



BACKGROUND PAPER

MEDICAL ASSISTANCE IN DYING: THE LAW IN SELECTED JURISDICTIONS OUTSIDE CANADA

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Medical Assistance in Dying: The Law in Selected Jurisdictions Outside Canada
(Background Paper)

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EXECUTIVE SUMMARY

Over the last decades, movements have arisen in several jurisdictions around the world to legalize medical assistance in dying. Until recently, only a few jurisdictions permitted medical assistance in dying, including Oregon, Washington State, Vermont, the Benelux countries (Belgium, the Netherlands and Luxembourg) and Switzerland. In the last five years, six United States (U.S.) jurisdictions have legalized the practice, as have the Australian state of Victoria and Canada. In other countries, such as Germany, Spain, Italy and New Zealand, legislative proposals and court decisions on the issue are increasingly common. At the same time, there continues to be vocal opposition to the elimination of criminal sanctions for individuals who either assist in or cause the death of persons who have requested that their life be terminated.

In Canada, the term “medical assistance in dying” includes both assisted suicide (the patient self-administers a substance) and euthanasia (someone else, usually a medical practitioner, administers the substance). Some jurisdictions around the world allow one of these options, while others allow for both.

According to available statistics, the general trend in the countries that have legalized assisted dying has been for year-to-year increases in deaths by assisted dying. Such deaths, however, remain a small percentage of total deaths, and there have been some recent year-to-year decreases. Regardless of jurisdiction, most patients who receive medical assistance in dying have cancer.

Broadly speaking, Australian and North American jurisdictions have more restrictive rules in place for assistance in dying than the European jurisdictions that permit the practice. The nine U.S. jurisdictions where it is legal, for example, generally require a prognosis of six months or less to live and permit only assisted suicide. Only adults are eligible. The Australian state of Victoria has similar criteria, though with some notable differences. For example, Victoria allows both euthanasia and assisted suicide.

In contrast, in the Benelux countries there is no requirement that a patient have a terminal illness. A psychiatric illness may be enough to qualify for assistance in dying if other conditions are met. In addition, euthanasia is permitted in those jurisdictions and is far more common than assisted suicide.

The three Benelux countries allow advance directives, meaning that the patient need not have the capacity to make the decision at the time of death. However, the scope for advance directives is much broader in the Netherlands, where they can be used in situations of dementia, for example. In Belgium and Luxembourg, advance directives can only be relied upon where the individual is unconscious at the time of the procedure.

Though the rules are not exactly the same, both the Netherlands and Belgium allow some minors to receive assistance in dying. As in the U.S. jurisdictions that have legalized assisted suicide, Luxembourg only allows adults to receive assistance in dying.

Switzerland's Criminal Code allows assisted suicide, as long as the assistance is provided for unselfish reasons. However, that country does not have a regulatory regime with specific criteria like the other countries noted above. This means that non-residents can receive assistance in dying in Switzerland and the practice is not limited to physicians.

Constitutional Court decisions have legalized euthanasia in Colombia, but it remains rare. While the court called for legislation, no legislative efforts have been successful to date, as the issue is quite contentious. The government was required by the court to create a regulatory framework for medical assistance in dying to fill the void created by the lack of legislation.

Assistance in dying is being discussed in many legislatures, particularly in North America and Europe. If current trends continue, legalization of assistance in dying in other jurisdictions is likely.

MEDICAL ASSISTANCE IN DYING: THE LAW IN SELECTED JURISDICTIONS OUTSIDE CANADA

1 INTRODUCTION

Over the last few decades, movements have arisen in a number of jurisdictions in favour of the legalization of what is now referred to in Canada as “medical assistance in dying.” At the same time, there continues to be vocal opposition to the elimination of criminal sanctions for individuals who either assist in or cause the death of a person who has requested that their life be terminated.

While the debate continues, several jurisdictions around the world have made legislative changes to legalize medical assistance in dying. The term includes both assisted suicide, where the patient self-administers a substance to bring about death, and euthanasia, where someone else, usually a medical practitioner, administers the substance. Jurisdictions have made different choices regarding which of the two practices have been legalized.

This paper reviews developments surrounding the issue of medical assistance in dying in the United States (U.S.), the Netherlands, Belgium, Luxembourg, Switzerland, Colombia, Australia, Germany, Italy and the United Kingdom (U.K.).¹ An appendix provides an overview, in table format, of the current legal status of medical assistance in dying in jurisdictions that have relevant legislation in place. Note that other Library of Parliament publications discuss the situation in Canada.²

2 UNITED STATES

The majority of U.S. states have laws explicitly prohibiting assisted suicide, while some rely on crimes established in common law through judicial decision-making to prohibit the practice. No U.S. jurisdiction has legalized euthanasia. The prosecution of cases of euthanasia is addressed through regular homicide laws.

To date, Oregon, Washington State, Vermont, California, Colorado, the District of Columbia, Hawaii, Maine and New Jersey are the only nine U.S. jurisdictions that have passed laws explicitly permitting some form of physician-assisted suicide. In addition, Montana’s Supreme Court concluded that doctors could use the defence of consent to protect themselves, if certain conditions are met, should they be prosecuted for assisting a suicide.³

The following sections outline some of the main constitutional challenges to legislation prohibiting assistance in dying, before outlining the rules in those jurisdictions that permit the practice.

