HOW IS DEATH HASTENING DONE?
A REVIEW OF EXISTING SANCTIONED DEATH HASTENING DECISION-MAKING PROCESSES AND PRACTICES

By

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Abstract

Death hastening is a controversial terminal care option that is currently carried out in only four countries and some US states, with Canada posed to allow it on June 6, 2016. This article focuses on how assisted suicide and euthanasia have been managed in the four countries and US states where it has been sanctioned and practiced. A systematic literature review and additional searches were employed to gain information on the methods, recipients, procedures, regulations, outcomes, and other information available on state-sanctioned death hastening. The findings reveal many different possible models and thus considerations required for planning in advance of death hastening actually occurring.

Key Words: literature review; assisted suicide; euthanasia; Canada; procedures; policies; law

Although death hastening has been practiced in some countries for years, if not decades, death hastening remains a highly controversial terminal care option. Both forms of death hastening, assisted suicide and euthanasia, have raised concern among some individuals and groups, while others have sought to have one or both forms legalized. Assisted suicide occurs when a person ends their own life with the help of one or more persons. With assisted suicide, the person ending their own life has an active role in their death hastening. Euthanasia, alternatively, occurs when one or more persons end the life of someone who is unable to participate in the actions that lead to their early death, such as in cases where they become unconscious after having requested death hastening. One or both of these two forms of death hastening are legally sanctioned and procedurally regulated in four countries now: Belgium, the Netherlands, Luxembourg, Switzerland, and a growing number of American states after Oregon was the first in 1997 to enable requests from terminally-ill adults for lethal prescriptions. Three

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additional American states (Washington, Montana, and Vermont) have since adopted that specific approach to death hastening (Oregon Health Authority, 2016).

Death hastening is currently being introduced in Canada and debated in many more countries; including China, Germany, France, England, Scotland, New Zealand, Australia, South Africa, and some South American countries. For instance, Columbia has had a law since 1997 that permits death hastening when terminal pain cannot be alleviated, but regulations have not been developed to enable it, with involved persons at risk then of being charged with murder (Martin, 2015). The many concerns associated with death hastening necessitate not only legal sanctioning but deliberative procedural, regulatory, and other developments to ensure vulnerable people are safeguarded, and that effective decision-making processes and life-ending methods exist prior to any actual hastening of deaths.

Background

The precaution about being well prepared for death hastening is of particular relevance to Canadians. On February 6, 2015, the Supreme Court of Canada ruled in favor of hastened death or physician-assisted dying for terminally-ill or dying persons who request it (Carter v Canada, Attorney General, 2015). This ruling essentially decriminalizes assisted or hastened death, as assisted suicide and other forms of death hastening have been expressly prohibited by Canada's Criminal Code. The 2015 Supreme Court ruling follows a 2012 British Columbia (provincial) Supreme Court ruling that granted the right for one terminally-ill woman, Gloria Taylor, to receive assisted suicide; although she suddenly died later in 2012 before her death hastening could take place. The February 2015 Supreme Court ruling also follows the long-standing deliberative actions of the province of Quebec, actions that have led to the expansion of end-of-life care options in that province to include medical aid intended to end life earlier than if nature were to take its course (National Assembly of Quebec, 2014). The first cases of hastened death in Quebec were openly acknowledged there in December of 2015, after *An Act Respecting End-of-life Care* was enacted on December 10, 2015. Previous to this, many private members' bills for legalized death hastening had been tabled in the Canadian Parliament without being passed. Canada's Supreme Court also ruled in 1993 (in a 5 to 4 decision) against decriminalizing assisted suicide in the Sue Rodriguez case (Rodriguez v British Columbia, 1993).

Although the February 2015 Supreme Court of Canada's unanimous decision after hearing the case of *Carter v Canada* essentially made death hastening or physician-assisted dying legal in Canada, a twelve-month suspension was given to permit the planning needed for death hastening to actually occur. In January 2016, another 4-month extension was given when it

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became obvious that the federal and provincial governments were not ready to initiate this new terminal care option. Until June 6, terminally-ill or dying people who want hastened death can apply to a judge to gain permission for it to be done. It is not clear in these cases who will receive approval, how hastened death will be performed, and who will perform the death hastening. On or before June 6, 2016, every Canadian province and territory needs to have mechanisms in place to permit this radically new end-of-life approach to safely and effectively occur.

