



### REVIEW OF THE PHYSICIAN-ASSISTED SUICIDE IN THE UNITED STATES, GERMANY AND SERBIA

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**Abstract:** Assisted suicide is the act whose manner of criminalization or non-criminalization varies from country to country, regardless of the continent in question. Special attention has been paid to this form of deprivation of life lately, with the medical assisted suicide becoming current. Medical services include a wide range of services that exist in the modern era of mankind, and, at the end of the 20<sup>th</sup> and the beginning of the 21<sup>st</sup> century, the United States brought about a special medical service, known as a physician's assistance in committing suicide. The authors of this article primarily deal with assisted suicide in the legal system of the states where decriminalization of this form of deprivation of life came about. After failing to pass the law in certain states, the first US legislation that legalized assisted suicide was the Oregon one, which brought about the law on death with dignity, which was unique in the world at the time. Successful implementation of this law contributed to the decriminalization of physician-assisted suicide first in Washington, then in Montana, Vermont and California. After this group of legislations, the authors explain the two European legislations that have an entirely different approach to regulating this issue. Firstly, they handle the legislative system of Germany, where neither assisted suicide nor physician-assisted suicide is considered as a criminal offense. Then they explain the approach of the legislator of the Republic of Serbia, where they have performed research regarding this issue. The aim of this article is to explain and elaborate on the corresponding provisions of the law when processing any of these legislations, and then summarize the statistical data on committed assistances in suicide. Some of the legislative solutions are new, while about the laws in the other countries there are not enough literature in the English language. According to it, the authors consider that it is very important for the scientific community to get insights into these legislatures.

**Keywords:** assisted suicide, physician-assisted suicide, Serbia, Germany, United States

## Introduction

Assisted suicide is one of the felonies whose criminalization varies from country to country. Suicide is no longer punishable by any comparative criminal law, but this tendency was the most opposed by the English legal system, where suicide is decriminalized in 1961 (Stojanović, 2007). At that time, the Government seized the person's property, if he or she commits suicide, because they deprived the king of one vassal in that manner (Sheb and Sheb, 2011). In the early American legislation, the attempted suicide was treated as a misdemeanor, but today, as well as in the rest of the world, it is treated as an unpunishable act. In addition, there is a possibility of psychiatric examination of the person who attempted suicide (Hall, 2012). However, inducing someone to suicide and assisting him in it are punishable in the majority of countries. In some US countries, it is equated with murder, while in others, like Michigan, it represents a privileged form of murder (Hall, 2012). But, in some countries "the idea of ending one's life through assisted death "Euthanasia" is becoming indefatigable and socially acceptable" (Ladki et. al, 2016). In the comparative theory, there is a difference between assisted suicide and physician-assisted suicide in order to further the aid in committing a suicide (Paterson, 2008), whereby both procedures are related to the deprivation of life of the patient due to his serious health condition. In the first procedure, we have a perpetrator who is a third party and who helps a patient to terminate life (assisted suicide), while in the second case, a physician (physician-assisted suicide) occurs as a helper (Arrigo, 2014). It is common that a person is helped to commit suicide by doing something, but it is not uncommon to help him by not doing anything, which stands as one of the forms of passive euthanasia (Vuković, 2007).

Living and dying in accordance with the person's own beliefs and desires are considered to be one the greatest human freedoms, and one of the most common wishes of the patients who are in the terminal stage of the disease is to end their lives with a certain amount of dignity (Keegan and Drick, 2010). This raised a question of one of the most important problems in the past and present times. It is an issue of decriminalization of euthanasia and physician-assisted suicide. This also actualized the question of decriminalization of assisted suicide, but we have to also emphasize its ethical issue (Banović et. al, 2017). The debate on these issues has not decreased for many years, and it is refracted through the different types of legislative solutions, assisted suicide being the one of which appeared as a transitional form towards decriminalization of this type of murder in the United States. In other words, in some states in the United States, under prescribed conditions, a physician is able to provide a medication to the terminally ill patient that would lead to his death. The patient in terminal stage of disease and who, due to the physical, psychological or religious reasons, is unable to commit a suicide, has a possibility to reach a service he can find in medical institutions in some American states. This way, the relationship has been established, significant for both the criminal and medical law, between two phenomena characteristic of modern times: the huge number of services offered by the society, on the one hand, and autonomy of the individual will, on the other hand. If you look at the map of the United States, we note this procedure has in fact been legalized in the neighboring states, which are located around the perimeter of the continent.