2.1 CHALLENGES TO STATE LAWS THAT PROHIBIT PHYSICIAN-ASSISTED SUICIDE

2.1.1 Laws in the States of Washington and New York Prohibiting Assisted Suicide Upheld

On 1 October 1996, the Supreme Court of the United States agreed to hear an appeal of two Court of Appeal rulings from the states of Washington and New York, which had concluded that laws prohibiting physician-assisted suicide in those states were unconstitutional. The Supreme Court had previously refused to hear an appeal of a Michigan State Court decision that upheld a Michigan law prohibiting assisted suicide. The law had been passed after high-profile advocate Dr. Jack Kevorkian began his campaign of assisting terminally ill people to die.

On 26 June 1997, the Supreme Court reversed both decisions and upheld the Washington and New York statutes prohibiting assisted suicide.⁴ Since that decision, the appellate courts of other states such as Alaska, Colorado and New Mexico have also upheld laws criminalizing assisted suicide, concluding that they do not violate the states' respective constitutions.⁵ Although the courts have found that these statutes are constitutional, this does not mean that a law permitting assisted suicide would automatically be found unconstitutional. As noted above, nine U.S. jurisdictions (eight states plus the District of Columbia) have passed such laws. Oregon's laws were challenged and eventually upheld in the courts, and others have also been challenged without success.⁶

2.1.2 Defence of Consent for Doctors in Montana

In October 2007, in another challenge to laws preventing assisted suicide, two terminally ill patients, four doctors and a patients' rights organization in Montana brought a lawsuit before the district court claiming the "right to die with dignity." They alleged that the "application of Montana homicide statutes to physicians who provide aid in dying to mentally competent, terminally ill patients" contravened Article 2 of the state constitution, which protects the right to privacy and human dignity. The district court where the lawsuit was initiated concluded that the constitutional protection of these rights included the right for competent, terminally ill patients to die with dignity. In turn, this right was found to include protection from prosecution for a physician who might assist such a patient.⁷

The Montana government appealed the decision to the Montana Supreme Court, which decided the case without addressing the constitutional question. The majority of the court concluded in its December 2009 judgment that doctors could use the existing defence of consent if charged with homicide for assisting a mentally competent, terminally ill patient to commit suicide.⁸ The consent defence allows a defendant to argue that the victim consented to the act and that the defendant should thus not be convicted. In this way, physicians who prescribe medication for a mentally competent, terminally ill patient so that the patient may commit suicide have

a defence against homicide charges in Montana.⁹ Non-physicians may not benefit from the same protections, since the December 2009 decision addressed only the situation of doctors.

Although the decision provided a defence for doctors in the state, it did not outline any procedures, standards or safeguards. Because of this, in Montana, the practice of assisting a suicide is not regulated by law, unlike in those U.S. jurisdictions that have passed laws on the matter and where safeguards are outlined in the legislation on assisted suicide. Bills have been brought before the Montana Legislature both to overturn the state Supreme Court decision to make assisted suicide illegal in Montana and to provide a framework to regulate the practice, but none has passed to date.¹⁰

2.2 OREGON

In November 1994, Oregon voters approved a ballot initiative, Measure 16,¹¹ which was a legislative proposal to allow terminally ill adult residents of Oregon with a prognosis of less than six months to live to obtain a prescription for medication for the purpose of committing suicide. Because of a legal challenge, the *Death with Dignity Act* did not come into force until November 1997.¹²

Before a physician can issue such a prescription, certain conditions have to be met. For example:

- The patient must make two oral requests at least 15 days apart and one written request for the medication. The written request must be signed before two witnesses; criteria outlined in the law regulate who may be witnesses. Forty-eight hours must elapse between the written request and the provision of the prescription. In July 2019, an amendment was adopted by the state legislature and will go into effect in January 2020 to allow certain individuals near death to forego the waiting period of 15 days between requests and the 48-hour waiting period for the prescription.¹³
- A second medical opinion is required.
- The patient must be capable, meaning that,
 - in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, psychiatrist or psychologist, a patient has the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available.¹⁴

If either of the physicians is of the opinion that a patient's judgment may be impaired by a psychiatric or psychological disorder or depression, the physician must refer the

patient for counselling and cannot prescribe medication to end the patient's life until it is determined that the patient's judgment is not impaired.

- The physician must verify that the patient is making an informed decision, which is defined in the statute as a decision based on an appreciation of the relevant facts and made after the patient has been fully informed by the attending physician of
 - the person's medical diagnosis and prognosis;
 - the potential risks associated with taking the medication to be prescribed;
 - the probable result of taking the medication to be prescribed; and
 - the feasible alternatives, including comfort care, hospice care and pain control.¹⁵
- The physician must request that the patient inform next of kin of the request for a prescription, although the physician cannot obligate an individual to do so.

Details must be included in the patient's medical record concerning the requests, diagnosis, prognosis, any counselling that occurred and the doctor's offers to rescind the request. Doctors also have reporting obligations to Oregon's Department of Human Services once a prescription is written.¹⁶ Doctors are not obligated to participate in assisting a suicide.¹⁷

A number of bills have sought to amend the legislation in Oregon, including one that sought to expand eligibility beyond the period of six months' prognosis. The only bill that passed, however, is the above-noted amendment regarding the waiting period.¹⁸

2.2.1 Annual Reports

The *Death with Dignity Act* requires Oregon's Department of Human Services to annually review and report on information collected in accordance with the Act. Table 1 highlights some statistics that reports have provided since the legislation came into force.