To that end, an external panel was convened by the federal Ministers of Justice and Health to deliberate on this matter, with their 461 page report entitled "Consultations on Physician-Assisted Dying. Summary of Results and Key Findings" completed in December 2015 and then released for open discussion and use in formulating governing policies and procedures on January 18, 2016 (Government of Canada, Department of Justice, 2016). The mandate of this Panel was to "engage Canadians and key stakeholders in consultation on issues that are fundamental to a federal legislative response to the *Carter* ruling" (p. 6), with the Panel focusing on four key issues:

- The different forms of physician-assisted dying, namely assisted suicide and voluntary euthanasia
- Eligibility criteria and definition of key terms
- Risks to individuals and society associated with physician-assisted dying
- Safeguards to address risks and procedures for assessing requests for assistance in dying and the protection of physicians' freedom of conscience. (External Panel on Options for a Legislated Response to Carter v. Canada, 2016, p. iv)

One of the groups that the external panel met with was the Canadian Nurses Association. A brief dated October 2015 was provided to the external panel by the Canadian Nurses Association. The Canadian Nurses Association (2015) concluded their brief as such:

> Nurses are intimately involved in end-of-life care processes, including decision-making, and are therefore in a favourable position to develop therapeutic relationships with patients and their families and to work collaboratively with all members of the health-care team. Our comments reflect this specialized knowledge and experience and offer an assessment through the lens of CNA's code of ethics. CNA's consultation with experts in the field highlight the importance of recognizing nurses and other members of the interprofessional health-care team who are involved in PAD. (p. 10)

After the external panel report was completed, a Special Joint Committee comprised of

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members from the Canadian Senate and Canadian Parliament was established in January of 2016 to "make recommendations on the framework of a legislative response on physician-assisted dying" (Government of Canada, Department of Justice, February 25, 2016, para. 5). On February 26, 2016 the Canadian Nurses Association (CNA) welcomed the Special Joint Committee's "21 recommendations for the federal government to consider in crafting a framework on medical assistance in dying (MAID)" (para. 1), and stated:

> we support the committee in acknowledging that MAID may be performed by a nurse practitioner, or a registered nurse working under the direction of a physician, by recommending an exemption for RNs, NPs and physicians under sections 14 and 241(b) of the Criminal Code. This change would protect from prosecution nurses and other health professionals involved in MAID. (para. 6)

Many other groups have also made their views or position evident. For instance, the Canadian Nurses Protective Society released a paper on February 17, 2016 entitled "Physician-Assisted Death: What Does this Mean for Nurses?"

At this point in time, when assisted or hastened death is still being planned, it is important to recognize that there are many ways to end a life, just as there are many different possible decision-making processes to determine who can have their death hastened and who cannot. The model that is being decided on now by the federal government and by each provincial government will greatly impact who can get help to end their life early, what kind of application process is needed, who approves these requests, and how it is done. After a careful review of what other countries do where death hastening has been openly practiced for some time now, it is clear that there are many different options. This report outlines current legally-sanctioned, government regulated, and openly practiced death hastening decision-making processes and life ending methods. Information on the outcomes or impacts of death hastening where sanctioned hastened death currently occurs was also sought and is reported as found.

Information Search Method

A systematic literature review was initially conducted using the two main library databases (i.e. Medline and CINAHL) that are commonly used to share or obtain health and healthcare information. "Assisted suicide" or "euthanasia" were initial search keywords, with many thousands of articles identified. When linked with the keywords "legislature, Act, regulations, policies, procedures, or standards" and limited to the last 10 years and English-language, over 500 articles were still present. These titles and abstracts were reviewed, with

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some promising full papers also read. Most were found to be opinion or theoretical articles, with some such articles and all research reports retained if they contained information to answer four questions about sanctioned death hastening in the four countries and state of Oregon.