Unlike euthanasia, in which a physician deprives the patient's life by active engagement, at physician-assisted suicide (hereinafter: PAS), a doctor prescribes a medication that a patient will take when he decides to die. Therefore, PAS is an act by which a physician facilitates a patient's death by providing him necessary information and means to perform the very act. Based on this, we come to the crucial difference between euthanasia and PAS, which consists in an entity that directly undertakes the action. In the procedure of euthanasia, it is a physician, while in PAS it is a patient. Due to that fact, PAS is somewhere in the middle between euthanasia and suicide. The physician prescribing a medication bears responsibility to assess whether a patient is aware of his decision and whether he is capable of making a decision. Furthermore, another important difference between these two forms of deprivation of life lies in the fact that during the performance of the act in question, patients are not in the stage of sustaining life on life support nor do they have the option of refusing a medical treatment which would lead to their death, as it is the case with worldwide justified passive euthanasia. For some patients PAS is only a way to avoid suffering and greater loss of control over their own body (Ward, 2005). As a primary argument in favor of PAS, we could find autonomy of the will and the right to the patient's own will, then, PAS shows compassion and mercy, and ensures release from suffering (Fernandes, 2001; Sharma, 2003). It is important to emphasize the fact that there are two impartial witnesses, in the states that decriminalized PAS, besides physicians and patients. The medical institution will appoint one of them, under certain conditions, and with qualifications prescribed by the Ministry of Service.

In the midst of the world fight for the legalization of voluntary euthanasia, some American and European (Gürücü et. al, 2016) countries decided to undertake the milder step, which is the decriminalization of assisted suicide, provided that it was carried out by a physician under the prescribed conditions. These are Oregon, Washington, Montana, Vermont and California whilst some others are in the middle of a debate regarding the issue. Courts in some judgments (such *In re Conroy* and *In re Guardianship of Browning*) emphasize "highly sensitive nature of the right-to-die issue" (Hunt, W. E. 1993). One more state that could soon pass a similar law is Quebec, where there has recently been an acquittal in a case with assisted suicide, which opened the door to its decriminalization (Sharma, 2008). After the first known assistance in suicide, of doctor Jack Kevorkian in Massachusetts in June 1990, later better known as "Doctor Death", citizens across the United States began to support the right to a more dignified death wherein some data indicated that eight of ten Americans were convinced that a patient should have a choice to end his life under certain circumstances, and 55% of them were convinced that the moral right of the patients is to commit suicide (Hillyard, 2001; about the current situation in this state see Orlando, 2013). Due to such attitudes, a campaign was initiated with the aim of decriminalization of physician-assisted suicide in California, Oregon and Washington, although the roots of decriminalization originated from 1968, when Florida's legislation created drafts for such a step. At one time, Dr. Walter Sackett, physician in Miami and one of the creators of the Florida laws, was the author at that time controversial legislative proposal that would allow for the patients who are terminally ill to death with dignity. In addition, he proposed an amendment to the Florida Constitution, which would, after the words "the right to life" added the words "and the right on death with dignity" (Mason, 2010).

The first recent attempt was made in California, without any significant results until 2015, because California was the only state with the Law on Natural Death. It was followed by a failure in Washington (at least for a short period). After that, the law that decriminalized PAS was passed in Oregon with the minimal majority (51% - 49%). Soon there were attempts in Michigan and Maine, but the expected decriminalization was not passed, whereby in Maine the law was rejected by a minimal majority (the same one that the law was passed in Oregon 51% towards 49% (Baron, 2008). In 2008, the Law on Death with Dignity was passed in Washington, while in the following year Montana became the third state that decriminalized PAS, but by the court decision.

In this work, we will deal with the legislative solutions in the Oregon, Washington, Montana, Vermont and California, as states in which physician-assisted suicide is decriminalized under the prescribed conditions. After that, we will explain (physician) assisted suicide in two more countries. In the German legislation, assisted suicide generally is not a felony, while in the Serbia assisted suicide and physician-assisted suicide is in the Criminal Code prescribed as a felony. In that way, we will deal with the countries where physician-assisted suicide is not a felony under certain circumstances, where is a felony and where is not.