Table 1 – Annual Statistics Relating to Oregon's *Death with Dignity Act*, 1998–2018

Year	Reported Prescriptions Written for a Lethal Dose of Medication	Reported Deaths by Ingestion of the Prescribed Medication ^a	Reported Deaths by Physician-Assisted Suicide per 1,000 Deaths
1998	24	16	0.55
1999	33	27	0.92
2000	39	27	0.91
2001	44	21	0.71
2002	58	38	1.22
2003	68	42	1.36

Year	Reported Prescriptions Written for a Lethal Dose of Medication	Reported Deaths by Ingestion of the Prescribed Medication ^a	Reported Deaths by Physician-Assisted Suicide per 1,000 Deaths
2004	60	37	1.23
2005	65	38	1.2 ^b
2006	65	46	1.47
2007	85	49	1.56
2008	88	60	1.94
2009	95	59	1.93
2010	97	65	2.09
2011	114	71	2.25
2012	116	85	2.35
2013	121	73	2.19
2014	155	105	3.10
2015	218	135	3.86
2016	204	138	3.72
2017	219	158	3.99
2018	249	168	4.59

Notes: a. The Oregon Department of Human Services reports also note cases in which the status of individuals who received a prescription is unknown.
b. The figure of 1.2 deaths by physician-assisted suicide for every 1,000 deaths in 2005 is an estimate only, although the annual report for 2005 does not explain why. See Oregon Department of Human Services, Office of Disease Prevention and Epidemiology, [Eighth Annual Report on Oregon's Death with Dignity Act](#), Portland, Oregon, 9 March 2006.

Source: Table prepared by the author based on data obtained from United States, State of Oregon, Oregon Health Authority, Public Health Division, ["Death with Dignity Act Annual Reports,"](#) *Death with Dignity Act*.

Although the number of prescriptions written and deaths resulting from ingestion of the prescribed medication have increased almost every year since the law was passed, relatively few prescriptions have been written, considering that more than four million people live in Oregon. In 2018, around 4.6 per 1,000 deaths in Oregon were by physician-assisted suicide.

The annual reports provide aggregate statistics about patients who choose assisted suicide. For 2018,

- 52% were men;
- 79% were aged 65 or older;
- 97% were white;
- 47% had a baccalaureate degree or higher;
- 91% were enrolled in hospice care and 88% died at home;

- 32% had private health insurance and 67% had some form of government health insurance; and
- 63% had cancer, 15% had neurological diseases and 10% had heart or circulatory disease.

The three most common reasons for choosing assisted suicide were concerns about losing autonomy (92%), being less able to engage in activities that make life enjoyable (91%) and experiencing a loss of dignity (67%).¹⁹ Being a burden on family, friends and caregivers was a concern for 54% of patients.²⁰ Despite concerns expressed in the media and in a 2015 California judgment, the financial costs associated with an illness do not appear to be a motivating factor in the great majority of requests for assisted suicide: 5% of those dying from assisted suicide in Oregon expressed such concerns in 2018.²¹

In recent years, the annual reports have published the number of cases per year in which a referral to the Oregon Medical Board was made for failure to comply with the requirements. From 2011 to 2017, no cases were referred to the board. The first two cases were referred in 2018.²²

2.3 STATE OF WASHINGTON

The State of Washington's *Death with Dignity Act* was passed by ballot initiative on 4 November 2008 and came into force on 5 March 2009.²³ It is based on the law in Oregon prior to its 2019 amendment and includes reporting requirements by which the Washington State Department of Health plays a collection and monitoring role similar to that of Oregon's Department of Human Services.

2.3.1 Annual Reports

Table 2 highlights some statistics that reports have provided since the legislation came into force. In 2017, the State of Washington had a population of more than 7 million, with just over 57,000 total deaths.²⁴

**Table 2 – Annual Statistics Relating to Washington State's
Death with Dignity Act, 2009–2018^a**

Year	Reported Prescriptions Written for a Lethal Dose of Medication	Reported Deaths by Ingestion of the Prescribed Medication
2009 ^b	63	36
2010	87	51
2011	103	70
2012	121	83
2013	173	119
2014	176	126

Year	Reported Prescriptions Written for a Lethal Dose of Medication	Reported Deaths by Ingestion of the Prescribed Medication
2015	215	166
2016	249	192
2017	212	164
2018	267	203

Notes: a. The Washington State Department of Health reports also note cases in which the status of individuals who received a prescription is unknown.
b. The numbers for 2009 represent the period beginning 5 March 2009 with the entry into force of the law.

Source: Table prepared by the author based on data obtained from United States, State of Washington, Washington State Department of Health, "[Annual Reports](#)," *Death with Dignity Data*.

The annual reports provide aggregate statistics about patients who choose assisted suicide. For 2018,

- 44% were men;
- 79% were aged 65 or older;
- 96% were white;
- 46% had a baccalaureate degree or higher;
- 92% were enrolled in hospice care and 86% died at home;
- 16% had private health insurance, 66% had some form of government health insurance and 9% had a combination of both; and
- over 75% had cancer, 10% had neurodegenerative diseases, including Amyotrophic Lateral Sclerosis (ALS), and 6% had heart disease.

The three most common reasons for choosing assisted suicide were the same as those in Oregon: losing autonomy (85%), being less able to participate in activities that make life enjoyable (84%) and experiencing a loss of dignity (69%). Being a burden on family, friends and caregivers was also a concern for 51% of patients. Nine percent mentioned concerns about the cost of treatment for an illness.²⁵

2.4 VERMONT

On 20 May 2013, Vermont's Governor Peter Shumlin signed Bill S.77, An act relating to patient choice and control at end of life into law. This is the first law permitting physician-assisted suicide to be passed by a legislature in the U.S.; the Oregon and Washington laws were passed by ballot initiative. This law is modelled on Oregon's law prior to its 2019 amendment.²⁶ A May 2015 amendment repealed a sunset clause and now requires the collection of information about compliance with the law and the publishing of reports by the Department of Health every two years,

starting in 2018.²⁷ The first report covers the period from 31 May 2013 to 30 June 2017.²⁸