1. Which persons potentially can have their death hastened?
2. What decision-making processes are in place for persons to request and achieve a legally-sanctioned and performed death hastening?
3. What methods or procedures or products are used to end life?
4. What are the identified outcomes or impacts of death hastening in the country/state?

However, minimal information was available in these publications. As a result, repeated Internet searches were undertaken for information specific to each of the five jurisdictions. In addition, information was sought directly from organizations that could provide statistical and other findings gained from death hastening report mechanisms in each country and the American state. This information for each jurisdiction is summarized in Table 1 (see Appendix A)

Findings and Discussion of Findings

As outlined in Table 1 (see Appendix A), major differences were often found across the jurisdictions. These differences included which persons can legally have their death hastened. With the exception of the Netherlands and Belgium, most of the jurisdictions only permit adults to apply for and thus receive sanctioned death hastening approval (people who then may or may not have their death actually hastened). Moreover, this permission is normally only given to those persons who have been determined to be suffering and near death. Typically, they are to be terminally-ill from incurable cancer or another life-limiting disease and with a prognosis that death is likely to occur within six months. In addition, a non-coerced clear and repeated request from the person needs to be made. A form is often needing to be completed to request hastened death by the person, with information gathered on this form fundamental to that person's decision-making process as well as the approval granting or denial process. However, some major differences across jurisdictions exist, with these including whether children can request and receive hastened death approval, how or to whom the death hastening request must be made, and if the suffering of the person must be associated with a life-limiting illness such as cancer or if this suffering can be from another illness or condition resulting in a reduced quality of life.

Considerable diversity in regulatory processes across the jurisdictions is also apparent. In part, this diversity is based on if assisted suicide is only permitted or if assisted suicide and

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euthanasia are permitted, as it is in Belgium, the Netherlands, and Luxemburg. Regardless, many steps are needed in all jurisdictions; such as the need to formally and repeatedly request death hastening and meet the criteria to be approved for it. Typically, two physicians are required to determine that the person's illness is non-curative and advanced or end-stage, with the requesting person needing to be determined near death and clearly wanting to have their death hastened over other measures such as continued treatments or palliative care. Some jurisdictions such as Oregon place decision-making emphasis on the individual who wants to hasten their death, others on the physician or physicians involved in the case, and others on committees or organizations specifically developed for hastened death approval or denial purposes. In some jurisdictions (Oregon and Switzerland) it was evident that physicians are not required to perform hastened death upon request, and with some jurisdictions (Luxemburg and Oregon) having clearly outlined requirements for physicians who are not willing to perform death hastening to refer patients to physicians who will perform it.

In most jurisdictions, a form is to be completed after the hastened death has taken place by the regular attending physician or the death hastening physician; with the information gathered through this form summarized and reported for corrective or other subsequent action. This information is critical for demonstrating that the people who request and have hastened death performed vary considerably in age, gender, and other characteristics. Switzerland alone does not require or keep standardized records on their citizens who receive assisted suicide or suicide tourists, and so lacks information on these persons. In Switzerland, suicide is not differentiated from assisted suicide, with death certificates therefore not viable or valid forms for data collection and compilation.

The methods used to end life are much less diverse across the countries and states where it is currently allowed. Death hastening in all jurisdictions involves the use of one or more medications. Barbiturates such as phenobarbital appear to be the most common class of medications used for death hastening. If two different medications are used, the first is typically given to sedate the person to the point of unconsciousness or coma and then the second is given to stop the functioning of the lungs and/or heart so death occurs. If only one medication is used, it is typically a large overdose of a sedative such as a barbiturate to depress the respiratory system to stop breathing efforts; with death then following. One difference in method across the jurisdictions is if the drug or drugs are in an injectable form or if they are the kind that can be swallowed or inserted through a feeding tube. Medications taken by mouth or feeding tube will take longer to act as compared to a very rapid effect whenever the medication is administered directly into the blood stream.

