235 See Griffiths, Weyers, and Adams, Euthanasia and Law in Europe (n 5).
236 See J. Griffiths, A. Bood and H. Weyers, Euthanasia and Law in the Netherlands (Amsterdam University Press, 1998) 43–86.
237 A general shift towards more secularization, individualization and democratization.
238 Just as in England and France today, the early debate in the Netherlands did not always conceptually distinguish ‘euthanasia’ from other similar types of MBSL.
239 Both pro-and anti-euthanasia groups were created. The main advocates for legalization of euthanasia were the Dutch Association for Voluntary Euthanasia (NVVE – which was, and still is, the largest). The main opponents were the Dutch Association of Physicians, the Dutch Association of Patients and sectors of religious groups, in particular the Calvinist churches and the Roman Catholic Church.
240 The most notable prosecutions arising from the Postma case (Nederlandse Jurisprudentie 1973, no.183: 558), and the Wertheim case (Nederlandse Jurisprudentie 1982, no. 63: 223).
241 See Griffiths, Bood and Weyers, Euthanasia and Law in the Netherlands Europe (n 236) 58.
242 See Griffiths, Weyers, and Adams, Euthanasia and Law in Europe (n 5) 30.
243 This was in response to questions from a State Commission on Euthanasia set up 1982 at the request of Parliament. It is important to note that the KNMG is a professional group that generally has a lot of public confidence in it.
both VAE and PAS were occurring in reality and clarified somewhat the conditions that must be satisfied should either occur.\[244\]

When the first Supreme Court decision concerning VAE (the Schoonheim case) was reached in 1984, the stance of the medical profession laid the groundwork for the Court to conclude that a doctor who complies with the requirements of due care can successfully invoke the justification of necessity (conflict of medical duties).\[245\] The appeal decision marked the first time a Dutch doctor was found not criminally liable for performing VAE. At the same time, a State Commission on Euthanasia clarified (note, in co-operation with the Medical Association) exactly what was meant by the term ‘euthanasia’ in the context of other MBSL, and produced a report advising the government to change the Criminal Code to permit both VAE and AS. However, the legislator avoided any amendments at that time.\[246\] Unlike in England and France, the Dutch judiciary did not fear a backlash here for stepping in and usurping the role of the legislator. Rather, such judicial activism was seemingly ‘respected’ by the Dutch politicians.\[247\]

In the early 1990’s, a number of cases came before the Dutch courts whereby it was repeatedly held that a doctor who complies with the requirements of due care can assume that he will not be prosecuted. The Ministry of Justice and the prosecution authorities further confirmed this to the Medical Association, as the next issue became more about effective control and less about the permissibility of assisted dying. Following on from the empirical research produced by the Remmelink Commission,\[248\] it was decided that doctors would be more willing to report if the ‘criminal character’ of the reporting procedure was reduced. As a result semi-public Regional Committees were created to assess the due care compliance of each reported case of assisted dying. These expert actors were delegated sole responsibility for creating the procedural

\[244\] There must be a voluntary and well considered request; ‘unacceptable’ suffering, a second doctor should be consulted and a certificate of ‘natural’ death should not be filed.


\[246\] Largely due to the essential role of the Christian-democratic party (CDA) in the coalition government and its position to block such legislation at the time.


\[248\] Officially known as ‘The Commission Appointed to Carry out Research Concerning Medical Practice in Connection with Euthanasia’, but more commonly known after its chairman and the Advocate General at the Supreme Court at the time. It was established in 1990 by the Government to conduct empirical research into the extent of euthanasia practice.
guidelines for investigating compliance. Furthermore, SCEN, a body of expert doctors on euthanasia was set up by the Medical Association and financed by the Ministry of Health to provide (by and large, successfully) an extra system of ex-ante control.

Over a forty year period, the law on assisted dying was, intentionally or not, ‘depoliticized’ allowing political and legal decisions to be made in stages. The prosecution authorities, the State Commission on Euthanasia, the ‘Remmelink’ Committee and the KNMG provided politically neutral and objective solutions which the Court - presented with somewhat of a legal vacuum - accepted. In 2002, Parliament finally amended the criminal code, which did little more than ratify what had already been accomplished elsewhere. The governance mechanism at play in the Netherlands not only evidences meaningful public-private actor interaction in the application and enforcement of the law, but also in the creation of the law.

Conclusions

The need to somewhat loosen the law on assisted dying from the shackles of state politics is apparent. Purely formal, command and control (i.e. public actor governance through the law), as seen in England and France, raises concerns. Namely, one may question the degree of accountability, effectiveness, proportionality, legal certainty, consistency and compliance with the human rights of suffering, fully competent patients. The practical fears raised about the effects of legalization do not seem to warrant a blanket prohibition, and can arguably be better addressed by the implementation of regulatory safeguards. Equally, it may be said that governance in the law does not always result in more satisfactory results. The Swiss approach to is an example of this. Private actors are predominately free to create and apply the law on within

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249 Note that since 2002, a judgement from this Committee that a reported case of euthanasia satisfies the conditions, now formally ceases the review and the prosecution authorities will not investigate the case.

250 In other words: the issue of euthanasia was made appear a ‘medical’ one and therefore politically neutral. See R. Andeweg & G. Iriwn, Dutch Government and Politics (London, MacMillan, 1993).


252 Note importantly, that the government coalition at that time, and for the first time since 1917, did not consist of a confessional party.
the very loose confines of state control. In practice, this has resulted in a lack of certainty and transparency. Comparisons may therefore be made. What appears common in all three nations is that central government institutions and political actors, despite opportunities to do otherwise, choose to maintain the status quo, while the judiciary and medical associations are unwilling to directly effect any legal change.

Generally speaking, lessons may be learnt from the creation, application and enforcement of the law on assisted dying in the Netherlands. Governance here relies heavily upon unique public-private actor interdependence: namely, between the Dutch Medical Association, SCÉN, individual physicians, the Regional Review Committee, specialised State Committees, the public prosecution authorities, the judiciary and then finally the Parliament. Notwithstanding the shortcomings mentioned (particularly regarding the role of nurses and the challenges raised in cases of advanced dementia) the Dutch approach appears to have done well in protecting self-determination in the dying process while proportionally protecting vulnerable persons. Unlike the Swiss form of governance in the law, the Dutch approach has attested the need to view as and vae in the wider context of other MBSL, to mobilise influential interest groups, to acquire nation-wide empirical data, and to seek greater accountability from health care professionals. From this perspective, private actors may positively decouple the legal and political decisions on assisted dying to benefit the ‘public interest’. Legitimate questions remain about the feasibility of fine tuning the Dutch approach, or the ‘exportability’ of governance modes and legal policies. But these are questions for another study, and do not detract from the comparative failures and success identified between the four law and governance approaches above.