The law was challenged and an injunction was sought by two medical organizations to prevent disciplinary proceedings or any other criminal or civil action that could arise if a physician refused to inform a patient about the option of physician-assisted suicide. A 2017 judgment concluded that the plaintiffs lacked standing for the lawsuit to proceed as no disciplinary action had yet occurred.²⁹

2.5 CALIFORNIA

In September 2015, California's legislature passed Bill AB-15 (*End of Life Option Act*), which allows assisted suicide; the law came into force on 9 June 2016.³⁰ The process by which the bill passed has been criticized, including by the state governor. A similar bill did not have the votes required to pass the committee stage earlier in 2015. Bill AB-15 was then introduced during a special session on health care financing. According to media reports, this means that it was not subjected to the same committee review as it would have received had it been introduced during a regular session of the legislature.³¹ A constitutional challenge to the law because of the process by which it was adopted is ongoing. At trial, the court concluded that the law was unconstitutional. That decision was appealed to California's Fourth District Court of Appeal, which concluded that the plaintiffs had not established standing and sent the case back to the trial court. The Court of Appeal allowed the law to continue to be in effect until a decision is made on its constitutionality.³²

While the law is similar to Oregon's legislation, there are some notable differences. The law expires in ten years unless legislators decide to renew it. Also, unlike the Oregon law, California's new law requires that the doctor meet privately with the person seeking to die to ensure that the person is not being coerced or unduly influenced. The law also prohibits an insurance carrier from communicating information about the availability of an aid-in-dying drug unless requested to do so. In addition, insurers cannot include denial of coverage for other forms of treatment along with information about aid-in-dying coverage in the same communications.³³

This last element with respect to communications with insurance companies may have been included to address some commentators' fears that assisted suicide will be seen by insurers as an economically attractive alternative, in contrast to costly life-sustaining care for the terminally ill. Media have reported that, for reasons of cost, Oregon's Medicaid has refused to cover patients' access to life-sustaining but non-curative cancer treatment because it would not cure their cancer – even though the treatment could prolong and improve the quality of the patients' lives.³⁴ However, the patients were reportedly told at the same time that the program would cover

comfort care, including the cost of the prescription for medication to commit suicide, if they wanted assistance in ending their lives.³⁵

There have been three annual reports to date, for the years 2016 to 2018.³⁶ Despite a more diverse population, California mirrors a trend identified in Oregon, Washington State and Vermont (states with predominantly white populations), where the vast majority of patients using physician-assisted suicide are white. According to one article, this is due to a number of factors, including racial disparities in access to care for terminal illnesses more generally (and thus access to knowledge about physician-assisted suicide), distrust of the medical community, later stage diagnosis of terminal illnesses for certain communities, philosophical differences and the way information is shared about physician-assisted suicide.³⁷

2.6 LEGALIZATION IN OTHER UNITED STATES JURISDICTIONS: COLORADO, THE DISTRICT OF COLUMBIA, HAWAII, MAINE AND NEW JERSEY

2.6.1 Colorado

In 2016, a ballot initiative, Proposition 106, legalized assisted suicide in Colorado, and the *Colorado End-of-Life Options Act* came into force at the end of that year. As with the other American aid-in-dying laws, Colorado's law is similar to Oregon's law prior to its recent amendment. Like California's law, it requires the attending physician to meet privately with the patient to ensure there is no coercion or undue pressure. To date, two reports have been published with statistics. Unlike states such as Oregon, Colorado cannot say, based on the information they collect, how many people actually died after ingesting aid-in-dying medication. The state only knows the number of prescriptions written for aid-in-dying medications, the number of such prescriptions dispensed, and the subsequent deaths of patients to whom such medications were dispensed, but not whether the deaths were caused by ingesting the prescribed medication.³⁸

A cancer patient in Colorado and his physician started a lawsuit in August 2019 challenging the policy of the hospital where he was receiving treatment that bars its physicians from prescribing aid-in-dying medication.³⁹

2.6.2 District of Columbia

The Council of the District of Columbia (D.C.) has also legalized assisted suicide, based on the Oregon model prior to its 2019 amendment. D.C.'s *Death with Dignity Act of 2016* has been in force since 6 June 2017. Two reports have been published to date informing the public of statistical information relating to aid-in-dying in D.C.⁴⁰ There have been efforts in the U.S. House of Representatives to repeal the law, but none has been successful to date.⁴¹

2.6.3 Hawaii

Hawaii's *Our Care, Our Choice Act*, again based on the Oregon law prior to amendment, was signed into law on 5 April 2018 and came into force on 1 January 2019.⁴² There are some differences between Hawaii's law and Oregon's, such as requiring 20 days between oral requests instead of 15 and a requirement for capacity to be assessed by a counsellor, not only by the two physicians who assess other criteria. Hawaii Senate Bill 536 amended the law in July 2019 to clarify that various provisions of a law to curb the abuse of opioids do not apply to those who qualify for medical aid in dying.⁴³ A report on the first five months that the law was in force was published in July 2019.⁴⁴

2.6.4 New Jersey

New Jersey's *Medical Aid in Dying for the Terminally Ill Act* was passed on 12 April 2019 and came into force on 1 August 2019. The law is based on Oregon's law prior to amendment, although it has an additional requirement that the attending physician recommend that the patient participate in a consultation regarding treatment opportunities and services such as pain control and palliative care and refer the patient to a qualified health care professional for that purpose.⁴⁵ The law is being challenged but is in force while those proceedings take place.⁴⁶ On 6 June 2019, two bills were introduced in the General Assembly, one to repeal the new act and the other to make it a crime to coerce a patient to request medical aid in dying or to forge a patient's request.⁴⁷

2.6.5 Maine

The *Maine Death with Dignity Act* was signed into law on 12 June 2019 and came into force on 19 September 2019.⁴⁸ The law is based on Oregon's law prior to amendment but requires the attending physician to meet with the patient alone, as is required by some other more recent American laws on the topic.

