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A CALL FOR INTERNATIONAL REGULATION OF THE THRIVING “INDUSTRY” OF DEATH TOURISM

Alexander R. Safyan *

I. INTRODUCTION

On July 7, 2009, distinguished English conductor Sir Edward Downes traveled with his wife, Lady Joan, to Zurich, Switzerland.¹ Three days later, the couple visited the assisted suicide clinic Dignitas, where workers provided them with a clear, liquid drink that would enable them to end their lives together.² Sir Edward and Lady Joan drank the “cocktail of barbiturates,” lay next to each other holding hands, and died within minutes.³ Lady Joan was seventy-four years old, and in the final stages of terminal cancer; Sir Edward was eighty-five years old, and nearly blind and deaf.⁴ However, unlike his wife, Sir Edward was not terminally ill.⁵

This story sparked new controversy surrounding the practices of assisted suicide clinics such as Dignitas, which offer patients the ability to peacefully and painlessly end their lives. Yet this story is only one of several highly publicized reports of individuals traveling abroad in search of assistance in committing suicide. For example, in January 2003, a seventy-four-year-old man named Reginald Crew, who had been diagnosed with motor neuron disease, became one of the first

* J.D., Loyola Law School Los Angeles, 2011; B.A., University of Southern California, 2008. I would like to thank my parents for their unconditional love and support. I would also like to thank my friends Dan Hauptman, who gave me the idea for this note, and Jordan Ludwig and Michael Pearson, for proofreading it and providing input.

1. John F. Burns, *With Help, Conductor and Wife Ended Lives*, N.Y. TIMES (July 14, 2009), <http://www.nytimes.com/2009/07/15/world/europe/15britain.html>.

2. *Id.*

3. *Id.*

4. *Id.*

5. *Id.*

British citizens to die with the help of Dignitas's services.⁶ In April 2003, a British couple's decision to die at Dignitas generated widespread criticism of the clinic's practices because neither person was terminally ill.⁷ Robert Stokes, age fifty-nine, suffered from epilepsy, while his wife, Jennifer, age fifty-three, had back problems and diabetes.⁸ Perhaps the most controversial story surfaced in September 2008, when twenty-three-year-old Daniel James, who had been paralyzed from a rugby injury, ended his life at Dignitas with his parents by his side.⁹ The prevalence of such stories has led many authors and commentators to popularize the term "death tourism," which describes the phenomenon of citizens traveling to foreign countries in search of assistance in taking their lives.¹⁰

The emergence of death tourism as a new "industry" has revived international debate regarding the legalization of physician-assisted suicide and euthanasia. Indeed, several countries have recently taken steps to address the phenomenon. In February 2010, following a five-month-long public response period, the Director of Public Prosecutions in the United Kingdom issued new guidelines designed to clarify the circumstances under which individuals planning to assist another in suicide could expect to face prosecution.¹¹ Similarly, following its own several-month-long consultation process, the Federal Council in Switzerland recently announced that it planned to introduce stricter regulations against assisted suicide.¹² Other countries, however, have dismissed death tourism as a potential problem, either because their laws expressly prohibit it or because their culture prevents it from

6. See Fiona Fleck, *Dignitas "Helps Physically Healthy to Die"*, TELEGRAPH (Jan. 26, 2003, 12:01 AM), <http://www.telegraph.co.uk/news/worldnews/europe/switzerland/1420106/Dignitas-helps-physically-healthy-to-die.html>.

7. *UK Couple Die at Suicide Clinic*, BBC NEWS (Apr. 15, 2003, 17:33 GMT), http://news.bbc.co.uk/2/hi/uk_news/2948365.stm.

8. *Id.*

9. See Daniel Foggo, *Why Daniel James Chose to Die*, SUNDAY TIMES (Oct. 19, 2008), <http://www.timesonline.co.uk/tol/news/uk/article4969423.ece>.

10. Rohith Srinivas, *Exploring the Potential for American Death Tourism*, 13 MICH. ST. U. J. MED. & L. 91, 94 (2009); see Hilary White, *Switzerland Refuses to Alter Assisted Suicide Law to Nix Death Tourism*, LIFESITENEWS.COM (June 2, 2006, 11:15 EST), <http://www.lifesitenews.com/ldn/2006/jun/06060210.html>.

11. *A Public Consultation on the DPP's Interim Policy for Prosecutors on Assisted Suicide*, CROWN PROSECUTION SERV., http://www.cps.gov.uk/consultations/as_index.html (last visited Sept. 6, 2011).

12. Press Release, Swiss Federal Council, *Specific Regulations for Organised Assisted Suicide in Switzerland; Swiss Federal Council Acknowledges Results of Consultation Process* (Sept. 17, 2010), <http://www.admin.ch/br/aktuell/00091/index.html?lang=en&msg-id=35187> [hereinafter Swiss Federal Council Press Release].

occurring.¹³ In any case, leaders agree that they would not like to see their countries become breeding grounds for “death tourists.”¹⁴

With reports of death tourism on the rise,¹⁵ and criticism of the increasingly ineffective safeguards of local assisted suicide laws mounting, the question becomes: Should international law do anything to address this phenomenon? If the answer to this question is “yes,” then the logical subsequent question is: What form should a resolution take, such that it preserves individual nations’ sovereignty while simultaneously promoting the integrity of obligations imposed by domestic law?

This Note asserts that regulation of death tourism is an essential step in defusing the international community’s concerns over the controversial practice. Further, this Note posits that the most effective tool for curtailing death tourism is the adoption of an instrument of “soft law,”¹⁶ which would grant countries flexibility in shaping their responsibilities toward assisted suicide of non-citizens, as well as provide a less formal, and thus more conciliatory, framework for compliance with those responsibilities. It is important to note that this Note does *not* undertake a debate as to the moral, ethical, or legal justifications for or against assisted suicide. Rather, this Note argues that—notwithstanding one’s personal views about the legality of the practice—a system where non-terminally ill individuals can travel abroad and enlist the services of death clinics to help them end their lives offends both notions of international comity and respect for the obligations of domestic law.

Part II of this Note sets forth the various end-of-life procedures available to patients and examines some of the principal arguments surrounding the use of those procedures. Part III analyzes and compares the laws of four countries with contrasting positions on the legitimacy of end-of-life procedures: the United Kingdom, the United States, the Netherlands, and Switzerland. The choice (and order of presentation) of these four countries represents a broad sweep over the spectrum of end-

13. See Srinivas, *supra* note 10, at 102–03.

14. See, e.g., Steven Ertelt, *Switzerland Government Official Wants Assisted Suicide Death Tourism to Stop*, LIFENEWS.COM (July 14, 2008, 9:00 AM), <http://www.lifeneews.com/bio2510.html> (Swiss Minister Eveline Widmer-Schlumpf seeking to curb death tourism in Switzerland).

15. *Id.* (stating that as of May 2008, the number of individuals, especially British citizens, choosing to end their lives at Dignitas was on the rise).

16. Part IV of this Note elaborates on the definition of soft law and explores the benefits of utilizing a soft law instrument rather than an instrument of “hard law,” such as a binding treaty. For now, a sufficient working definition of soft law is an informal, non-binding instrument, such as a resolution or recommendation, that can be viewed as a third *source* of international law, in addition to treaties and customary international law.

of-life jurisprudence, and features countries whose laws move from most restrictive to least restrictive. Additionally, Part III considers which of these countries presents the greatest potential for death tourism, affording special attention to recent proposals for change introduced by the countries' policymakers. Part IV articulates a proposal for international regulation of death tourism through the means of a soft law instrument and explains why such an instrument would be favorable to a hard law alternative. Finally, Part V concludes that although non-binding in nature, "soft" regulation of death tourism could lead to the desired effect of influencing countries' behavior toward each other's citizens and increasing their respect for the laws of their sovereign neighbors.

II. DEFINING AND CONCEPTUALIZING VARIOUS END-OF-LIFE PROCEDURES

A. Defining the Terminology

Before engaging in a comparative analysis of the laws in different countries governing end-of-life procedures, it is necessary to identify and define the terminology that describes these procedures. The first important distinction to make is between assisted suicide and euthanasia. While many believe these terms are synonymous,¹⁷ a more accurate definition focuses on *who* ultimately brings about the patient's death.¹⁸ As the word "suicide" suggests, assisted suicide entails the patient ultimately taking her own life. The American Medical Association defines physician-assisted suicide (PAS)¹⁹ as "a physician facilitat[ing] a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act."²⁰ Thus, under this scenario, while the patient receives assistance from a physician—either in the form of medication, instruction, or advice—the key component is that the patient *herself* carries out the final act, rather

17. See Lara L. Manzione, *Is There a Right to Die?: A Comparative Study of Three Societies (Australia, Netherlands, United States)*, 30 GA. J. INT'L & COMP. L. 443, 445 (2002) (noting that "[t]he term euthanasia is more routinely used by the population at large as a general one to mean any form of hastened death").

18. See Srinivas, *supra* note 10, at 94.

19. Although assisted suicide does not *have* to involve a physician, most commentators prefer this term since it is generally the case that a physician is required to provide the patient with the appropriate means to end her life (i.e., by writing a prescription). See, e.g., WASH. REV. CODE ANN. § 70.245.020(1) (West 2010); OR. REV. STAT. § 127.805 (2003).

20. *Opinion 2.211: Physician-Assisted Suicide*, AM. MED. ASS'N, <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2211.shtml> (last visited Sept. 6, 2011).

than the physician. Conversely, euthanasia, which originates from the Greek *eu*, meaning “good,” and *thanatos*, meaning “death,”²¹ involves the *physician* acting to cause the patient’s death.²² The physician will most often do this by administering a lethal injection or removing the patient from some form of life-support.²³ Whatever the action, the defining characteristic of euthanasia is that the physician, not the patient, carries out the ultimate life-ending act.