## Physician-Assisted Suicide in the United States

### *Oregon*

The first known case of the PAS in the United States dates back from 1920, when Frank Roberts from Michigan assisted his wife in committing suicide. In the process *People v. Roberts*, the court convicted him and he died in prison (Hilliard, 2000). In the 1998, an anonymous doctor in the *Journal of the American Medical Association* published an article in which he described in detail how he injected a lethal dose of medication to the terminally ill cancer patient (Mason, 2010). In the 1992, *New England Journal of Medicine* published an article in which three doctors urged for the decriminalization of PAS, seeking a solution that would create a balance between the protection of ill persons and their wishes (Dunsmuir et. al, 1998). The Patient Self-determination Act of 1990 served as a stepping-stone for the adoption of such a law. This law was passed during the mandate of George W. Bush and it opened the possibilities for making further development in achieving patients' autonomy. Based on it, the possibility of further progress towards the autonomy of the patient's will is created. At the end of 1994, Death with Dignity Act (hereinafter: ODWDA) entered into a procedure, and came into force on 27 October 1997 with a minimal majority (with 51% who voted *For* and 49% who voted *Against*). This Act legalized PAS that was forbidden up to that point in time and Oregon got a unique, and, we can say, experimental law, which had not existed anywhere in the world. In the other North American states, PAS was still considered to be a criminal offence. In the majority of them, it has remained such. However, through the theory and jurisprudence, there is a prevalent understanding that the Oregon legal text owes its success to a poor medical care for patients who are terminally ill, believing that the focus of attention should be greater care of these patients and better palliative care (Ward, 2005).

According to the ODWDA, a patient may request a prescription for a medication that would lead to his death from a physician, assuming that the following conditions are met: the patient

is at least 18 years old; he is suffering from a terminal disease; his death in the natural course will inevitably occur within six months (this prediction is very hard to make); he freely and voluntarily expressed wish to accelerate his own death, and he wrote a request for the assisting in suicide (paragraph 2.01. ODWDA).

The request has to be written in the form prescribed by the law on a specific form, dated and signed by the patient and at least two witnesses, who will sign it in the presence of the patient. They will testify to the best of their knowledge and belief that the patient is able to express such a desire, and that he signed this request voluntarily and without being under pressure by anyone. One of the witnesses must not be relative, in-law, as well as relative by adoption with the patient, nor should they expect any benefit from him. In addition, they must not be the owners of the medical facilities or employees of the same institution where the patient requests assisting. The physician in charge of the patient must not be a witness (paragraph 2.02. points 1-3 ODWDA). However, in a case of a patient who has been cured for a long time in that institution, it is desirable that one of the witnesses be appointed by the medical institution as well as to have certain qualifications prescribed by the Ministry of Service (paragraph 2.02. point 4. ODWDA).

The patient's request must be submitted both orally and in a written form, and between the day of the request and its execution at least 15 days have to pass. A patient may withdraw his request without stating reasons for doing so. After 15 days from the day of the request, he has to repeat the request orally (paragraphs 3.01. and 3.06. ODWDA). The legislator left this period for the patient in order to provide him an opportunity to change their mind and sufficient time to do so and to withdraw the request. After this period, the physician is obliged to offer withdrawal to the patient; otherwise, the procedure of assisting cannot be continued. The repeated request allows the doctor to pass to the phase of prescribing certain medicament, but he cannot prescribe it until the deadline of at least 48 hours passes from the repeated request (paragraph 3.08. ODWDA). However, it is recommended that a physician should never be a subject who would suggest a lethal medicament as a way out of this life situation (Ward, 2005).

A physician who attends to a particular case has to diagnose that the patient suffers from the terminal disease, as well as to determine his ability to set such a request and his freedom of will, and to establish that a patient is a citizen of Oregon. Under the explicit legal provision, a patient proves his or her citizenship by providing his or her driver's license, proof of entitlement to vote in Oregon, proof of possession of his or her own or leased property or with tax payment for the previous year, but it is not impossible to find a way to prove citizenship otherwise (paragraph 3.10. ODWDA). By prescribing the above condition of citizenship, Oregon avoided a possibility to become a destination for "death tourism" as it previously happened with the Netherlands and Belgium (Turanjanin, 2013). The patient will then be informed about the diagnosis and prognosis of movement of illness and about the risks associated with taking medicaments and about the ultimate result of their use. Then, he will inform a patient of all alternatives for treatment that are not limited to the dedicated care about him and pain control (paragraph 3.01. points a-c ODWDA). The physician has to point out that palliative care and hospice care are feasible alternatives, but they are not required to be knowledgeable about how to relieve either physical or emotional suffering in terminally ill