2.7 LEGISLATIVE INITIATIVES IN OTHER STATES

According to the Patients Rights Council, a non-profit organization focused on euthanasia, assisted suicide and end-of-life issues, five proposals to legalize euthanasia and/or assisted suicide by ballot initiative (including an earlier one in Washington State) have been defeated since 1991. According to the council, 269 bills were proposed on the issue between January 1994 and January 2019 in more than 39 states, including a number of bills being considered in 2019.⁴⁹

3 THE NETHERLANDS

3.1 DEVELOPMENT OF THE LAW

Traditionally, euthanasia was prohibited under the Dutch penal code, which states that anyone who terminates the life of another person at that person's explicit request is guilty of a criminal offence. Nonetheless, physicians who practised euthanasia in the Netherlands were not prosecuted as long as they followed certain guidelines. The guidelines were developed through a series of court decisions in which physicians who had been charged with practising euthanasia were found not to be criminally liable. In February 1993, the Netherlands passed legislation on the reporting procedure for euthanasia (the Termination of Life on Request and Assisted Suicide [Review Procedures] Act). Although it did not legalize euthanasia, the legislation provided a defence to physicians who followed certain guidelines. In effect, this provided doctors with concrete protection from prosecution.

With respect to infants, in 1995, Dutch courts dealt with two separate but similar cases in which doctors had ended the lives of severely disabled infants, both of whom were in pain and were not expected to survive their first year. In each case, the doctor had acted at the explicit request of the child's parents. The courts concluded that the doctors had met the requirements of good medical practice in those cases.⁵⁰ In 2004, some doctors and the district attorney in Groningen developed a protocol to identify when euthanasia of infants is appropriate. The Groningen Protocol has since been ratified by the Paediatric Association of the Netherlands, and doctors who respect the protocol's requirements appear not to be prosecuted in the Netherlands, although the protocol is not an actual law.⁵¹

3.2 CURRENT STATE OF THE LAW

In August 1999, the Dutch Minister of Justice and the Minister of Health tabled a legislative proposal in the House of Representatives – the lower house of Parliament – to exempt physicians from criminal liability in situations of euthanasia and assisted suicide as long as certain conditions are met. The bill passed the legislature in 2001.⁵²

The statutory provisions made no substantive change to the grounds on which euthanasia and assisted suicide were permitted, but did spell out in more detail the existing criteria for due care. To avoid criminal liability, the physician must

- be satisfied that the patient's request is voluntary and well considered;
- be satisfied that the patient's suffering is unbearable and that there is no prospect of improvement (not necessarily a terminal illness or *physical* suffering);
- inform the patient of their situation and further prognosis;

- discuss the situation with the patient and come to the joint conclusion that there is no other reasonable solution;
- consult at least one other physician with no connection to the case, who must then see the patient and state in writing that the attending physician has satisfied the criteria for due care; and
- exercise due medical care and attention in terminating the patient's life or assisting in the patient's suicide.⁵³

There is no requirement that the request be made in writing and there is no mention of a need for repeated requests in the legislation, although this appears to be the general practice. Although the law has no explicit residency requirement, the patient must have a "medical relationship" with a physician; in practical terms, this limits the law's application to residents of the Netherlands.⁵⁴ As in other jurisdictions, physicians are not obligated to assist a suicide or provide euthanasia if asked. Unlike the U.S. jurisdictions where assisted suicide is legal, the physician must stay with the patient in cases of assisted suicide until the patient has died. Individuals may write an advance directive outlining the circumstances in which they would want euthanasia to be performed, meaning that they need not have the capacity to make the decision at the time of their death.

Physicians must report cases to a regional review committee (this requirement predates the law and was introduced in 1998), which refers cases in which one of the criteria is not met to the Board of Procurators General (public prosecution service) and the regional health care inspector.⁵⁵

The most controversial aspect of the legislation was a proposal that children as young as 12 be permitted to request euthanasia or assisted suicide. However, the legislation as passed follows the Netherlands' Medical Treatment Contracts Act, and parental consent is required for persons under the age of 16. In principle, 16- and 17-year-olds can decide for themselves, but their parents must always be involved in the discussion. A June 2019 news article states that about 10 minors have received euthanasia since 2002.⁵⁶

The situation with respect to persons with Alzheimer's disease or other non-terminal illnesses remains contentious and is currently before the courts (as outlined in further detail in the next section). Given the difficulties in such cases, the Royal Dutch Medical Association is planning to provide more guidance to physicians carrying out euthanasia requests based on an advance directive for patients who are no longer capable of making decisions.