Euthanasia can further be classified as active or passive, and voluntary or involuntary. Active euthanasia involves a physician or other person directly acting to end a patient’s life.²⁴ An example of this would be a physician injecting a patient with a drug that causes the patient’s death. On the other hand, passive euthanasia entails foregoing or discontinuing life-sustaining treatment.²⁵ For instance, a physician may refrain from inserting a feeding tube into a patient’s body or he may disconnect the patient from life-support. Passive euthanasia is allowed in most countries, as this practice is generally associated with a patient’s right to refuse medical treatment, rather than a request that the physician “kill” her.²⁶ Most countries that criminalize euthanasia specifically proscribe active euthanasia. These countries view active euthanasia as a form of “killing,”²⁷ and distinguish between “killing” and “letting die,” the latter of which they consider morally acceptable.²⁸

Though the line between killing and letting die may be blurry, the distinction between voluntary and involuntary euthanasia is clear.²⁹ This distinction plays a crucial role in the moral debate surrounding end-of-life procedures. Voluntary euthanasia refers to a situation where a

21. Manzione, *supra* note 17, at 445.

22. See Wendy N. Weigand, *Has the Time Come for Doctor Death: Should Physician-Assisted Suicide be Legalized?*, 7 J.L. & HEALTH 321, 322–23 (1992–93).

23. *Id.* at 322.

24. See Lindsay Pfeffer, Note, *A Final Plea for “Death With Dignity”: A Proposal for the Modification and Approval of the Assisted Dying for the Terminally Ill Bill in the United Kingdom*, 15 CARDOZO J. INT’L & COMP. L. 497, 510 (2007).

25. See N. Ferreira, *Latest Legal and Social Developments in the Euthanasia Debate: Bad Moral Consciences and Political Unrest*, 26 MED. & L. 387, 389 (2007).

26. See Remigius N. Nwabueze, *Biotechnology and the New Property Regime in Human Bodies and Body Parts*, 24 LOY. L.A. INT’L & COMP. L. REV. 19, 55–57 (2002) (explaining the distinction between refusal of life-sustaining treatment, which is a constitutional right recognized in the United States, and assisted suicide or [active] euthanasia).

27. Raphael Cohen-Almagor, *Euthanasia and Physician-Assisted Suicide in the Democratic World: A Legal Overview*, 16 N.Y. INT’L L. REV. 1, 3 (2003).

28. See Kelly Green, *Physician-Assisted Suicide and Euthanasia: Safeguarding Against the “Slippery Slope”—The Netherlands Versus the United States*, 13 IND. INT’L & COMP. L. REV. 639, 645 (2003).

29. See Srinivas, *supra* note 10, at 95.

physician ends a patient's life at the request of the patient and with the patient's informed consent.³⁰ Involuntary euthanasia, however, refers to a case where a patient has *not* consented, either because she is physically or mentally unable to, or because she has expressly stated that she does not wish to be euthanized.³¹ Some describe the former situation—where the patient is unable to consent—as non-voluntary euthanasia, and the latter situation—where the patient has indicated that she does not want to be euthanized—as involuntary euthanasia.³² For purposes of this Note, however, this distinction is irrelevant.

B. Competing Positions

Arguments for and against these aforementioned procedures abound, most of which are enveloped in larger debates concerning moral, ethical, and legal issues. The arguments in support of PAS and euthanasia center around two main principles: “personal autonomy and the right to be free from undue suffering.”³³ With regard to the first principle, proponents contend that individuals have a right to self-determination.³⁴ In other words, people are free to make decisions that affect their own lives. The underlying premise of this argument is the belief that the right to choose how to live one's life necessarily encompasses the right to choose how to end it.³⁵ The second principle, the right to be free from extreme suffering, is founded upon notions of mercy and compassion. This principle maintains that individuals should not contribute to the pain and suffering of others, but rather, should alleviate such pain whenever possible,³⁶ including by ending an afflicted individual's life. Advocates of these two principles urge their countries to pass laws permitting PAS and voluntary euthanasia under the proper circumstances.

On the other side of the debate, those who oppose life-ending procedures argue that a physician should never be permitted to knowingly and voluntarily take a patient's life. This argument is deeply rooted in several fundamental beliefs. First, most opponents of PAS and euthanasia contend that a theoretical “right to die” never outweighs the value of human life.³⁷ In support of their position, opponents point to

30. See Ferreira, *supra* note 25, at 390.

31. *Id.* at 392.

32. See Srinivas, *supra* note 10, at 95.

33. See Green, *supra* note 28, at 642.

34. *Id.* at 643.

35. *Id.*

36. *Id.*

37. See Ferreira, *supra* note 25, at 391.

the use of modern drugs to control pain and new developments in medicine that will extend patients' lives further than ever imagined.³⁸ Second, opponents of PAS and euthanasia emphasize the difficulty physicians face in determining whether the patient has voluntarily consented.³⁹ This difficulty stems from such problems as ascertaining whether the patient is rational or competent to consent in the first place.⁴⁰ Third, and perhaps most controversially, those who disapprove of PAS and euthanasia raise "slippery slope" arguments against these practices.⁴¹ These arguments theorize that the legalization of PAS and euthanasia will lead to widespread abuse of vulnerable groups of people.⁴² Specifically, the poor and the elderly may feel pressure to prematurely end their lives so as not to impose financial or emotional burdens on their families.⁴³ In addition, the mentally ill and disabled may be misled into requesting death, either by their loved ones or by their treating physicians.⁴⁴ Regardless of the specific objection, most opponents agree that the proliferation of life-ending procedures would result in a deterioration of the physician-patient relationship,⁴⁵ as it would erode the trust in the relationship as well as the view that physicians are healers.⁴⁶

III. COMPARATIVE LAW AND THE POTENTIAL FOR DEATH TOURISM

This section analyzes and compares the laws regulating end-of-life procedures in the United Kingdom, the United States, the Netherlands, and Switzerland. In the course of this analysis, this section also considers the extent to which each of these countries represents a potential death tourism destination.

A. The United Kingdom

With its policymakers endlessly debating the legalization of PAS and its citizens comprising the largest number of people traveling abroad to be assisted in death, the United Kingdom is at the forefront of the death tourism phenomenon. The U.K.'s House of Lords has repeatedly rejected attempts to pass a bill permitting assisted suicide,

38. *See id.* at 392.

39. *See id.* at 391.

40. *Id.*

41. *Id.*; Green, *supra* note 28, at 646.

42. *See* Green, *supra* note 28, at 646.

43. *See id.* at 647–48.

44. *See id.*

45. *Id.* at 649.

46. *Id.* at 649–50.

and popular sentiment in favor of the practice has gone largely unheeded.⁴⁷ Only the recent decision by the Director of Public Prosecutions (DPP) to promulgate new guidelines regarding the prosecution of assisted suicide violators has produced any hope for a change in the status quo.⁴⁸

In 1961, Parliament passed the Suicide Act, which eliminated suicide as a crime while simultaneously introducing a new offense for assisting another in suicide.⁴⁹ The Act provided that “[a] person who aids, abets, counsels or procures the suicide of another, or an attempt by another to commit suicide” would be subject to imprisonment for up to fourteen years.⁵⁰ This punishment remains one of the most severe of its kind in Europe.⁵¹ Not coincidentally, therefore, the United Kingdom has experienced perhaps the greatest public clamor for relaxation of its assisted suicide laws.

1. The Case of Diane Pretty

The first highly publicized challenge to the U.K.’s assisted suicide ban came in 2000, when a woman named Diane Pretty petitioned the DPP to declare that her husband would not be prosecuted for helping her commit suicide.⁵² Ms. Pretty was diagnosed with motor neuron disease—a condition that would ultimately paralyze her—and sought permission for her husband to assist her in peacefully ending her life.⁵³ The DPP refused her request, leading Ms. Pretty to bring her challenge to the judiciary.⁵⁴

The Divisional Court dismissed Ms. Pretty’s claim. It found that the DPP did not have power to grant immunity to Ms. Pretty’s husband for future or proposed criminal conduct, and that the Suicide Act 1961 was not incompatible with the European Convention on Human

47. Pfeffer, *supra* note 24, at 521; see *Lords Block Assisted Dying Bill*, BBC NEWS (May 12, 2006, 16:43 GMT), <http://news.bbc.co.uk/2/hi/health/4763067.stm>.

48. Caroline Davies, *Assisted Suicide Guidelines Will Ease Fears, Says DPP*, GUARDIAN (Sept. 23, 2009, 21:23 BST), <http://www.guardian.co.uk/society/2009/sep/23/assisted-suicide-guidelines-dpp>.

49. Suicide Act, 1961, 9 & 10 Eliz. 2, c. 60, §§ 1–2 (Eng.).

50. *Id.* § 2(1).

51. Pfeffer, *supra* note 24, at 498.

52. John Keown, *European Court of Human Rights: Death in Strasbourg—Assisted Suicide, the Pretty Case, and the European Convention on Human Rights*, 1 INT’L J. CONST. L. 722, 723 (2003); see Suicide Act, 1961, *supra* note 49, § 2(4) (stating that “no proceedings shall be instituted for [assisted suicide] except by or with the consent of the Director of Public Prosecutions”).

53. Keown, *supra* note 52, at 722.

54. *Id.* at 723.

Rights.⁵⁵ Ms. Pretty appealed the Court's decision to the House of Lords, which also rejected her claim.⁵⁶ Finally, Ms. Pretty brought her case before the European Court of Human Rights (ECHR).