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However, if the drug(s) are intravenously administered (i.e., injected directly into the blood stream), an access site into a blood vessel is required. Unless the person wanting death hastening already has a blood vessel port present and ready for use, a person with some technical skill is required to insert a needle into a blood vessel and inject the drug(s). Consequently, it is possible that some or complete assistance will be needed for hastened death to occur with injected medications. It is also possible that some or complete assistance will be needed for very weak or minimally-conscious persons when the oral or tube feeding route is used. For this reason, some jurisdictions (the Netherlands, Belgium, and Luxemburg) have legalized euthanasia in addition to assisted suicide, as persons who are to receive death hastening can be denied it at the time it is scheduled if they are not able to actively consent or participate in the actions needed to end life.

Minimal evidence-based outcomes or impact information was found in the available literature and other obtained information. Instead, much debate was found to exist over potential positive or negative aspects of hastened death. This debate was typically based on ethical, legal, human rights, or religious tenets. Among these, slippery slope arguments are the most common; essentially the concern that an increasing number of vulnerable people will be killed or pressured to die early once hastened death begins to be practiced. However, the evidence, although scanty, did not indicate an escalation in the number of cases from year to year in the jurisdictions where records have been kept, nor was there any evidence of vulnerable persons in any jurisdiction being coerced or forced into hastened death. With the exception of Oregon, where no healthcare professional is required to be present at the time of the medication use and so information is not routinely kept to identify outcomes or impacts such as those possible on the person or family members who may be present, few issues or problems with hastened death were noted. Most significantly, in all but a few cases where a death did not occur as rapidly as expected, the intended death was the outcome or result of the deliberate assisted suicide or euthanasia actions.

Conclusion

Death hastening has much planning required prior to any practice of it. Above all, it is critically important to ensure vulnerable people are protected from unwanted or premature “mercy killing,” that care providers who legally practice euthanasia or assist suicides are protected from prosecution and civil actions, and that people who are suffering and who want to have their life ended early can do so without undue delays, additional costs, or extreme effort on their part. They should also be confident that their life will end at a time of their choosing without additional pain or suffering induced by the death-hastening method. For that reason, the

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information in this report is intended to further the deliberative development of procedures, mechanisms, and other criteria to govern death hastening before death hastening actually occurs in Canada or another country.

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Table 1: Death Hastening in Four Countries and One American State

Country or State (year) and Information About Act	Death Hastening Applicants and Recipients	Decision-making Processes and Bodies	Life Ending Method(s)	Outcomes or Impacts
♦**SWITZERLAND** - Assisted suicide could be practiced as early as 1937 in keeping with Article 115 of the Swiss Criminal Code, which prohibits any person who for selfish motives incites or assists another to commit or attempt to commit suicide; they would be liable to a custodial sentence not exceeding 5 years or a monetary fine if the other person commits or attempts to commit suicide. - Article 114 of the Swiss Penal/Criminal Code specifically prohibits euthanasia. - The prescription of medications for pain and other medical reasons, medication that contribute to or cause death, is not in violation of Article 26 of the Law on Pharmaceutical Products or Article 11 of the Narcotics Law.	- To avoid prosecution under Articles 114 and 115, it is commonly reported that all adult legally/mentally competent persons meeting 3 conditions can request and have assisted suicide: (a) the person is suffering unbearable pain, (b) their illness is incurable, and (c) their demand is made in full consciousness. - One report indicated approximately 1,800 requests for assisted suicide are made each year, with 2/3 rejected after screening, and ½ of those accepted actually dying of other causes; with around 300 suicides said to be assisted by death hastening societies annually (0.45% of all deaths in Switzerland).	- The three conditions must be certified to. - A Swiss doctor's prescription is needed to legally get the drug or drugs required for assisted suicide.	- A lethal drug (such as phenobarbital) or a cocktail of drugs is provided to the person who then is to take this medication under supervision. - A physician is not required to be present at the time of the medication use.	- Organizations such as Dignitas have formed to provide assisted suicide in Switzerland. - With private organizations providing assisted suicide services, and no distinction of assisted suicide from suicide, standard information such as the number of assisted suicides, and outcomes or impacts is not available. - Some hospitals have banned the practice of assisted suicide on site. - Death suicide tourists from other countries can receive assisted suicide in Switzerland. This requires them to travel to Switzerland and perhaps die earlier than if they could do this death hastening in their home country. They may also be away from family and friends at the time of their death, and family members who accompany them or help with these arrangements may be charged in their home country for having assisted a suicide.