Guidelines were published in 2018 to assist physicians in cases where a patient has a psychiatric disorder.⁵⁷ There has been some discussion in the Netherlands of allowing euthanasia and/or assisted suicide for people who are simply "weary of life."⁵⁸ In 1998

(before the current law was in place), a doctor assisted an 86-year-old former senator who had no physical or psychiatric illness or disorder to die because he no longer wanted to live. At the appellate level, the doctor was found guilty of assisting a suicide since he had not respected the requirements set out in the case law, though he received no punishment because, as was reported in a January 2003 *British Medical Journal* article, “he had acted out of great concern for his patient.”⁵⁹ The Schnabel Commission recently studied whether to expand eligibility for euthanasia to include those who have “completed life” or allow for a pill that individuals could use to kill themselves without the assistance of a doctor. The Commission is reported to have rejected both propositions, although it concluded that the euthanasia legislation already permits cases of “completed life” since that is equivalent to “the symptoms of old age.”⁶⁰

3.3 ANNUAL REPORTS AND REVIEWS OF THE SYSTEM

As in other jurisdictions, most cases of reported deaths by euthanasia and assisted suicide involve individuals suffering from cancer. There have been significant increases in reported deaths by euthanasia and assisted suicide in recent years in the Netherlands (as high as 19% between 2009 and 2010). Although regional review committees have been examining the reasons for these increases, they do not appear to have come to any clear conclusions as to whether the statistics on euthanasia and assisted suicide reflect an actual trend, or simply more frequent reporting, given that reporting had not been universal in the past. Multiple reviews and studies of the system, both official and independent, have been undertaken in recent years.⁶¹ The law has been officially reviewed three times, in 2007, 2012 and 2017. The 2017 review concluded that the goals of the legislation were being met, while also making several recommendations regarding policy making and research.⁶²

2018 was the first year that saw a reduction in the number of euthanasia and assisted suicide deaths since 2006.⁶³ Research on the situation in the Netherlands shows that the majority of requests do not result in euthanasia or assisted suicide. Among the various reasons for this, the most common are that the patient died before the procedure was performed or did not meet the statutory criteria.⁶⁴ Failure to meet the statutory standard of due care is found in very few cases: between 2013 and 2018, four to 12 cases each year have failed to meet that standard out of thousands of cases.⁶⁵

In 2018, for the first time in more than ten years, the Health and Youth Care Inspectorate brought a euthanasia case before the medical disciplinary board. The physician in question was also the first to be prosecuted criminally since it came into force in 2002.⁶⁶ The physician in that case was charged with murder but the prosecutor did not ask for a punishment (the prosecutor was primarily asking for clarity in the law where a physician is relying on an advanced directive of a patient

who lacks capacity). The physician in the case had provided euthanasia to a patient with dementia who had an advance directive and was accused of not doing enough to find out if the patient still wanted to die. She was acquitted of the charges and found to have acted in accordance with the advance directive. The prosecution has appealed the case directly to the Supreme Court, which did not yet appear to have made its decision at the time of writing.⁶⁷ In 2018, the Board of Procurators General also conducted criminal investigations into four other cases from 2017 where the physician had been found not to have exercised due care, though in at least two of those cases the board decided not to prosecute.⁶⁸

The 2012 review mentioned above found that physicians have become more comfortable over time considering requests from patients with mental illness or dementia. It found that this is because the meaning and scope of the requirements have become clearer with more years of experience.⁶⁹ The majority of cases of assisted suicide or euthanasia over the period addressed by the report (2007–2011) involving a patient with dementia related to individuals in the early stages of the disease who were still able to understand the illness and its symptoms.⁷⁰ Nonetheless, when the report was written, more than half of doctors were unwilling to be involved in such cases, although most of these doctors were willing to refer the patient to another physician.⁷¹

Annual reports prior to 2014 included summaries of cases to help physicians understand their statutory duty of care. In 2015, a *Code of Practice* was published that summarized the requirements for ease of access, as recommended during the 2012 review mentioned above. The Code was updated in 2018.⁷²

In 2018, statistics for individuals who died by euthanasia or assisted suicide showed that

- 52% were men;
- 87% were aged 60 or older; and
- 80% died at home.⁷³

Tables 3 and 4 highlight some further statistics from review committee annual reports in recent years. The Netherlands had a population of more than 17 million people and over 150,000 deaths in 2018.

Table 3 – Annual Statistics Regarding the Netherlands’ Law Relating to Euthanasia and Assisted Suicide, 2003–2018

Year	Reported Deaths by Euthanasia	Reported Deaths by Assisted Suicide	Reported Deaths by a Combination of Euthanasia and Assisted Suicide	Total
2003	1,626	148	41	1,815
2004	1,714	141	31	1,886
2005	1,765	143	25	1,933
2006	1,765	132	26	1,923
2007	1,923	167	30	2,120
2008	2,146	152	33	2,331
2009	2,443	156	37	2,636
2010	2,910	182	44	3,136
2011	3,446	196	53	3,695
2012	3,965	185	38	4,188
2013	4,501	286	42	4,829
2014	5,033	242	31	5,306
2015	5,277	208	31	5,516
2016	5,856	216	19	6,091
2017	6,306	250	29	6,585
2018	5,898	212	16	6,126

Source: Table prepared by the author based on data obtained from The Netherlands, RTE Regional Euthanasia Review Committees, [Annual reports](#).

Table 4 – Disorders or Illnesses of Patients Who Died in the Netherlands by Euthanasia or Assisted Suicide in 2018

Disorder or Illness	Number of Patients	Percentage of Reported Deaths
Cancer	4,013	65.5
Neurological disorders	382	6.2
Cardiovascular disease	231	3.8
Multiple geriatric syndromes	205	3.3
Pulmonary disorders	189	3.1
Other disorders	155	2.5
Dementia	146 ^a	2.4
Psychiatric disorders	67	1.1
Combination of disorders	738	12.0
Total	6,126	100.0

Note: a. 144 patients were in the early stages of dementia when they died and two were at advanced stages.

Source: Table prepared by the author based on data obtained from The Netherlands, RTE Regional Euthanasia Review Committees, [Annual report 2018](#).