Before the ECHR, Ms. Pretty asserted two primary arguments under Articles 2 and 3 of the European Convention on Human Rights and several alternative arguments under Articles 8, 9, and 14.⁵⁷ First, Ms. Pretty asserted that Article 2, which protects the right to life, also guarantees a negative right, the right to choose *not* to live.⁵⁸ The ECHR, however, found that Article 2 was concerned with the protection and preservation of life and could not, without a distortion of language, be interpreted to also confer the right to choose to die.⁵⁹ Ms. Pretty's second argument focused on Article 3 of the Convention, which states, "[n]o one shall be subjected to torture or to inhuman or degrading treatment or punishment."⁶⁰ Ms. Pretty claimed that the State's prohibition on assisted suicide and the DPP's refusal to grant prospective immunity to her husband constituted inhuman and degrading treatment in violation of the Convention.⁶¹ The Court rejected this argument as well, explaining that Article 3 only required states to ensure that individuals within their jurisdictions were not subjected to inhuman treatment, but did not require them to actively provide treatment to individuals who required medical care.⁶²

In addition to the aforementioned arguments, Ms. Pretty raised alternative arguments under Articles 8, 9, and 14 of the Convention. Based on Article 8, which prohibits interference in individuals' lives except when necessary to protect interests such as public safety,⁶³ Ms. Pretty claimed that the State's assisted suicide ban violated her right to privacy and self-determination.⁶⁴ The Court found that interference by the State in this matter was justified because the State

55. *Pretty v. Dir. of Pub. Prosecutions*, [2001] EWHC (Admin) 788, [31]–[32], [66] (Eng.).

56. Keown, *supra* note 52, at 723.

57. *See id.* (discussing each of Ms. Pretty's arguments before the ECHR).

58. *See id.*; Article 2 of the European Convention for the Protection of Human Rights and Fundamental Freedoms states, "[e]veryone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law." European Convention for the Protection of Human Rights and Fundamental Freedoms, art. 2, Nov. 4, 1950, 213 U.N.T.S. 221 [hereinafter ECHR].

59. *See Pretty v. United Kingdom*, App. No. 2346/02, 35 Eur. H.R. Rep. 1, 4–8 (2002); Keown, *supra* note 52.

60. ECHR, *supra* note 58, art. 3.

61. *See Keown, supra* note 52, at 724.

62. *Pretty*, 35 Eur. H.R. Rep. at 9.

63. ECHR, *supra* note 58, art. 8.

64. *See Pretty*, 35 Eur. H.R. Rep. at 4.

had the right to use criminal law to protect vulnerable groups of people (such as the terminally ill) and to regulate activities that endangered the safety of others.⁶⁵ Under Article 9, Ms. Pretty argued that the State's prohibition on assisted suicide violated her freedom of thought, conscience, and religion.⁶⁶ The Court quickly rejected this contention, finding that Ms. Pretty's views on assisted suicide were not manifestations of religious belief or thought.⁶⁷ Finally, with respect to Article 14, which prohibits discrimination under the Convention,⁶⁸ Ms. Pretty claimed that a blanket ban on assisted suicide discriminated between individuals who *were* physically able to commit suicide without assistance and those who were unable to do so.⁶⁹ As with her other claims, the ECHR refused to entertain Ms. Pretty's contention. It concluded that the State had legitimate safety reasons for refusing to distinguish between people who were capable of committing suicide on their own and those who required assistance.⁷⁰

2. Recent Developments in the United Kingdom

Since the ECHR's dismissal of the *Pretty* case, the United Kingdom has witnessed several key developments in the assisted suicide/death tourism story. In 2004, Lord Joel Joffe introduced the Assisted Dying for the Terminally Ill Bill, modeled after Oregon's Death with Dignity Act,⁷¹ discussed below in Part III.B. The House of Lords formed a Select Committee to review the Bill, and the committee published an extensive report with statistical findings, analyses of other countries' laws, and recommendations for improving the bill.⁷² Following the report, Lord Joffe submitted a new version of the bill in 2005. The bill's stated purpose was to "[e]nable an adult who has capacity and who is suffering unbearably as a result of a terminal illness to receive medical assistance to die at his own considered and persistent request."⁷³ The proposed legislation authorized a physician to assist a patient in suicide by prescribing lethal medication, or, in the case of a patient who was unable to orally ingest that medication, by providing

65. See *Pretty v. United Kingdom*, App. No. 2346/02, 35 Eur. H.R. Rep. 1, 3–4 (2002).

66. See ECHR, *supra* note 58, art. 9.

67. See *Pretty*, 35 Eur. H.R. Rep. at 3–4.

68. See ECHR, *supra* note 58, art. 14.

69. See *Pretty*, 35 Eur. H.R. Rep. at 40.

70. See *id.* at 4–5.

71. Paul Raine, *A Right to Die? The Case of Diane Pretty* (2006) (on file with the Loyola of Los Angeles International & Comparative Law Review); Pfeffer, *supra* note 24, at 503.

72. *Id.*

73. Assisted Dying for the Terminally Ill Bill, 2005, H.L. Bill [36] (Gr. Brit.).

means of self-administration.⁷⁴ Despite providing many of the same safeguards as other countries' assisted suicide laws—including requirements of capacity, a terminal illness, an effective year-long residency, and minimum waiting periods⁷⁵—the bill was rejected by the House of Lords in May 2006.⁷⁶ Since then, no other proposed law has made it as far in the legislative process.⁷⁷ In May 2009, however, Lord Charles Falconer launched a campaign calling for the legal protection of individuals who traveled abroad to assist loved ones in committing suicide.⁷⁸ His campaign achieved mixed results: the law remains unchanged today, but recent steps taken by the DPP have somewhat clarified the uncertainty surrounding the prosecution of assisted suicide.⁷⁹

In September 2009, the DPP provided this clarification by finally agreeing to issue new guidelines regarding his office's decisions to prosecute cases of assisted suicide.⁸⁰ Besides Diane Pretty, many others had unsuccessfully petitioned the DPP to issue such guidelines for decades. The most recent challenger, a woman named Debbie Purdy, finally succeeded. Like Diane Pretty, Ms. Purdy, who had been diagnosed with multiple sclerosis, sought assurance from the DPP that her husband would not be prosecuted for accompanying her abroad to help her commit suicide.⁸¹ The DPP denied Ms. Purdy's request, and the U.K. courts rejected her subsequent legal challenge. Surprisingly, however, in its decision, the House of Lords expressed support for clarification of the DPP's policies on prosecuting assisted suicide.⁸² The DPP obliged by issuing an interim policy, which established "public

74. *Id.* § 1.

75. *See id.* §§ 1–16; John Coggon & Søren Holm, *The Assisted Dying Bill—"Death Tourism" and European Law* (2006), available at http://www.ccels.cf.ac.uk/archives/issues/2006/coggon_holm.pdf.

76. Diana Hassel, *Sex and Death: Lawrence's Liberty and Physician-Assisted Suicide*, 9 U. PA. J. CONST. L. 1003, 1025 n.133 (2007).

77. *See* Isabel Oakeshott, *Lord Falconer Backs Suicide Reform*, SUNDAY TIMES (May 31, 2009), <http://www.timesonline.co.uk/tol/news/politics/article6395949.ece>.

78. *Id.*

79. *See* Liam Creedon, *New Guidelines Ease Relatives' Fear of Assisted Suicide*, INDEPENDENT (Sept. 23, 2009), <http://www.independent.co.uk/life-style/health-and-families/health-news/new-guidelines-ease-relatives-fear-of-assisted-suicide-1791910.html>.

80. *See id.*

81. *See* Francis Gibb & Helen Nugent, *MS Sufferer Loses Battle on Assisted Suicide*, TIMES, Oct. 30, 2008, at N1.

82. *Id.*

interest factors” in support of, and against, prosecution.⁸³ Following publication of this policy, the DPP sought public consultation through a collection of individual responses and comments to a series of questions regarding the policy.⁸⁴ After considering the public’s responses, the DPP issued its final policy in February 2010.⁸⁵

According to the new policy, “encouraging or assisting suicide” remains an offense under the Suicide Act 1961.⁸⁶ However, prosecutors must now apply a “Full Code Test,” which is comprised of two stages: an evidential stage and a public interest stage.⁸⁷ A prosecution will only proceed if *first*, the evidential stage is met, and *second*, a prosecution is deemed necessary in the public interest.⁸⁸ For the evidential stage, a prosecutor must prove that: “[1] the suspect did an act capable of encouraging or assisting the suicide or attempted suicide of another person; and [2] the suspect’s act was intended to encourage or assist suicide or an attempt at suicide.”⁸⁹ If there is sufficient evidence of both elements, the DPP will then consider whether prosecution is in the public interest. The DPP does this by reviewing the facts and merits of the particular case and weighing “public interest factors” both for and against prosecution.⁹⁰ Public interest factors in favor of prosecution include whether the victim was under eighteen years of age or did not have the capacity to reach an informed decision, and whether the assisting party persuaded or pressured the victim into committing suicide.⁹¹ Public interest factors against prosecution include whether the victim made a voluntary and informed decision to commit suicide, whether the assisting party was wholly motivated by compassion, and whether the assisting party reported the victim’s suicide to the police and fully assisted them in their investigation.⁹²

83. See DIR. OF PUB. PROSECUTIONS, INTERIM POLICY FOR PROSECUTORS IN RESPECT OF CASES OF ASSISTED SUICIDE (2009), available at http://www.cps.gov.uk/consultations/as_consultation.pdf.

84. See *A Public Consultation on the DPP’s Interim Policy for Prosecutors on Assisted Suicide*, CROWN PROSECUTION SERV., http://www.cps.gov.uk/consultations/as_index.html (last visited Sept. 6, 2011).

85. See Dir. of Pub. Prosecutions, *Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide*, CROWN PROSECUTION SERV. (Feb. 2010), http://www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.html.

86. *Id.* ¶ 1.