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♦ **OREGON STATE** - The Death with Dignity Act (DWDA) was passed in 1994, but did not come into effect until late 1997. - This Act was a citizens' initiative passed first in a November 1994 general election (51% to 49%). An injunction delayed the implementation of it until October 27, 1997. In November 1997, a measure was placed on the general election ballot to repeal the Act; but voters retained it (60% to 40%). - This law allows terminally-ill Oregonians to end their lives through the voluntary self-administration of lethal medications, expressly prescribed for that purpose. Assisted suicide is thus permitted, but with euthanasia also possible as no medical personnel are required to be present with the fatal drug overdose is administered or taken.	- The 1994 law allows for terminally ill, mentally competent adult (age 18+) persons who are residents of Oregon with less than 6 months to live to request and receive a prescription for life-ending medication. - As of February 2, 2015, 1,327 people have had DWDA prescriptions written and 859 have died from ingesting the prescribed medications. - In 2014, 155 persons had prescriptions written, with 105 such deaths in 2014; of these, most had cancer (68.6%) and died at home (89.5%); 67.5% were age 65+, 95.2% were white, and 47.6% had at least a baccalaureate degree. The 3 most common end-of-life concerns cited by them were loss of autonomy, decreasing ability to participate in activities that made life enjoyable, and	- The person wanting death hastening must complete a form (Request for medication to end my life in a humane and dignified manner), which is witnessed by 2 select persons. - The person must provide that form to and ask their attending physician for assisted suicide at least twice, with these requests at least 15 days apart. - That physician must be a Doctor of Medicine or Doctor of Osteopathic Medicine who is licensed to practice medicine by the Board of Medical Examiners for the State of Oregon. This physician must also be willing to participate. - The physician, after determining that the person is within 6 months of death as confirmed by a second consulting physician, gives the requesting person a lethal prescription and informs their pharmacy of this prescription. - The requesting person may be referred for psychiatric or psychological evaluation before a prescription is written. - The prescription is	Secobarbital is the most common drug, followed by phenobarbital; but other drugs have also been prescribed; such as combinations of secobarbital, phenobarbital, and/or morphine. - The medication is to be self administered. Even if the attending physician is present at the time, they are not to inject, give, or insert the medication.	- Not all persons who get the prescription have it filled. Even if filled, not all take the drug(s); some die without the death hastening procedure or could change their mind about ending their life early. - Concern exists over the risk that this medication could be used by other people, that the person may be forced to take the medication as no medical or other professional is required to be present at the time the medication is taken; and that euthanasia (illegal in all American states) can occur if someone other than the person injected or puts the drug(s) into them. - Concern exists over an escalation in the annual number of assisted suicide deaths, although the annual reports for Oregon do not demonstrate this increase. - There is potential for unsuccessful death hastening attempts, with people then left in comas or perhaps also waking up after the suicide attempt; although no such cases were noted in the most recent annual report by the Oregon Public Health Division.