patients (Hendin, et. al 1998). After this step, the physician will refer the patient to another physician who has to confirm the diagnosis and medical opinion of the first physician (paragraph 3.02. point d ODWDA). However, “no provision is made for the independent selection of this consulting physician” (Hendin, et.al 1998). If it is necessary, this physician will refer the patient to the counseling about his decision (paragraph 2.02. ODWDA). In addition, during the discussion with the patient, the physicians could doubt that patient suffers from the psychiatric or psychological illness or depression, in which case they must send the patient to the specialist for observation (paragraph 3.02. ODWDA). In this case, no medicament should be prescribed to the patient until a specialist determines that patient is not suffering from the psychiatric or psychological illness or depression. Positive diagnosis leads to the inability to further implementation of this procedure. It is believed that at this condition should be paid a particular attention, since people who are inclined to suicide have curable mental illnesses, like depression or alcoholism. Therefore, in the literature indicate that the legalization of the physician-assisted suicide will lead “intolerable numbers of the physically ill persons, who should be supported to live, will instead be helped to die” (Moskowitz, 1996-97).

A physician will also advise the patient to inform his or her family about his decision and to explain to him the importance of the fact that someone should be with him in the moment of taking the medication, and about the prohibition of taking it in a public place (paragraph 3.01. points f-g ODWDA). However, the refusal of the patient to inform his family or his or her inability to do so will not lead to the rejection of the request. Statistics show that the highest percentage of patients inform family and/or his friends about their decision. Finally, the physician will advice the patient about his right to withdraw the request in any moment and opportunity. Here, it is important to note that, whether the patient withdraws or not from his request, he is not obliged to use the medication he received. Therefore, in practice, there are a significant number of patients who eventually died from the disease they suffered from.

Before he prescribes the medication that will lead to the termination of the patient’s life, the doctor has to verify in writing that the patient has been informed about his or her rights, as well as to support the written documents by law. The physician has to be certain that all the legally prescribed steps have been undertaken and that they are fully in accordance with the law. Only after he undertakes the above steps can a physician prescribe the required medication (paragraph 3.01 ODWDA). By doing so, the physician has two possibilities. Firstly, he may directly prescribe the medication to the patient, including the supporting medication that might ease his or her pain, issued by the licensed physician or a physician with a certificate of prescribing medications. Secondly, with the patient’s consent, the physician may get in touch with the pharmacist, whom he will inform about the prescribed medication, deliver the prescription in person or via email. The pharmacists may then hand over the medication to the patient himself or herself or the person whom the patient had authorized, or the doctor who issued the prescription (paragraph 3.01 ODWDA). According to the Jansen (1995), here “physician merely assists by doing the two things he or she can do as a physician: determining the medication that will most effectively, humanely and painlessly end the patient’s life, and writing a prescription for the medication and dosage”.

There is a written record of each PAS since the physician because the physician has to prepare medical records of the particular case with all the requests, diagnosis and opinions, and evidences that the patient was informed about all the options and all the steps prescribed by law have been undertaken (Reporting Requirements of the Oregon Death with Dignity Act, 333-009-0010[1][a]). It is interesting to note that the legislator nowhere imposes a duty of the physician who assists in suicide to report the act to the appropriate state commission, which would verify whether the legal procedure is properly implemented. His only obligation is to deliver the data for statistics, which are published every year. It is believed that this is not public information that could be subjected to the scrutiny of the public (Yount, 2007). ODWDA protects both the physician and the medical institution where he works, proscribing that the physician cannot be criminally, civilly or disciplinary prosecuted and punished if he acted in the good faith and in accordance with the law, whereas the medical institution cannot be placed under suspension or be deprived of licenses and privileges in its possession and membership in the relevant medical bodies and chambers due to assisted suicide (paragraph 4.01. points 1-2. ODWDA).