87. *Id.* ¶ 13.

88. *Id.*

89. *Id.* ¶ 17.

90. *Id.* ¶¶ 38–39.

91. There are sixteen total factors that weigh in favor of prosecution. See *id.* ¶¶ 43(1)–(2), (5), (7).

92. There are six total factors that weigh against prosecution. See *id.* ¶ 45(1)–(2), (6).

The DPP announced that the new policy did not decriminalize assisted suicide or assure any person that she will be immune from prosecution for encouraging or assisting another in suicide.⁹³ Rather, the new policy is intended to “provide a clear framework for prosecutors to decide which cases should proceed to court and which should not.”⁹⁴ While assisted suicide is still an offense punishable by up to fourteen years imprisonment, the DPP acknowledged early on that the new policy may lead to an increase in assisted suicide in the United Kingdom.⁹⁵ Certainly, there will be no flurry of assisted suicide clinics opening in the country to welcome death tourists; but the new policy may make it easier for British citizens to travel abroad for suicide with reassurance that their loved ones will not be prosecuted for assisting them. Only time will tell what kind of effect the new policy will have.

B. The United States

No federal law in the United States directly permits or prohibits PAS or euthanasia. Instead, the right to legislate on end-of-life procedures lies within the purview of the individual states.⁹⁶ Currently, only Oregon and Washington have enacted statutory provisions allowing PAS under certain conditions.⁹⁷ However, in Montana, a district court judge declared in December 2008 that the State’s constitution recognizes the right of terminally ill patients to “die with dignity” by obtaining a prescription for lethal medication from their physicians.⁹⁸ The State Attorney General appealed the case to the Montana Supreme Court, which issued a ruling in December 2009 affirming the district court’s judgment, albeit on much narrower grounds.⁹⁹ Specifically, the Court refrained from answering the constitutional question whether terminally ill patients actually enjoy a right to “die with dignity”; instead, the Court held that a physician’s aid in a patient’s death does not violate the State’s public policy exception

93. *Id.* ¶ 6.

94. Press Release, Crown Prosecution Serv., DPP Publishes Assisted Suicide Policy, available at http://www.cps.gov.uk/news/press_releases/109_10/.

95. Caroline Davies, *Assisted Suicide Guidelines Will Ease Fears, Says DPP*, GUARDIAN (Sept. 23, 2009, 21:23 BST), <http://www.guardian.co.uk/society/2009/sep/23/assisted-suicide-guidelines-dpp>.

96. See *Vacco v. Quill*, 521 U.S. 793, 798–99 (1997).

97. See Oregon Death with Dignity Act, OR. REV. STAT. §§ 127.800–.995 (2003); WASH. REV. CODE. § 70.245 (2009).

98. *Baxter v. State*, No. ADV-2007-787, 2008 Mont. Dist. LEXIS 482 (Dec. 5, 2008), vacated, 2009 MT 449.

99. Kirk Johnson, *Montana Ruling Bolsters Doctor-Assisted Suicide*, N.Y. TIMES (Dec. 31, 2009), <http://www.nytimes.com/2010/01/01/us/01suicide.html>.

to the consent defense.¹⁰⁰ The Court's decision effectively makes Montana the third state to legally recognize PAS, though that right has not yet been codified by statute. Even with these states' acceptance of PAS, euthanasia remains illegal in every state.¹⁰¹

1. Judicial Background Regarding the Constitutionality of PAS

Several United States Supreme Court decisions from the past twenty or so years have helped shape the current landscape of PAS jurisprudence in the United States. In 1990, the Supreme Court faced the question of whether the United States Constitution guaranteed a right to refuse life-sustaining treatment.¹⁰² The patient in that case, Nancy Cruzan, suffered severe injuries in an automobile accident that rendered her permanently disabled and in a "persistent vegetative state."¹⁰³ Her parents sought to remove Cruzan from an artificial nutrition and hydration device that was keeping her alive. The Supreme Court held that patients have the right, guaranteed by the Due Process Clause of the Fourteenth Amendment to the Constitution, to refuse unwanted medical treatment.¹⁰⁴ The Court based its decision on traditional common law principles of battery, bodily integrity, and freedom from unwanted touching,¹⁰⁵ declining to draw a corollary between the right to refuse treatment and a "right to die with dignity."¹⁰⁶

In 1997, following the passage of Oregon's assisted suicide law, the Supreme Court issued a critical decision that threatened the rights of assisted suicide supporters in the United States. In *Washington v. Glucksberg*, the Court upheld a Washington state law that banned assisted suicide, finding that the Constitution did *not* confer a fundamental right to "commit suicide with another's assistance."¹⁰⁷ The Court balanced the patient's asserted right to assistance in suicide against the State's multiple interests in preserving life, preventing suicide, and protecting the integrity of the medical profession, and concluded that Washington's assisted suicide ban was reasonably

100. *Baxter v. State*, 2009 MT 449, 354 Mont. 234, 224 P.3d 1211. Under Montana law, a victim's consent to a crime is a defense to that crime. MONT. CODE ANN. tit. 45, § 45-2-211(1) (2009). However, there are four exceptions to the consent defense, the relevant one here being a violation of public policy in recognizing the defense. *Id.* § 45-2-211(2).

101. *See* *Vacco*, 521 U.S. at 804-05.

102. *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 269 (1990).

103. *Id.* at 265-66.

104. *Id.* at 277.

105. *Id.* at 269.

106. *Id.* at 302 (Brennan, J., dissenting).

107. *Washington v. Glucksberg*, 521 U.S. 702, 725 (1997).

related to legitimate state interests.¹⁰⁸ Opponents of *Glucksberg* have criticized the Court's narrow interpretation of the asserted right in that case—to wit, the right to commit suicide with another's assistance—and have instead characterized it as a right to “die with dignity” or to choose the means of one's death.¹⁰⁹ Advocates of PAS, however, have noted that in its decision, the Court encouraged individuals to continue to engage in “an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide.”¹¹⁰

On the same day it decided *Glucksberg*, the Supreme Court ruled in *Vacco v. Quill* that New York's prohibition of PAS did not violate the Equal Protection Clause of the Fourteenth Amendment.¹¹¹ The plaintiffs in *Vacco* argued that the State of New York unfairly discriminated against the rights of the terminally ill by permitting competent patients to refuse medical treatment—as in *Cruzan*—while forbidding patients from requesting assisted suicide.¹¹² The Court rejected this argument and drew a clear line between refusing life-sustaining treatment and requesting life-ending treatment.¹¹³ The Court concluded that the State had acted rationally in differentiating between these two competing rights and declared that the state's laws followed a “longstanding and rational distinction.”¹¹⁴ Importantly, the Court's decision, insofar as it was based on its interpretation of the *federal* Constitution, confirmed that the states were free to decide for themselves whether their respective *state* constitutions recognized a right to PAS or euthanasia.¹¹⁵

2. State Laws Recognizing PAS

In the midst of the Supreme Court's adjudication of the right to assisted suicide, Oregon became the first state to legalize PAS in limited circumstances.¹¹⁶ Oregon's Death with Dignity Act (ODWDA) was first passed in 1994 by a state ballot measure that drew a fifty-one percent vote of Oregon residents.¹¹⁷ After multiple legal challenges and court-

108. *Id.* at 728–32, 735.

109. See Yale Kamisar, *Can Glucksberg Survive Lawrence? Another Look at the End of Life and Personal Autonomy*, 24 ISSUES L. & MED. 95, 102–03 (2008).

110. *Glucksberg*, 521 U.S. at 735.

111. *Vacco v. Quill*, 521 U.S. 793, 797 (1997).

112. *Id.* at 797–98.

113. *Id.* at 800–01.

114. *Id.* at 807–08.

115. See *id.* at 799.

116. Srinivas, *supra* note 10, at 101.

117. Trevor Stiles, *Gonzales v. Oregon and the Future of Agency-Made Criminal Law*, 97 J. CRIM. L. & CRIMINOLOGY 1261, 1269 (2007).

ordered injunctions delayed its enforcement, the law finally went into effect in 1997, when Oregon voters rejected a measure to repeal the law by a sixty percent vote.¹¹⁸

The ODWDA allows competent, terminally ill patients who are residents of Oregon to request PAS under certain conditions. It provides:

An adult who is capable, is a resident of Oregon, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner¹¹⁹

Under the ODWDA, a patient is considered “capable” if, in the opinion of the court or the patient’s attending or consulting physician, psychiatrist, or psychologist, the patient is able to make and communicate health care decisions to her physicians.¹²⁰ The patient must be suffering from a terminal disease, defined by the ODWDA as an incurable and irreversible disease that will, within reasonable medical judgment, produce death within six months.¹²¹ The patient’s decision to die must be voluntary and “informed,”¹²² and the patient must make and sign a written request for lethal medication in the presence of at least two witnesses, one of whom must not be a relative, a person entitled to any part of the patient’s estate, or a health care provider.¹²³

The attending physician must make the initial determination as to whether the patient is capable, has a terminal disease, and has made the request for medication voluntarily.¹²⁴ The attending physician must also ensure that the patient has made an informed decision, meaning that the physician has informed the patient of: (1) the physician’s medical diagnosis; (2) the physician’s prognosis; (3) the potential risks associated with taking the prescribed medication; (4) the probable result of taking the prescribed medication; and (5) the feasible alternatives, including hospice care and pain control.¹²⁵ Finally, the attending physician must refer the patient to a consulting physician, who must

118. Cohen-Almagor, *supra* note 27, at 13.

119. OR. REV. STAT. § 127.805 (2003).

120. OR. REV. STAT. § 127.800(3) (2003).

121. *Id.* § 127.800(12).

122. § 127.830.