4 BELGIUM

Belgium conditionally decriminalized euthanasia in 2002.⁷⁴ Unlike the law in the Netherlands, the Belgian law does not specifically mention assisted suicide. The law defines euthanasia as an act of a third party that intentionally ends the life of another person at that person's request. The Belgian oversight body for euthanasia had determined that euthanasia, as defined in the law, encompasses assisted suicide. However, an April 2019 judgment discussed below challenges this interpretation. The judgment will have an impact on the regulatory regime for assisted suicide in Belgium (as opposed to euthanasia).⁷⁵

Anyone who has reached the age of majority (18 years) or is an emancipated minor (by marriage or court order), is mentally capable and is conscious may make a request if that person has an incurable condition that results in constant and unbearable physical or psychological suffering. As in the Netherlands, the patient does not need to have a terminal illness or experience *physical* suffering, but must reside in the country.⁷⁶

In 2014, the legislation was amended to permit a person of any age with the “capacity for discernment,” and who is conscious at the time of the request, to ask for euthanasia, although the conditions are narrower for minors who are not emancipated. They must experience constant and intolerable *physical* pain, have a serious and incurable condition, be close to death and have their parents' or legal guardians' permission. In addition, a child psychiatrist or psychologist must be consulted to verify the minor's capacity for discernment in relation to the decision to request euthanasia.⁷⁷

This change to the law was challenged before the Constitutional Court in October 2015. The Court upheld the constitutionality of the law and provided some clarifications. Since a capacity for discernment is required, newborns and young children are excluded from the provisions of the law (i.e., they do not have access to euthanasia). Also, in the case of unemancipated minors, the view of the independent child psychiatrist or psychologist about the patient's capacity for discernment, which must be in writing, is binding on the treating physician.⁷⁸

The legislation establishes conditions that must be met by both the person seeking euthanasia and the physician who performs it. The doctor must meet the patient several times with a reasonable delay between visits. The doctor must also seek the opinion of at least one independent doctor, or two doctors if the patient is not expected to die in the near future. There is a waiting period of at least one month between the written request and the performance of euthanasia in situations where death is not imminent. As in other jurisdictions, no one is obligated to practise euthanasia.

Physicians are required to fill out a registration form each time they perform euthanasia; this form is then reviewed by Belgium's Commission fédérale de contrôle

et d'évaluation de l'euthanasie, whose role it is to determine whether the euthanasia was performed in accordance with the conditions and procedures established by the legislation. If two-thirds of Commission members are of the opinion that the conditions were not fulfilled, the case is referred to the Crown prosecutor.

Generally, where issues have been identified, they have been procedural (information missing from a form, etc.) and no criminal prosecution has occurred.⁷⁹ It appears that the first case referred to the Crown prosecutor's office was in the fall of 2015. The case involved an 85-year-old woman whose daughter had died recently and who was depressed. The mother was not referred to a psychiatrist during the assessment of her situation. The physician had provided the patient with a substance that she drank, which would be considered assisted suicide. The proceedings against the doctor were dismissed in April 2019 because the doctor was considered not to have performed euthanasia and thus was not subject to the euthanasia law. This appears to contradict the interpretation of the Commission that euthanasia includes assisted suicide, with the result that the practice of assisted suicide could remain unregulated in Belgium.⁸⁰

The 2016–2017 report of the Commission notes that it debated whether to refer another case to the Crown prosecutor's office, as there was no clear request for euthanasia. The patient who died had two to three days to live and had been in extreme pain for 24 hours. Her behaviour and non-verbal communication had been interpreted as a request. The case was not referred to the Crown prosecutor as only nine of the 16 Commission members voted to do so (two-thirds are required).⁸¹

November 2018 news reports stated that three doctors had been charged with offences under the euthanasia law after granting an application for euthanasia due to psychological suffering. The trial does not appear to have taken place as of the time of writing.⁸²

Individuals who are 18 years old or above or emancipated minors can make an advance directive expressing their desire to be euthanized as long as certain conditions are met when the procedure actually takes place. Unlike in the Netherlands, an advance directive is valid only for persons who are unconscious at the time of the euthanasia. This means that individuals with conditions affecting decision-making capacity, such as dementia, are not able to use an advance directive to request euthanasia for a future date when they are no longer capable of making decisions. Also, the directive is only valid for five years but can be renewed.

Various amendments to the law continue to be proposed by parliamentarians. Topics of recent bills include expanding euthanasia to individuals with illnesses affecting their capacity, such as dementia, if an advance directive is in place; introducing a requirement for a doctor unwilling to perform euthanasia to refer a patient to one who will do so; and the explicit regulation of assisted suicide. These bills do not appear to have passed.⁸³

A few euthanasia cases in Belgium have made international headlines in recent years, including the case of deaf twins who were going to lose their sight and requested to die together.⁸⁴ According to media reports, Tom Mortier, a Belgian man whose mother received euthanasia at her request because of long-standing depression, is challenging the Belgian law at the European Court of Human Rights.⁸⁵

4.1 BIENNIAL REPORTS

Belgium's commission on euthanasia publishes biennial reports that aggregate statistics about those who choose euthanasia. For 2018, statistics for individuals who died by euthanasia showed that

- 47% were men;
- 86.9% were aged 60 or older;⁸⁶ and
- 46.9% died at home.⁸⁷

Tables 5 and 6 highlight some statistics from Belgium's biennial reports in recent years.