According to the strict legal provision, any person who changes the request of the patient without his or her will, hides it or destroys it, as well as the person who forces the patient or influences his or her will with the intention of making a new request, will be legally responsible. Likewise, the criminal prosecution of the perpetrator does not limit his or her civil responsibility for the damage he or she has made (paragraph 4.02. points 1-2. ODWDA).

Statistical data are kept and completed for each year separately and for all the years together, starting from the first year when the law was applied, according to gender, age, race, marital status, education, place of residence, type of disease, the reasons for this procedure and other relevant data. Due to the volume of our research, we will not explain the statistics in detail, but we will show only the most basic. According to the data, in the period from 1998 to 2014, 1,327 persons filed for the request for mediation in suicide, 859 of who actually used the medication. This number has been growing from year to year. Otherwise, in the entire observed period, from the time of application until the day of taking the medication 47 days pass on average, while the relation between the patient and the doctor to whom the request was made lasts for 13 weeks on average. Patients mostly suffered from cancer, and they feared the most to lose their autonomy, dignity and control over their bodily functions (Oregon Public Health Division, 2012). From the available data on the number of assistances undertaken and the reasons that led patients to undertake the step, supporters and opponents of assisted suicide draw diametrically opposed conclusions. Thus, the supporters point out the strong autonomy of will and desire for independence from diseases being strong personal values of individuals who have applied for assistance in committing suicide, noting the same arguments when emphasizing the fact that people generally have different psychological power to make decisions, especially the one like this. However, the opponents of the procedure believe that patients would not choose the moment of death if they had had better medical treatment, and that the key to the failure of arriving at this decision lies in the improvement of medical services and reducing social stigmatization, because in this case, patients would choose a longer life (Sharma, 2008). Likewise, this practice is considered to turn against the poor, the old and poorly educated people (LaFrance, 2008).

## **Washington**

In the famous judgment *Washington v. Gluckberg* (521 U.S. 702 [1997]), the Court took a view that individuals have not a constitutional right PAS, and he noted that devaluation of the human life and medical care, exposure to the abuse and neglect of the vulnerable groups could lead to the legalization of the non-voluntary euthanasia (also judgment *Judgment Vacco Vs Quill* [521 U.S. 793 [1997]; see: Burt, 1997). However, Washington Death with Dignity Act (hereinafter: WDWDA) was passed on the 04 November 2008, with the majority of 58% - 42% of the voters, and entered into force on the 05 March 2009. However, physicians were deeply divided over this initiative (Jansen A. 1995). WDWDA is almost identical to ODWDA, but there are certain differences between these two laws. Due to this fact, we will only briefly pay attention to this law, explaining the details that distinguish it from the Oregon's. Thus, according to WDWDA, a request for PAS may only be submitted by Washington citizens older than 18 years, with no more than six months of life left, judging by the opinions of two independent physicians. Minors and mentally incompetent persons cannot request PAS (section 2 of the WDWDA). The patient has to be examined by two independent physicians who will determine all the relevant circumstances of the act and who will complete medical records within 30 days from the day of the request. The conditions required by WDWDA are identical to the terms of ODWDA.

The request for the PAS patient has to be submitted twice, first orally and in writing, and after 15 days, it has to be repeated orally. After repeating the oral request, the physician is obliged to present to the patient the opportunity to withdraw the submitted request, at any time (section 12 WDWDA). Following the completion of the PAS, within 72 hours the physician has to make Certificate of Death, which he would send to the local and state health agency. However, it is typical that the local health agency keeps the Certificate 30 to 60 before delivering it to the state agency. Provisions regarding the exemption from the criminal procedure as well as prescribing the criminal acts in cases where the conditions for the physician's assistance have not been fulfilled, these are identical to the ODWDA.

Similarly, to Oregon, in the Washington legislation, statistical data are processed for each year separately. According to the statistical data for the state of Washington and for the period of the first two years for which the date has been collected, the number of PAS slightly increased in the year of 2010, when we have 87 prescriptions issued. Bypassing a detailed analysis for every year, we will note down that 176 patients filed a request in 2004, 126 of whom actually took the medication, 17 died without using the medication, and there are no accurate data regarding the remaining 27 patients. The reasons for this step are the same as in Oregon. Here, it is inevitable to mention the length of the doctor-patient relationship, with the largest percentage of less than 25 weeks (43%), followed by long-term relationships, which is longer than one year (40%) and between 25 and 51 weeks (13%) (Retrieved from Washington State Department of Health 2014 Death with Dignity Act Report).