123. OR. REV. STAT. § 127.810 (2003).

124. OR. REV. STAT. § 127.815(1)(a) (2003).

125. *Id.* § 127.815(1)(c).

confirm the attending physician's diagnosis and verify that the patient is capable and acting voluntarily.¹²⁶ Once these requirements are satisfied, the attending physician may write a prescription for lethal medication;¹²⁷ however, the attending physician must wait at least fifteen days after the patient's initial oral request, or at least forty-eight hours after the patient's written request, before providing the patient with the prescription.¹²⁸

Oregon remained the only state to have legalized PAS for over a decade.¹²⁹ Then, in November 2008, voters in the State of Washington approved a law that virtually mirrored the law in Oregon.¹³⁰ Washington's Death with Dignity Act (WDWDA) contains nearly identical language to its Oregon counterpart, differing only with respect to a few trivial characteristics.¹³¹ The WDWDA includes all of the same procedural requirements and safeguards as the ODWDA and shares its fundamental purpose.

3. The Potential for Death Tourism

A unique feature of both the ODWDA and WDWDA, which distinguishes these laws from those in the Netherlands and in Switzerland, is that the patient must prove that she is a resident of the state to qualify for PAS.¹³² In Oregon, the patient can prove residency through some combination of possessing a state-issued driver's license, being registered to vote in the state, owning or leasing property in the state, or filing a tax return in the state.¹³³ In Washington, the same criteria apply, with the exception of filing a tax return in the state.¹³⁴

These residency requirements act as buffers for death tourism. Unlike the assisted suicide laws in the Netherlands and in Switzerland (detailed below), Oregon and Washington's assisted suicide laws make it extremely difficult for foreign citizens to travel to the United States in

126. *Id.* § 127.815(1)(d); *see id.* § 127.815(1)(b), (e) (remaining requirements of the attending physician).

127. *Id.* § 127.815(1)(L).

128. OR. REV. STAT. § 127.850 (2003).

129. Srinivas, *supra* note 10, at 101.

130. *Id.* at 101–02.

131. *See, e.g.*, WASH. REV. CODE ANN. § 70.245.020(1) (West 2010) (using the word “competent” rather than “capable,” and adding language indicating that the patient should self-administer the medication prescribed by the attending physician); WASH. REV. CODE ANN. § 70.245.130 (West 2010) (omitting the ability to demonstrate residency in the state by providing proof of a state tax return).

132. OR. REV. STAT. § 127.860 (2003); WASH. REV. CODE ANN. § 70.245.130 (West 2010).

133. OR. REV. STAT. § 127.860(1)–(4). These factors are not exhaustive. *Id.* § 127.860.

134. WASH. REV. CODE ANN. § 70.245.130 (West 2010).

search of aid in death. In Oregon, it may be possible for a non-resident patient to purchase land in the state and file a state tax return.¹³⁵ However, the factors are not dispositive in establishing residency for purposes of the ODWDA,¹³⁶ and would nevertheless make death tourism an incredibly expensive endeavor. Moreover, even a patient who goes through the trouble of establishing a residence in Oregon must satisfy additional criteria, such as having a terminal illness and demonstrating capability to make the request for assisted suicide.¹³⁷ The statutorily defined terminal illness requirement itself poses significant hardship, as a patient who is expected to die within six months would likely find it too burdensome to devise a plan to feign residency in the state.

In addition to the residency requirements, the minimum waiting periods between the patient's request and receipt of the prescription specified by the ODWDA and WDWDA limit the opportunities for death tourism. Under both Acts, at least fifteen days must pass between the patient's initial oral request and the physician's grant of the prescription, and at least forty-eight hours must pass after the patient's written request.¹³⁸ These waiting periods prevent hasty action, ensuring that the patient exercises extreme diligence and care in her decision to request and ultimately carry out her own death. Furthermore, both Acts stipulate that the attending physician must offer the patient the opportunity to rescind her request before providing the prescription, and explicitly give the patient the right to rescind her request even when not asked by the physician.¹³⁹ Such strict time requirements prevent patients from being able to request assisted suicide in the morning and have that request granted by the afternoon. When viewed in conjunction with the Acts' residency requirements, it is no surprise that there have been few, if any, reports of patients moving to Oregon or Washington to take advantage of their assisted suicide laws.¹⁴⁰

C. The Netherlands

In 2001, the Netherlands became the first country to legally recognize both PAS and euthanasia with the passage of the Termination

135. *See* OR. REV. STAT. § 127.860.

136. *See id.*

137. *See* WASH. REV. CODE ANN. § 70.245.020(1) (West 2010).

138. OR. REV. STAT. § 127.805 (2003); WASH. REV. CODE ANN. § 70.245.110 (West 2010).

139. *See* OR. REV. STAT. § 127.840 (2003); OR. REV. STAT. § 127.845 (2003); WASH. REV. CODE ANN. § 70.245.090 (West 2010); WASH. REV. CODE ANN. § 70.245.100 (West 2010).

140. *See* Srinivas, *supra* note 10, at 101.

of Life on Request and Assisted Suicide Act (TLRSA).¹⁴¹ Prior to 2001, assisted suicide and euthanasia had been “practiced and tolerated” in the Netherlands for several decades, despite the country’s ban on both practices.¹⁴² In the mid-twentieth century, developments in medical technology and the maturation of a doctor-patient relationship opened the door for discussion regarding end-of-life procedures.¹⁴³ In 1984, in the landmark case of *Schoonheim*, the Dutch Supreme Court announced an exception to the country’s laws prohibiting assisted suicide and euthanasia.¹⁴⁴ In *Schoonheim*, a physician administered a lethal injection to a ninety-five-year-old woman following repeated requests from her that the physician end her life.¹⁴⁵ For the first time, the Supreme Court held that the physician’s conduct was justified under a theory of “necessity” (or *overmacht*), finding that the physician acted appropriately after weighing his conflicting duties to end the patient’s suffering on the one hand and to preserve her life on the other.¹⁴⁶

In 1994, the Dutch Supreme Court extended the scope of the physician’s “necessity” defense in a case called *Chabot*.¹⁴⁷ There, a physician provided lethal medication to a patient who was experiencing major depression and intense psychological suffering, but had no terminal illness. The Supreme Court held that the “necessity” defense applied even where the patient was not terminally ill and was suffering from purely psychological symptoms.¹⁴⁸ After *Chabot*, the Dutch Parliament made several unsuccessful attempts to legalize PAS and euthanasia.¹⁴⁹ Finally, in 2001, Parliament passed the TLRSA.¹⁵⁰

141. Wet Toetsing Levensbeëindiging op Verzoek en Hulp Bij Zelfdoding [Termination of Life on Request and Assisted Suicide (Review Procedures) Act], Stb. 2001, nr. 194 (Neth.) [hereinafter TLRSA], available at <http://www.nvve.nl/nvve-english/pagina.asp?pagkey=72087> (English trans.).

142. Cohen-Almagor, *supra* note 27, at 5.

143. See JOHN GRIFFITHS ET AL., EUTHANASIA AND LAW IN THE NETHERLANDS 46–49 (1998).

144. HR 27 november 1984, NJ 1985, 106 m.nt. (*Schoonheim*) (Neth.), translated in GRIFFITHS ET AL., *supra* note 143, at 322–28.

145. *Id.* at 323.

146. Neil M. Gorsuch, *The Legalization of Assisted Suicide and the Law of Unintended Consequences: A Review of the Dutch and Oregon Experiments and Leading Utilitarian Arguments for Legal Change*, 2004 WIS. L. REV. 1347, 1355 (2004).

147. HR 21 juni 1994, NJ 1994, 656 m.nt. (*Chabot*) (Neth.), translated in GRIFFITHS ET AL., *supra* note 143, at 329–40.

148. Gorsuch, *supra* note 146, at 1356–57.

149. *Id.* at 1357.

150. *Id.*

1. The Netherlands' Assisted Suicide Law

Interestingly, the TLRSA, which went into effect in April 2002,¹⁵¹ did not explicitly legalize PAS and euthanasia; rather, it exempted from prosecution physicians who followed a specific due care requirement.¹⁵² The Act amended Articles 293 and 294 of the Dutch Penal Code—which, respectively, made it a crime to “take another person’s life,”¹⁵³ and to “intentionally incite or assist another in committing suicide”¹⁵⁴—by adding a paragraph that immunized physicians who satisfied the due care requirements outlined in Article 2 of the Act. These due care requirements are met where the physician:

- a. holds the conviction that the request by the patient was voluntary and well-considered,
- b. holds the conviction that the patient’s suffering was lasting and unbearable,
- c. informed the patient about the situation he was in and about his prospects,
- d. and the patient hold the conviction that there was no other reasonable solution for the situation he was in,
- e. has consulted at least one other, independent physician who has seen the patient and has given his written opinion on the requirements of due care, referred to in parts a–d, and
- f. has terminated a life or assisted in a suicide with due care.¹⁵⁵

The Act also provides for PAS and euthanasia for minors as long as the minor’s parents are “involved in the decision process” (if the minor is between the ages of sixteen and eighteen)¹⁵⁶ or explicitly consent (if the minor is between the ages of twelve and sixteen).¹⁵⁷

Thus, under the TLRSA, both euthanasia and assisted suicide are permissible, as long as the treating physician satisfies the Act’s due care requirements. According to the Dutch Ministry of Health, Welfare and Sport, euthanasia is understood as “the termination of life by a doctor at the patient’s request, with the aim of putting an end to unbearable suffering with no prospect of improvement.”¹⁵⁸ In the Ministry’s view,

151. TLRSA, *supra* note 141.

152. *See id.* art. 293, ¶ 2.

153. *See* SR. art. 293 (Neth.), *translated in* GRIFFITHS ET AL., *supra* note 143, at 308.