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- The Act requires the Oregon Health Authority to collect information about cases and issue an annual report. - In March of 2015, a bill to amend the Act (HB 3337) was introduced, to expand the definition of terminal disease predicted to cause death to one year from the current 6 months.	loss of dignity.	filled by a pharmacist, with the drug(s) then available for use at a time or place of the person's choosing. - A follow-up questionnaire is to be completed by the physician in each case and provided to the Oregon Health Authority. - Complaints about any physician not adhering to the requirements can be made to the Oregon Board of Medical Examiners.		
♦ **THE NETHERLANDS** - Although assisted suicide had been practiced for many years without sanction, the Termination of Life on Request and Assisted Suicide Act was passed in 1999 and came into effect April 1, 2002. This Act permits and regulates the ending of life on explicit request by the individual. - Euthanasia and assisted suicide are legal only if the criteria laid down in the Termination of Life on Request and Assisted Suicide (Review Procedures) Act are	- The criteria for voluntary euthanasia and/or assisted suicide is: (a) the person must make a request, (b) they must be suffering unbearably and with little or no reasonable hope of cure/ improvement, (c) information must be provided to them, and (d) there is consultation with another physician. - Most recipients have had cancer. - One or both procedures are most often carried out at the home. - Minors may request euthanasia starting at the age of 12, although the	- To demonstrate their compliance, the Act requires physicians to report all "unnatural" deaths to the municipal pathologist, who notifies 1 of 5 regional Euthanasia Review Committees; these are comprised of at least 3 persons (a medical doctor, an ethicist, and a legal expert). - The doctor is required to be present at life ending to make sure the potion is not taken by a different person, or taken by accident (such as in an "unauthorized" suicide or murder), and to monitor the process.	- The sedative sodium thiopental is often intravenously administered to induce a coma, if the requesting person is not already in a coma. Once the person is in a coma, often in less than one minute, pancuronium is given to stop breathing and cause death. Alternatively, an assisted suicide may involve the	- In 2010, 4,050 persons died from euthanasia or assisted suicide in this country. - 1.2% of all deaths in the country were hastened in 2003, and this percentage has not increased over time. - A total of 2 physicians over time have been reprimanded for not staying to see the person die. - 41 cases had both death producing procedures done as the person drank the potion, but it did not cause death and so a second drug method was used to end life.

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fully observed. Only then is the involved physician considered immune from criminal prosecution.	consent of their parents or guardian is mandatory until they reach the age of 16. Sixteen and seventeen-year-olds do not need parental consent but their parents must be involved in the decision-making process. From the age of 18, young people have the right to request euthanasia or assisted suicide without parental involvement.		person drinking a (10 gram) barbiturate potion.	
♦BELGIUM - In 2002, the Euthanasia Law was passed to permit and regulate the ending of life, with it coming into effect September 22, 2002. - On February 13, 2014, Belgium also legalized euthanasia by lethal injection for children of any age. - The Act stipulates that persons requesting assisted suicide or euthanasia must be informed of the possibilities of and right to palliative care, with funding to ensure every hospital and nursing home in the country had a	- Doctors in Belgium can help people end their lives when they have freely expressed a wish to die because they are suffering intractable and unbearable pain or suffering. - Adults can also receive euthanasia if they have clearly stated this wish before entering a coma or vegetative state. - Children also must be conscious of their decision, terminally ill, close to death and suffering beyond any medical help; they also need the	- The person must apply to be assessed before having it done. - The physician has to be present at the bedside to the last breath.	- The law does not specify a method to end life; but a lethal injection usually occurs. - A barbiturate alone is used in around 1/3 of cases, with a barbiturate and neuromuscular relaxant used in around 60% of cases. - Morphine alone or in combination with a sedative is	- Despite concerns over an increase in hastened deaths; there were 1,807 cases in 2012-13, compared with 1,432 cases in 2011-12, 708 cases in 2007-8 and 235 cases in 2002-3; the percentage of assisted versus total deaths has not increased over time. - Concern was raised that assisted death would reduce palliative care services, but prior to the passage of the 2002 law, the federal budget for palliative care was doubled. - There is no age limit for minors seeking a lethal injection, but parents must agree with the decision, however, there is concern about pressure being placed on