## **Montana**

After the judgment from the 31 December 2009, Montana becomes the third state that recognized a patient's right to the PAS. According to the Court, there is no social danger if the

terminally ill patients demand for assistance in ending of his life, and that the Law on the Rights of terminally ill patients (Montana's Rights of Terminally Ill Act; Report to the 62nd Legislature for the State of Montana, November 2010), does not prohibit PAS (Tucker and Salmi, 2010). In the aforementioned judgment, the Court held that "constitutional rights in Montana are the right to privacy and human dignity, which, taken together, establish the right of the patients in the terminal stage of the disease to end their lives with dignity, under conditions that they capable for making such decisions" (Opinion of the judge Dorothy McCarter in the verdict *Baxter v. State of Montana*, 2009 MT 449). The judge also noted that a patient's right on death with dignity includes protection of his doctors from criminal proceedings, which could possibly be brought against him. A judgment made constitutional PAS, but unlike Oregon and Washington, Montana still does not have a law that would regulate this issue exclusively. This is an urgent issue, because, according to the dissenting opinion in the judgment, this right is not limited only to physicians (Knaplund, 2010). The law would, from one side, protect the rights of the persons who seeks assistance in suicide, while one the other side, it would protect other vulnerable patients from the abuse. In addition, in the absence of the legislation the boundary between permissible and impermissible can be, and is, blurred. In the meantime, Montana has a "The Rights of the Terminally Ill Act". This legal text nor allow or tolerate euthanasia or PAS, observe them as different legal issues (Hunt, W. E. 1993).

As it is a case in the two above mentioned states, the patient must be a citizen of Montana, then, he or she must not to be under 18 and capable of such a decision, and he or she has to complete and sign a form that represents his request. However, the basic difference between the laws in the states of Oregon and Washington on the one hand and Montana, on the other, is in the fact that here a patient does not have to be in a terminal stage of the disease, that is, to have more than 6 months to live according to the physician. Such limitation does not exist here. It is sufficient that a patient suffers from the terminal disease. Since this represents a completely new view about PAS, there are still no registered statistical data in Montana.

### ***Vermont and California***

Legal texts in Vermont and California do not differ largely from the previously adopted ones, but these are not identical laws. Some studies conducted in Vermont before the legalization also showed a great fragmentation between doctors regarding this issue, and therefore, in one of them, 38, 2 % of them believed that PAS should be legalized, 26% of them considered that it does not need to be regulated by law, 16% that should be prohibited, and 15, 7% were indecisive (Craig et. al, 2007). Due to the criticism addresses to the Oregonian law, Dahl and Levy (2006) recommended that laws in Vermont and California introduce additional safeguards for the patients, because that would reduce the number of the complaints of abuse.

California law (Senate Bill No. 128) is very similar to Oregon's, thus followed by identical criticism, starting with the fact that it permits one of the witnesses to be the person concerned, and even the person "entitled to the patient's estate". Furthermore, specific criticisms are directed to the fact that the law in question implicitly permits the requirements to be placed by phone, then, that it does not protect the patient sufficiently after the doctor prescribes the medication, because it does not allow for "someone who would benefit from the individual's

death could trick or even force the person into taking the fatal drugs, and no one would know,” then, it does not protect mentally ill patients sufficiently. A special problem arises with the provision which predicts the occurrence of death within six months, since it did not allow the possibility of controlling the disease and thus enabling the patient to live substantially longer (California “End of Life Option Act” – Analysis of Senate Bill 128).

Unlike all previously listed and described laws, Vermont Patient Choice at End of Life (Patient Choice and Control at End of Life [18 V.S.A. Chapter 113]) requires the presence of two or more witnesses, who must not be the interested party, and must be at least 18 years of age, and “who signed and affirmed that the patient appeared to understand the nature of the document and to be free from duress or undue influence at the time the request was signed” (paragraph 5283). Furthermore, the provision which stipulates that „a health care facility may prohibit a physician from writing a prescription for a dose of medication intended to be lethal for a patient who is resident in its facility and intends to use the medication on the facility’s premises, provided the facility has notified the physician in writing of its policy with regard to the prescriptions” is of great importance.