154. *Id.*

155. TLRSA, *supra* note 141, art. 2.

156. *Id.* art. 2, ¶ 3.

157. *Id.* art. 2, ¶ 4.

158. MINISTRY OF HEALTH, WELFARE AND SPORT, EUTHANASIA: THE NETHERLANDS’ NEW RULES 2 (2002), *available at* http://english.minvws.nl/includes/dl/openbestand.asp?File=/images/broch-euthanasia-eng_tcm20-108102.pdf.

this definition includes assisted suicide.¹⁵⁹ “Withdrawing or refraining from medical treatment at a patient’s request,” however, is not considered euthanasia; nor is a physician’s attempt to relieve pain with strong medication that incidentally hastens the patient’s death.¹⁶⁰

The TLRSA does not require a patient seeking assistance in death to suffer from a terminal illness. Instead, the Act simply mandates that the patient’s suffering be “lasting and unbearable.”¹⁶¹ In addition, the TLRSA lacks a requirement that the physician assess the patient’s competence to request death. While the Act does require physicians to ensure that the patient’s request was “voluntary and well-considered,” and that the patient has accepted “that there was no other reasonable solution,”¹⁶² the Act leaves open the possibility that patients with severe psychological illnesses, such as major depression or schizophrenia, may be granted assistance in death despite a potential lack of competence in requesting it.

2. The Netherlands as a Potential Death Tourist Destination

The Ministry of Health, Welfare and Sport has downplayed the idea that the Netherlands can serve as an attractive death tourist destination. In response to the question, “Can patients from other countries come to the Netherlands for euthanasia?” the Ministry has stated:

No. This cannot happen because a close doctor-patient relationship is required. Under the new Act, a patient’s suffering must be unbearable, with no prospect of improvement, and his request for euthanasia must be voluntary, carefully considered and repeated. To assess these criteria, a doctor has to know a patient well. This means that the patient needs to have been seeing the doctor for some time already.¹⁶³

Contrary to the Ministry’s position, it is, in fact, feasible for the Netherlands to play a role in the death tourism industry. Although a close doctor-patient relationship is endorsed, several of the TLRSA’s provisions actually undermine the Ministry’s stance. First, noticeably absent from the TLRSA’s criteria is a requirement that the patient be a resident of the Netherlands. Second, while the TLRSA requires the treating physician to consult an independent physician, who must see

159. *Id.*

160. *Id.*

161. TLRSA, *supra* note 141, art. 2, ¶ 1(b).

162. *Id.* art. 2, ¶ 1(a), (d).

163. MINISTRY OF HEALTH, WELFARE AND SPORT, *supra* note 158, at 9.

the patient and confirm in writing the requirements of due care,¹⁶⁴ the Act does not dictate a specific amount of time required between the patient's initial request for death, the two physicians' evaluations, and the ultimate life-ending act. Consequently, it is conceivable that a foreign citizen could travel to the Netherlands, see a primary and consulting physician in a matter of days, and be assisted in death. Finally, the TLRSA's omission of a terminal illness requirement makes the Netherlands an attractive option for a wider group of potential death tourists, including those suffering from depression, physical disabilities, and other non-life-threatening illnesses.

Despite these factors, death tourism has thus far not proven to be a significant concern in the Netherlands. This may be attributed to the culture of the Dutch medical community, which favors long-standing relationships between physicians and patients,¹⁶⁵ making it unlikely that a physician would agree to assist a patient in death after having just met and evaluated her. Additionally, Dutch physicians enjoy wide discretion in deciding whether to grant a patient's request for PAS or euthanasia,¹⁶⁶ providing another explanation for the rare incidence of death tourism in the country. Still, the language of the TLRSA makes the Netherlands a more viable death tourist destination than its leaders would care to admit.

D. Switzerland

This Note has thus far considered the laws of three countries: the United Kingdom—where both assisted suicide and euthanasia are strictly forbidden, though new guidelines issued by the DPP may relax the prosecution of assisted suicide in some cases; the United States—where only Oregon and Washington have passed laws permitting PAS in certain situations, and euthanasia remains unconditionally prohibited; and the Netherlands—where assisted suicide and euthanasia are allowed as long as the physician satisfies the TLRSA's requirements of due care. At this point, it is important to mention that in addition to the Netherlands and the aforementioned states in the United States, there are only three other countries that currently allow assisted suicide. Those countries are Belgium, Luxembourg, and Switzerland.¹⁶⁷ This

164. TLRSA, *supra* note 141, art. 2, ¶ 1(e).

165. *See Green, supra* note 28, at 679.

166. *See GRIFFITHS ET AL., supra* note 143, at 304.

167. Srinivas, *supra* note 10, at 103.

Note does not address the laws of the former two,¹⁶⁸ but will instead focus on the latter country in this final part of the analysis.

1. The Law in Switzerland

Switzerland currently boasts the most liberal assisted suicide laws of any country in the world.¹⁶⁹ It has approved of the practice for over sixty years.¹⁷⁰ Although it does not permit euthanasia, the Swiss law contains several key features that make the country the most popular destination for death tourists today.¹⁷¹

Articles 114 and 115 of the Swiss Penal Code govern end-of-life jurisprudence in Switzerland. Article 114 provides, “[a] person who, for decent reasons, especially compassion, kills a person on the basis of his or her serious and insistent request, will be sentenced to a term of imprisonment [between three days and three years].”¹⁷² In other words, active euthanasia is expressly banned. Article 115 provides, “[a] person who, *for selfish reasons*, incites someone to commit suicide or who assists that person in doing so will, if the suicide was carried out or attempted, be sentenced to a term of imprisonment [. . .] of up to five years.”¹⁷³ The negative implication of this provision is that a person who assists another in committing suicide for *unselfish* reasons will not be punished. Such, in fact, is precisely the case: assisted suicide is permissible under Swiss law as long as the assisting party is not motivated by selfishness.¹⁷⁴

There are several important aspects of the Swiss law that distinguish it from that of other countries. First, and most strikingly, the Swiss law does not limit assisted suicide to physicians.¹⁷⁵ Thus, whereas the Netherlands and the States of Oregon and Washington require a physician to oversee the patient’s death, the Swiss law allows *any* individual to assist another in committing suicide. This is especially

168. The law in Belgium is similar both facially and in practice to the law in the Netherlands, and as a result, its analysis will not provide any additional insight to this Note. On the other hand, Luxembourg’s assisted suicide law did not go into effect until late 2008, and there is not yet enough data concerning its impact to sufficiently analyze it.

169. See Pfeffer, *supra* note 24, at 509–10.

170. Cohen-Almagor, *supra* note 27, at 21.

171. See Pfeffer, *supra* note 24, at 512–13; Srinivas, *supra* note 10, at 109–10.

172. CHRISTIAN SCHWARZENEGGER & SARAH J. SUMMERS, CRIMINAL LAW AND ASSISTED SUICIDE IN SWITZERLAND: HEARING WITH THE SELECT COMMITTEE ON THE ASSISTED DYING FOR THE TERMINALLY ILL BILL, HOUSE OF LORDS 3 (2005), available at <http://www.rwi.uzh.ch/lehreorschung/alphabetisch/schwarzenegger/publikationen/assisted-suicide-Switzerland.pdf>.

173. *Id.* (emphasis added).

174. Srinivas, *supra* note 10, at 105.

175. *Id.* at 106.

significant because the lack of legally-mandated physician presence enables clinics such as Dignitas to operate using clinical workers and volunteers. Second, the Swiss law does not require a second opinion from a consulting physician before the patient is granted her request to die.¹⁷⁶ This omission is in stark contrast to the laws of both the Netherlands and the United States, where attending physicians must refer the patient to a consulting physician before providing the patient with a prescription for lethal medication. In practice, these first two features of the Swiss law make it possible to grant a patient assistance in suicide relatively quickly after she makes her initial request.¹⁷⁷

A third significant feature of the Swiss law is that it does not require that the patient be terminally ill or suffer from a severe physical disability.¹⁷⁸ This aspect of the law has generated perhaps the most criticism from the international community.¹⁷⁹ Dignitas founder Ludwig Minelli has openly advocated helping healthy individuals commit suicide, and has admitted that the Dignitas clinic helps kill non-terminally ill patients with schizophrenia and bipolar disorder.¹⁸⁰ Although the Dutch law also lacks a terminal illness requirement, the TLRSA nevertheless requires the patient's suffering to be "lasting and unbearable," and the physician must be certain that the patient's request was voluntary and well-considered.¹⁸¹ Under the Swiss law, however, the combination of assistance to the non-terminally ill and failure to ensure the patient's competence and voluntariness results in the realistic possibility of patients being killed even if they are suffering from mental disorders that adversely affect their decision-making abilities.

In addition to these features, the Swiss law's final defining characteristic, the absence of a residency requirement, makes Switzerland the most popular destination for death tourists. Indeed, as one commentator has stated, "[p]erhaps the status of the Netherlands and Belgium (and eventually Luxembourg) as death-tourism

176. Pfeffer, *supra* note 24, at 509–10.

177. *But see* Ludwig A. Minelli, Secretary General, Speech at the Friends at the End (FATE) London Meeting 6 (Dec. 1, 2007), available at <http://www.dignitas.ch/images/stories/pdf/diginpublic/referat-dignitas-in-switzerland-fate-01122007.pdf> (stating that the period between the patient's request and the "provisional green light" varies between three and eight hundred days, with an average of seventy-seven days).

178. *See* Pfeffer, *supra* note 24, at 509–10.

179. *See supra* Part I.

180. *See* David Brown, *Dignitas Founder Plans Assisted Suicide of Healthy Woman*, SUNDAY TIMES (Apr. 3, 2009), <http://www.timesonline.co.uk/tol/news/world/europe/article6021947.ece>.