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palliative care team. - Parliament also created a Control and Evaluation Commission (Federal Committee on Oversight and Enforcement) to which assisted suicide and euthanasia cases must be reported and specified that four of its 16 members be palliative care workers (the others including doctors, ethicists and lawyers), with an annual report is to be produced, and biennial reporting to the legislature.	consent of their parents. No children have had assisted death so far. - Approximately ½ of all requests for death hastening end in death hastening. - The 2012-13 report of the Federal Committee on Oversight and Enforcement showed 1,807 hastened deaths, with just over half of people aged 70+ and 80% of applications made by Dutch speakers. - Most hastened death cases involve cancer. - Half of hastened deaths take place in Belgium hospitals.		occasionally used.	parents and/or their children to hasten death.
♦LUXEMBURG - On March 16, 2009, the Euthanasia and Assisted Suicide Act was passed, which defines both as a medical procedure where a physician intentionally ends the life of another person at their express and voluntary request. - At the same time, legislation was also passed on palliative care (legalized	- The person must be an adult, conscious and capable of making a decision at the time of request, with the request made voluntarily after reflection and repeated, and with no external pressure. - The person must be in a severe advanced and terminal condition, with constant and unbearable physical	- The death hastening request must be in writing, dated and signed by the person, unless they need this writing to be done for them, with this document registered whenever possible with the Commission for Control and Assessment. - The physician who receives the request must inform the patient of their health state and life expectancy, as well	- Death is achieved by the doctor inducing a coma with a general anaesthetic (i.e. biopental injected intravenously), followed by an intravenous injection of a neuromuscular paralysing agent to cause death	- Despite concerns that the Act would not be followed, the first Commission report stated there were no concerns with the law not being followed or any other concerns, although all cases involved euthanasia, none involved assisted suicide. - Although concerns have been raised about delayed dying, pain when dying, or worsened health from unsuccessful death hastening

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advance directives) and end-of-life accompaniment (leaves from work to care for dying persons). - Assisted suicide and euthanasia consist of helping another person to end their life, and this includes providing the necessary means for this purpose. - Doctors who carry out euthanasia and assisted suicide as expected will not face "penal sanctions," medical board reviews, or civil lawsuits. - The law describes the conditions for a legal request for euthanasia or assisted suicide, the steps to be taken by the doctor who receives a request for euthanasia or assisted suicide, as well as his/her obligations. - The law also resulted in a Commission for Control and Assessment to be set up, with formal reporting expected every 2 years. This group consists of 9 members; 3 are	or mental suffering, and with little or no prospects of improvement. - The person may be awake and assisted to commit suicide, or not conscious when the death hastening actions occur. - A total of 681 citizens for 2009 and 2010 were recorded as having had death hastening in the first report, with 285 males and 396 females, all suffering from cancer, and with most having several physical and psychological concerns that were described as constant and unbearable.	as the written information that has been provided by a second doctor, as a consultation with another doctor about the terminal illness prognosis is required; deal with future therapeutic possibilities and palliative care options; be convinced that the request is voluntary and that in the patient's eyes there is no other acceptable solution; have several interviews with the patient at reasonable intervals to see persistent physical and/or mental suffering and hear repeated requests for hastened death from them; unless the patient objects, discuss their request with the care team; unless the patient objects, talk to any appointed persons about their request for hastened death; and obtain information from the Commission as to whether any end-of-life provisions have been registered by the patient. - Within 8 days of performing euthanasia or assisted suicide, the doctor must submit a registration document to the National	through cardio-respiratory arrest. - No euthanasia cases involved morphine alone or in combination with a sedative.	medication use; the first report said in all cases, a serene and rapid death within minutes was reported by the doctors. - Although death tourism is not prohibited, the Act requires a close relationship between the patient and their doctor, which is considered only possible when there has been a relationship for some time. - Although there is some concern about doctors being forced to perform death hastening, doctors in Luxembourg are not required by law to hasten death. However, if a request is made and the doctor refuses to perform death hastening, that doctor is to inform the patient and/or their agent of this decision within 24 hours of the request so they can quickly go elsewhere.

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doctors of medicine, 3 are lawyers, 1 is from the higher council of other health professions, and 2 are to be from organizations that defend the rights of the patient.		Commission for Control and Assessment, which is then used to determine if the conditions and procedures provided by the law have been met or not. - Criminal proceedings are to be considered and/or initiated if there are any concerns that the law was not adhered to.		

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