### ***Assisted Suicide in Germany***

Suicide in Germany, as in other countries, is not regarded as a criminal act. However, this country has gone a step further in relation to others, because it does not consider assisted suicide to be a criminal act. In this way, Germany has centered its position among the countries in which euthanasia and physician-assisted suicide are legalized, on the one hand, and the others (Banović and Turanjanin, 2014), where these two procedures are felonies (Oduncu and Sahn, 2010; Turanjanin and Mihajlović, 2014), on the other hand. In Germany, even in recent years, there have been debates about the legalization of the active direct euthanasia, since in this country, it was taboo for a long period, due to the Nazi crimes in the World War II and (mis) use of the term *mercy*. Opening of the branch of the Swiss organization *Dignitas* (Turanjanin, 2013), has increased a discussion about physician-assisted suicide (Oduncu and Sahn, 2010). According to some studies, in recent years, more than 80% of the population supports euthanasia (Jušić, 2002). Similarly, medical practice constantly develops principles of the medical care of persons who are in the terminal stage of the disease (Oduncu and Sahn, 2010). However, the idea of legalizing euthanasia has legally revived at the beginning of the XXI century, along with the sympathetic judges’ view on the murders committed due to mercy reasons. In Germany, courts believe that there is no felony, even in cases of active euthanasia (Wolfslast, 2008). The lack of legal frame for suicide and PAS to be regarded as criminal acts contribute to such views. There are several reasons for the fact that suicide and PAS are not regarded as criminal acts. In the first place, these are considered to be a technical matter, because since a suicide is not a crime, therefore assisting in it is not either (Wolfslast, 2008). Then, this legislation recognizes the principle of the autonomy of the will. Suicide exists when a person freely and voluntarily decides to end his or her life. Accordingly, a physician will not be liable if he provides the medication to the patient that would lead to the end of the patient’s life, if he decides to use it. Conversely, if a patient does not have such a free will, the role of the helper will be transformed into a perpetrator who will be responsible for the murder (Wolfslast, 2008).

### *Assisted Suicide in Serbia*

Assisted suicide in Serbia is considered a criminal offence by the article 199 of the Criminal Code, entitled *Inducement to suicide and assisted suicide*. Thus, the same article regulates assisting and inducing the person to commit a suicide. The basic form of the felony is encouraging or aiding someone to commit suicide, and the act itself is attempted or committed. This felony is punishable by imprisonment from six months to five years. According to the one, not so indisputable verdict of the Serbian Supreme Court “the defendant intentionally helped his under aged wife to commit suicide in a way that, when she said that she would kill herself because of their troubled relationship, he pulled out the gun, put a bullet in it and handed her the gun, telling her that he wanted to see how she would kill herself; so she took a gun and shot herself, which led to her death” (Judgment of the High Court in Belgrade no. K. 613/89 from 23 March 1990 and judgment of the Serbian Supreme Court no. Kž. 575/90 from 07 September 1990; see also: Lazarević, 2011; Čejović, 2008).

The second, easier form of the assisted suicide is related to the deprivation of life due to compassion, so it is stated that this type of criminal act is done by a person who assists another person to attempt or commit suicide out of compassion and due to a serious health condition of a person and followed by the person’s explicit request. If someone assists in suicide to the juvenile, or to a person who is in a state of the considerably diminished mental capacity, he will commit a more severe form of this felony punishable by imprisonment from two to ten years, but if someone assists in suicide to a child or mentally incompetent person, it represents the most severe form, punishable by imprisonment from at least ten years or 30-40 years. The legislator here stated that the act could be performed against the person who is in a state of the considerably diminished (limited) mental capacity or of a mentally incompetent person. That poses a problem, because in practice these two conditions usually have to be determined for the offender, not the victim. It is therefore necessary to establish that the person who committed a suicide was in such a state at the time of committing a suicide (Stojanović, 2007), which can be determined only by expert opinion. In practice, this could pose a problem in a situation where a suicide was committed, but that would be easier to determine in a case in which suicide was just attempted. Theoretically, if we set a rule for determining mental incompetence or substantially diminished mental capacity at the time of the offence, we can also pose a question of the position of the defendant and his responsibility for the concrete form of the criminal offence if the victim at a time of instigation/assisting in suicide was in a state of the considerably diminished mental capacity or mentally incompetent person and *vice versa*. Therefore, intention is necessary for the criminal responsibility of the offender is, whereby awareness of the perpetrator has to encompass the fact that assisting is done against the minor or a person who is in a state of the considerably diminished mental capacity or mentally incompetent person (Lazarević, 2011).