181. TLRSA, *supra* note 141, art. 2.

destinations remains untested because Switzerland offers an unambiguous opportunity for assisted suicide abroad.”¹⁸²

Thousands of individuals have been assisted in obtaining death in one of Switzerland’s several assisted suicide clinics. The largest of these clinics, EXIT, has been operating since 1982 and currently has over fifty thousand members.¹⁸³ EXIT sets itself apart from Dignitas in a number of ways. Although Swiss law does not require it, EXIT only accepts terminally ill or severely suffering patients.¹⁸⁴ EXIT also ensures that patients have proper capacity to request assisted suicide and will not grant such a request if the patient is suffering from depression.¹⁸⁵ Finally, EXIT only accommodates Swiss citizens or foreign citizens who permanently reside in Switzerland.¹⁸⁶ In light of these practices, it appears that EXIT is not a significant player in the death tourism industry.

Dignitas is reportedly the only clinic that accepts non-resident patients. It is thus the driving force behind the death tourism phenomenon. Dignitas has helped hundreds of foreign citizens commit suicide, more than one hundred of whom have come from the United Kingdom.¹⁸⁷ It also currently possesses over eight hundred British members,¹⁸⁸ and more than half of its non-resident patients have come from the United Kingdom and Germany.¹⁸⁹ Minelli has stated that he believes the right to die is the very last human right, and there can be no discrimination in the granting of this right simply based on an individual’s residence.¹⁹⁰ Therefore, he sees no reason to restrict Dignitas’s services solely to citizens or residents of Switzerland.

According to Minelli, media reports that patients can arrive at the clinic and commit suicide that same day are sensationalized.¹⁹¹ He claims that there is a more formal process in place: first, the patient has to become a member of Dignitas, which includes paying a registration

182. Srinivas, *supra* note 10, at 105.

183. See EXIT auf einen Blick, http://www.exit.ch/wDeutsch/2110002/exit_auf_einen_blick.php?navanchor=2110029 (last visited Sept. 6, 2011).

184. Rodrigo Carrizo Couto, *Assisted Suicide Activist Speaks Out on Debate*, SWISSINFO.CH, (Dec. 18, 2008, 21:12), http://www.swissinfo.ch/eng/Assisted_suicide_activist_speaks_out_on_debate.html?cid=7107364 (interview with Swiss surgeon and president of EXIT, Jérôme Sobel).

185. *Id.*

186. *Id.*

187. Roger Boyes, *Swiss Crackdown on “Suicide Tourism” Could Spell End of Dignitas Clinic*, TIMES (Oct. 29, 2009), http://www.timesonline.co.uk/tol/life_and_style/health/article6894726.ece (noting that at least 119 British citizens have ended their lives at Dignitas).

188. See *id.*

189. Pfeffer, *supra* note 24, at 512.

190. Minelli, *supra* note 177, at 3.

191. *Id.* at 6.

fee and annual membership; then, the patient must send a letter of request and her medical file.¹⁹² Once a patient takes these steps, Dignitas arranges an appointment for the patient with a physician (recall that the Swiss law does not *require* a physician to participate in the assisted suicide), who will meet with the patient and ultimately determine whether he will write a prescription for lethal medication.¹⁹³ Minelli emphasizes that, in accordance with the Swiss prohibition on euthanasia, the patient must be able to take the ultimate life-ending act herself.¹⁹⁴

Despite Minelli's assurances that Dignitas takes procedural precautions against death tourists, the clinic remains the most viable option for patients seeking a "quick death." The Swiss assisted suicide law has no residency or terminal illness requirement and does not mandate that the assisting party be a physician; the law only prohibits assisted suicide for selfish reasons.¹⁹⁵ While EXIT nevertheless accepts primarily Swiss patients who are terminally ill or severely suffering, Dignitas accommodates a much wider range of patients seeking death. As a result of Switzerland's permissive assisted suicide law, Dignitas has established the country as the death tourist capital of the world.

2. The Future of Dignitas

For all of the criticism it has endured, Dignitas remains committed to its goals and methods. However, in the wake of the Downes' story and increasingly intense debate about the clinic's practices, the Swiss government has threatened tighter regulations of assisted suicide organizations and possible closure of the Dignitas clinic. In October 2009, the government proposed two bills for public debate:¹⁹⁶ the first of these bills proposed stricter duties of care for employees of assisted suicide organizations, while the second bill proposed a complete ban on organized assisted suicide.¹⁹⁷ Groups of cantons, political parties, and other organizations deliberated on the bills, and while a majority ultimately rejected both, they agreed that some type of federal-level action was necessary.¹⁹⁸ The first bill, which would have required assisted suicide patients to be terminally ill and three physicians to confirm a patient's legal capacity to make the decision and verify the

192. *Id.* at 5.

193. *Id.* at 5–6.

194. *Id.* at 6.

195. Srinivas, *supra* note 10, at 105–06.

196. Boyes, *supra* note 187.

197. See Swiss Federal Council Press Release, *supra* note 12.

198. *Id.*

presence of a terminal illness, was criticized as too complex, opaque, and discriminatory.¹⁹⁹ The second bill, which would have completely banned the practices of assisted suicide clinics, was rejected as an unlawful restriction on the patient's right of self-determination.²⁰⁰

Recognizing the desire of the public for some type of regulation of assisted suicide organizations, in September 2010, the Swiss Federal Council announced that it would instruct the Federal Department of Justice and Police to revise the first bill and the Federal Department of Home Affairs to make recommendations to improve suicide prevention and palliative care.²⁰¹ Both bodies were expected to submit their proposals to the Swiss parliament by the end of 2010,²⁰² at which point parliament would engage in a debate over a future course of action. According to Justice Minister Markus Notter, any new legislation would not ban suicide trips to Switzerland, but would effectively end "quick suicides" for foreign citizens.²⁰³ Although it is possible that new legislation may force Dignitas to significantly change its practices, the opportunities created by Switzerland's assisted suicide law could lead to the establishment of more clinics like Dignitas that accommodate death tourists.

IV. SOFT LAW REGULATION OF INTERNATIONAL DEATH TOURISM

Death tourism is a divisive issue that engenders public and political debate about a largely private and non-political topic. It produces a wide array of opinions, based on varying ideological beliefs and political views. Some may consider death tourism a wonderful possibility, one that recognizes the fundamental right to "die with dignity" and grants patients an opportunity to achieve that which their own country denies them.²⁰⁴ Others, however, may perceive death tourism as an exploitative venture, one that disregards legal principles of comity and sovereignty.

Those who fall into the first category might wonder: Why do anything about death tourism at all? How is death tourism any different from individuals traveling to foreign countries and engaging in activities that are unavailable or forbidden in their own countries? After all,

199. *Id.*

200. *Id.*

201. *Id.*

202. *Id.*

203. John Jalsevac, *Switzerland Attempting to Curb "Suicide Tourism" with Stricter Regulations*, LIFESITENEWS.COM (July 20, 2009, 11:15), <http://www.lifesitenews.com/news/archive/ldn/2009/jul/09072007>.

204. Minelli, *supra* note 177, at 1.

assisted suicide is legal in Switzerland. What obligation does Switzerland have to actively deny British citizens the same right it extends to its own citizens? These questions are legitimate and well-founded. As mentioned earlier, this Note's purpose is not to advocate or object to assisted suicide. Rather, this Note argues that assisted suicide is *inherently different* from any other activity in which citizens engage while abroad. The moral implications of assisted suicide and its unalterable finality distinguish it from such activities as experimenting with illicit drugs or engaging in benign mischief. It is a practice to which nations have been afforded a margin of appreciation in regulation and enforcement.²⁰⁵ Because of its unique and absolute consequences, assisted suicide transcends domestic restrictions and implicates core principles of sovereignty and international comity. The current system, which encourages individuals to shop for clinics that abide by the least restrictive assisted suicide laws, offends these core principles and should be regulated.

At first glance, it appears that death tourism is largely an internal phenomenon, operating solely in Switzerland, and even more exclusively, only in the Dignitas clinic. However, as mentioned above, Switzerland's position as the unequivocal leader of the death tourism industry may explain why countries such as the Netherlands and Belgium have not drawn similar appeal.²⁰⁶ Even the prospective domestic regulation of clinics such as Dignitas may not fully inhibit the trend, as current laws leave open the possibility that other clinics in Switzerland or elsewhere may emerge. Therefore, international regulation of death tourism is essential in curtailing the practice.

The most effective tool for curtailing death tourism is an instrument of soft law. As explained below, the informality and flexibility of soft law, as well as its persuasive mechanisms, make it uniquely suited for regulating morally and ethically charged issues such as assisted suicide. Part A defines soft law and distinguishes it from the traditional concept of hard law. Part B then explains why soft law provides a more favorable means of regulating death tourism than a hard law alternative.

205. See Emily Wada, Note, *A Pretty Picture: The Margin of Appreciation and the Right to Assisted Suicide*, 27 LOY. L.A. INT'L & COMP. L. REV. 275, 275-79 (2005) (explaining that the margin of appreciation is a degree of discretion that courts have afforded states in the regulation of assisted suicide).