Finally, there is a special form of the offence in cases of the cruel and inhuman treatment of the person who is in any kind of subordination or dependence to the defendant, and the person commits or attempts suicide due to the above-mentioned state, which can be attributed to the negligence of the offender. The prescribed sentence is imprisonment of six months to five years. The legislator himself points out the variety of situations in which the victim is in a state of subordination or dependence by defining them as “any kind” (Čejović, 2008). In this

case, it is necessary to establish a causal link between the cruel and inhuman treatment and suicide, whereby in this provision there is a combination of intent and negligence. On the one hand, the intention of the offender should include awareness of its cruel and inhuman treatment towards a particular person and the fact that such person to him is in a state of subordination or dependence, while, on the other hand, suicide has to be attributed to his negligence (Stojanović, 2007). If the intention was aimed at the fact that the victim should commit a suicide, then there is one of the previous and usually more severe forms of the offence. Thus, his negligence will be reflected in the fact that he was aware of the possibility that a victim would commit a suicide, but he easily concluded that it would not come to that or that he would be able to prevent it. Alternatively, he was not aware of the possibility that a victim would commit suicide, although under the circumstances of the case and his personal abilities, he should and could have been aware of such a possibility. This treatment objectively should “be such that it can really induce a victim to commit a suicide” (Judgment of the Bosnian Supreme Court, no. Kž. 1699/62 from 12 December 1963; see Čejović, 2008).

Among the provisions that regulate offences against public health there is not, as in some other legislations, a separate criminal act of PAS, which redirects us to the crime of assisted suicide. Therefore, the perpetrator of this criminal act may be any person, and for the Serbian legislation, it is irrelevant whether it is a physician, who is subject to the criminal liability as well as any other person.

## Conclusion

Assisted suicide has lately become an increasingly frequent topic in discussions, with the development of medical assisted suicide in some comparative legislation systems. In Serbia, the assistance in committing suicide is considered a crime, and there is still no distinction according to the fact if the perpetrator is a doctor on any other individual. In Germany, however, assisted suicide is not considered as a criminal offense. In the United States, there is a similar legal solution when it comes to doctors. It is a situation when a doctor assists the patient in committing suicide by prescribing the appropriate medication which leads to the patient's death. Namely, during the 1990s, campaigns were started throughout the American continent with the aim of passing a law that would allow a doctor to assist a patient who is terminally ill to commit suicide. The revolutionary Law on Death with Dignity, unique in the world, was enacted in Oregon in 1994, and fourteen years later in Washington State. The last North American state where medical assisted suicide is not a criminal offense is Montana, for now, where by a court decision, which stands as a precedent on this issue, the right of the patient in the terminal stage of the disease to a dignified death is recognized. However, passing a law that would more precisely define and regulate this sensitive area prone to abuse, is a necessity in Montana. Similarly, this matter has been regulated in the legislations of Vermont and California - that legalized medical assistance to suicide.

The basic principle, on which this procedure is based, is to allow the patient the right to his or her own decision, at the same time protecting all his rights as a patient as well as protecting them from potential abuse. Based on that, the legal drafts in Oregon and Washington explicitly set rules that must be followed by all entities that are in any way involved in the procedure, starting from the patient and the acting physician to witnesses signing the request.

Firstly, the conditions that have to be fulfilled by the patient were set, starting from the necessity of being of legal age and suffering from incurable disease whose onset is inevitable within six months to his or her will to terminate life with dignity, which is expressed in oral and written form to the doctor in question. The doctor must meet a series of conditions in order to be able to carry out this procedure. At a crucial stage when a patient expresses a request in writing, two impartial and independent witnesses must be present. However, after one undertakes all the above steps and the doctor issues a medication to the patient, the patient does not necessarily have to take it, but some patients still die from the diseases they suffer from, causing the entire procedure to take place. However, according to certain research, the existing legal texts do not provide sufficient guarantees for patients. This field should be further improved, without ignoring the possible problems easily.

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