206. Srinivas, *supra* note 10, at 105.

A. Soft Law as a Less Formal and More Conciliatory Framework Than Hard Law

There are several approaches to defining soft law. As Professor Andrew T. Guzman explains, one approach is to identify what soft law is not.²⁰⁷ It is not hard law, “meaning [it is not] treaties or custom, nor is it a purely political understanding without a legal component.”²⁰⁸ Instead, it is “what lies between these two alternatives.”²⁰⁹ Another approach is to define soft law as a system of norms or principles that guide states’ actions, rather than a framework of formal rules.²¹⁰ In its clearest sense, soft law is a non-binding, informal instrument of international law that imposes moral or political commitments on nations, rather than legal obligations. It includes instruments such as declarations, recommendations, charters, and resolutions.²¹¹

Soft law differs in several important respects from hard law, the “classic” concept of international law. The most basic difference is that soft law is non-binding. Thus, whereas hard law has actual binding effect (such as a treaty upon ratification, or a custom that has “hardened” into actual law), soft law is only “*potentially* binding.”²¹² In other words, soft law can be conceived as a proposal that will gradually evolve into hard law. A clear example of this is the Universal Declaration of Human Rights, which has, since its creation in 1948, gained acceptance as customary international law.²¹³ A second difference between soft and hard law is that soft law is less formal, and thus involves fewer procedural costs and enables quicker implementation than a treaty, which requires formal ratification.²¹⁴ A third difference is in the enforcement of soft and hard law. Unlike hard law, which is more readily enforceable through judicial intervention, dispute resolution, or sanctions, soft law depends almost entirely on the willingness of states to regulate their own actions and fulfill their own commitments. These differences lead many to dismiss soft law as a weaker form of an already practically unenforceable international legal

207. Andrew T. Guzman, *The Design of International Agreements*, 16 EUR. J. INT’L L. 579, 583 n.18 (2005).

208. *Id.*

209. *Id.*

210. See Alan E. Boyle, *Some Reflections on the Relationship of Treaties and Soft Law*, 48 INT’L & COMP. L.Q. 901, 901–02 (1999).

211. Roberto Andorno, *The Invaluable Role of Soft Law in the Development of Universal Norms in Bioethics*, UNESCO (July 2007), <http://www.unesco.de/1507.html?&L=0>.

212. *See id.*

213. Hartmut Hillgenberg, *A Fresh Look at Soft Law*, 10 EUR. J. INT’L L. 499, 505 (1999).

214. *See* Andorno, *supra* note 211.

system.²¹⁵ In contrast to this view, however, there are advantages to adopting a soft law instrument instead of a hard law instrument.

The fact that soft law is non-binding encourages states to agree to its terms. Soft law's non-binding effect assures states that they will not be sanctioned for violating an agreement, and gives states flexibility in determining the extent of their obligations. One may wonder: If the agreement is non-binding, then what is the point of implementing it at all? The answer is that more states are likely to acquiesce to the agreement, which can lead to international compromise and mutually beneficial cooperation.²¹⁶ Furthermore, in the absence of direct sanctions, non-binding agreements can still impose "reputational" sanctions, which can be just as costly for states in the international arena. For example, states that violate international commitments signal to other states that they do not take such commitments seriously. Thus, when these states seek to enter into more formal agreements in the future, other states will take into account their previous actions and may be less willing to make concessions or compromises to accommodate the offending states.²¹⁷

In addition, the informality of soft law instruments makes the process of agreeing to them much simpler than that for hard law instruments. The lack of a requirement of ratification allows states to reduce their "contracting costs," such as the costs of negotiating and consulting with legal specialists, as well as their "sovereignty costs," such as the potential for inferior outcomes, loss of authority and control, and the diminution of sovereignty.²¹⁸ Without these costs, states are much more willing to acquiesce to certain commitments and to recognize their obligations under those commitments. The less formal framework of soft law also provides for quicker implementation and a more direct influence on states' behavior²¹⁹ than would a long and drawn out treaty-making process.

Finally, the soft enforcement, or "dispute avoidance,"²²⁰ of soft law can lead to more cooperative and conciliatory resolution of disputes. Rather than being adjudicated in an international court or subjected to compulsory settlement procedures, soft enforcement can take the form of negotiated inducements through a neutral third party or independent

215. See Kenneth W. Abbott & Duncan Snidal, *Hard and Soft Law in International Governance*, 54 INT'L ORG. 421, 422-23 (2000).

216. *Id.* at 423.

217. Guzman, *supra* note 207, at 596.

218. Abbott & Snidal, *supra* note 215, at 434-37.

219. See Andorno, *supra* note 211.

220. Boyle, *supra* note 210, at 909.

problem solving. Professor Alan E. Boyle cites the non-compliance procedure adopted by the parties to the 1987 Montreal Protocol to the Ozone Convention as an example.²²¹ Any party to the protocol can invoke the procedure, at which point the matter is referred to an Implementation Committee for investigation. The committee considers the information at hand and produces a report that calls for an amicable solution.²²² This solution can include the provision of financial, technical, or training assistance to the non-complying party. If this is insufficient, the committee can issue a caution against the party, or even suspend its rights if necessary.²²³ Whatever the ultimate solution, its significance is that soft law enforcement avoids obligatory and adversarial dispute resolution, and thus protects the legal interests of the parties involved.

B. A Soft Law Instrument is Favorable in Dealing with Death Tourism

With this backdrop of hard versus soft law in mind, it is evident that an instrument of soft law would most effectively curtail death tourism. A multilateral treaty is neither prudent nor feasible in this context. Indeed, Switzerland has no incentive in ratifying a treaty that prohibits it from extending its own assisted suicide guarantees simply on the basis of residency. Although its assisted suicide clinics are non-profit,²²⁴ Switzerland's economy undoubtedly benefits from being the sole destination for many prospective PAS patients and their families. It would be an egregious affront to the country's sovereignty if it were forced to deny a valid and legal protection of its laws to non-residents. Switzerland would suffer extremely high "sovereignty costs" in such an arrangement, and would face the threat of monetary sanctions for essentially abiding by its own laws within its jurisdiction.

Instead of a treaty, the United Nations General Assembly should propose a recommendation to decrease the incidence of death tourism. This recommendation should call for international comity through the recognition of, and respect for, other nations' assisted suicide laws. Thus, a non-terminally ill British citizen, who faces a ban against assisted suicide in her own country, would not be able to travel to Switzerland to be assisted in death in disregard of the U.K.'s assisted suicide protocol. Similarly, a United States citizen residing in

221. *Id.* at 910.

222. *Id.*

223. *Id.*

224. See Amelia Gentleman, *Inside the Dignitas House*, *GUARDIAN* (Nov. 18, 2009), <http://www.guardian.co.uk/society/2009/nov/18/assisted-suicide-dignitas-house>.

California, who suffers from lasting and unbearable pain as a result of a physical injury, would not be able to travel to the Netherlands and be euthanized after meeting with an attending and consulting physician. The recommendation would not ban assisted suicide or attempt to influence states' legislation on the subject within their own territory. Rather, it would simply call on states to abide by their neighbors' laws in the context of assisted suicide and prevent the spread of death tourism.

A recommendation from the General Assembly would necessarily be non-binding on the states that adopt it. Notwithstanding this aspect of the proposal, it is likely that a large number of states would agree to its terms. Only three states in the United States and four other countries in the world legally recognize some form of assisted suicide.²²⁵ In one way or another, nearly all of these countries have dismissed or expressed concern over its potential as a death tourist destination.²²⁶ Therefore, it is not overly ambitious to predict that nearly every state that is asked to adopt the recommendation would do so. Those states that refuse to, while not in violation of any legal obligation, could face international pressure from states that either prohibit or heavily regulate assisted suicide.

Additionally, the recommendation's informal nature would lead to quick implementation and an almost immediate impact on states' behavior. States would face little to no contracting costs in adopting the recommendation and would retain substantial flexibility in framing their own assisted suicide laws.

Finally, the soft enforcement mechanism afforded by the recommendation would grant states relative freedom in settling disputes if a party violates its commitment. States may choose to form an independent committee to oversee the regulation of the recommendation or they may choose to separately engage in cooperative dispute resolution. The recommendation would effectively serve to inform states of their mutual commitments, while simultaneously preserving their rights as sovereign nations to pass their own laws and govern behavior within their own borders.

V. CONCLUSION

Death tourism is a phenomenon that has produced both wide-ranging debate about the legitimacy of end-of-life practices and

225. Srinivas, *supra* note 10, at 102-03.

226. See Swiss Federal Council Press Release, *supra* note 12; MINISTRY OF HEALTH, WELFARE AND SPORT, *supra* note 158, at 9.

declarations by international leaders that their countries will not become breeding grounds for death tourists. It has prompted individuals to appeal to their countries' lawmakers to legalize assisted suicide so that terminally ill patients would not have to travel abroad to end their suffering. Regardless of one's views about the legality or morality of assisted suicide, most would agree that a one-way ticket for a "quick death" is hardly equivalent to a vacation that involves some irresponsible recreational activities. Still, proponents of assisted suicide may maintain that death tourists are simply taking advantage of duly enacted laws that govern the countries to which they travel.

There are currently only a handful of nations that allow assisted suicide.²²⁷ Of these nations, only Switzerland has thus far played a significant role in the death tourism industry.²²⁸ A change in Swiss law, however, is not necessary to deal with death tourism. As a sovereign nation, Switzerland has every right to pass laws legalizing assisted suicide. Rather, this is an issue that demands international regulation.

An instrument of soft law, in the form of a recommendation from the United Nations General Assembly, would be the most effective tool for reducing death tourism. The recommendation would be non-binding, yet it would attract the vast majority of countries that are asked to adopt it. It would grant states flexibility in determining their own obligations, while placing pressure on those states that are reluctant to fulfill their commitments. The recommendation's informal nature would allow it to go into effect almost immediately, which would result in a direct and rapid influence on states' actions. Finally, it would encourage cooperative dispute resolution and help states avoid the high costs of formal adoption, implementation, and enforcement.

Sir Edward and Lady Joan were neither the first nor likely the last couple to achieve their wish of dying together. Without proper international regulation of death tourism in place, it will not be long before a severely depressed, yet physically healthy teenager is able to purchase a train ticket to a neighboring country and convince a volunteer clinical worker that she would like to end her life.

227. See Srinivas, *supra* note 10, at 103.

228. *Id.* at 105.