**Table 5 – Annual Statistics Concerning Belgium's
Law Relating to Euthanasia, 2002–2018**

Year	Reported Deaths by Euthanasia	Deaths by Euthanasia per 1,000 Deaths
22 Sept. 2002–31 Dec. 2003 (approximately 15 months)	259	2.0
2004	349	3.6 (2004–2005 average)
2005	393	3.6 (2004–2005 average)
2006	429	4.4 (2006–2007 average)
2007	495	4.4 (2006–2007 average)
2008	704	7.0 (2008–2009 average)
2009	822	7.0 (2008–2009 average)
2010	953	10.0 (2010–2011 average)
2011	1,133	10.0 (2010–2011 average)
2012	1,432	13.0
2013	1,807	17.0
2014	1,928	18.0
2015	2,022	18.0

Year	Reported Deaths by Euthanasia	Deaths by Euthanasia per 1,000 Deaths
2016	2,028	Not reported
2017	2,309	Not reported
2018	2,357	Not reported

Source: Table prepared by the author based on data obtained from biannual reports available at Belgium, Service public fédéral, Santé publique, Sécurité de la chaîne alimentaire et Environnement, [Commission fédérale de contrôle et d'évaluation de l'euthanasie](#). The most recent biannual report is for 2016–2017. For the 2018 data, see Belgium, Service public fédéral, Santé publique, Sécurité de la chaîne alimentaire et Environnement, [Euthanasie – Chiffres de l'année 2018](#).

**Table 6 – Disorder or Illness of Patients in Belgium
Who Died by Euthanasia or Assisted Suicide in 2018**

Disorder or Illness	Number of Patients	Percentage of Reported Deaths
Tumours (Cancers)	1,447	61.4
Multiple diseases	438	18.6
Diseases of the nervous system	195	8.3
Cardiovascular disease	89	3.8
Mental and behavioural disorders	57	2.4
Diseases of the respiratory system	57	2.4
Diseases of the joints, muscles and connective tissues	22	0.9
Traumatic injuries, poisonings and other complications due to external causes	12	0.5
Digestive diseases	12	0.5
Genitourinary diseases	6	0.3
Diseases of the blood and hematopoietic organs and certain disorders of the immune system	4	0.2
Diseases of the eye and associated tissues	4	0.2
Abnormal symptoms, signs and results of clinical examinations and laboratory tests not classified elsewhere	4	0.2
Certain infectious and parasitic diseases	3	0.1
Endocrine, nutritional and metabolic diseases	3	0.1
Diseases of the ear and mastoid process	3	0.1
Congenital malformations and chromosomal anomalies	1	0

Source: Table prepared by the author based on data obtained from Belgium, Commission fédérale de Contrôle et d'Évaluation de l'Euthanasie - CFCEE, [Euthanasie – Chiffres de l'année 2018](#), News release, 28 February 2019. [TRANSLATION]

5 LUXEMBOURG

In 2008, Luxembourg passed a law decriminalizing doctors' involvement in euthanasia and assisted suicide where certain conditions are met. As in the Netherlands and Belgium, there is no explicit legal requirement for the patient to be a resident, but since a close relationship with a doctor is required, patients must, in practice, be residents.⁸⁸ Conditions similar to those in Belgium are set out in the legislation, the *Loi du 16 mars 2009 sur l'euthanasie et l'assistance au suicide*.⁸⁹ There are some differences, including the age at which a person may request euthanasia or assisted suicide. In Luxembourg, an individual must be at least 18 years old, the age of majority. Unlike in Belgium, advance directives have no limitation on their validity period, although they are registered with a government body that verifies every five years whether they continue to reflect the wishes of the person in question.

In 2019, the law was amended to clarify that a death by euthanasia or assisted suicide is a natural death for insurance purposes.⁹⁰

5.1 BIENNIAL REPORTS

Luxembourg's Commission Nationale de Contrôle et d'Évaluation de la loi du 16 mars 2009 sur l'euthanasie et l'assistance au suicide provides reports to the public every two years. The reports indicate that there has never been a case of euthanasia or assisted suicide that was sent to the prosecutor for charges to be considered. The annual reports provide aggregate statistics about those who choose euthanasia (only two assisted suicides have been reported to date). For 2018, statistics for individuals who died by euthanasia or assisted suicide showed that,

- 88% were men (7 out of 8);
- 100% were over the age of 60;
- 63% died at home (5 out of 8);
- 88% had cancer (7 out of 8); and
- 13% had a neurodegenerative disease (1 out of 8).

Table 7 provides information on the number of reported deaths by euthanasia per year. The country has a population of over 600,000 and had 4,318 deaths in 2018.

**Table 7 – Reported Deaths by Euthanasia or Assisted Suicide
in Luxembourg, 2009–2018**

Year	Reported Deaths by Euthanasia	Reported Deaths by Advanced Directive	Reported Deaths by Assisted Suicide
2009–2010	5	–	–
2011–2012	13	1	–
2013	8	–	–
2014	7	–	–
2015	8	–	–
2016	9	–	1
2017	11	–	–
2018	7	–	1

Source: Table prepared by the author based on data obtained from Luxembourg, Gouvernement du Grand-Duché de Luxembourg, [Cinquième rapport de la loi du 16 mars 2009 sur l'euthanasie et l'assistance au suicide \(années 2017 et 2018\)](#), 2019.

6 SWITZERLAND

Article 114 of the Swiss Criminal Code prohibits euthanasia, although the crime has a lesser sentence than other acts deemed homicide. Murder carries a mandatory minimum sentence of five years' imprisonment, while Article 114 provides that an individual who kills a person for compassionate reasons on the basis of that person's serious request will be fined or sentenced to a maximum term of imprisonment of three years. Assisted suicide is addressed in Article 115, which provides that someone who, for selfish reasons, incites someone to commit suicide or assists a suicide will be fined or sentenced to a maximum term of imprisonment of five years. Thus, it is implicit that assisted suicide is permitted if the person assisting the suicide does so for unselfish reasons.

Since Article 115 does not explicitly regulate assisted suicide for unselfish reasons, the Swiss Criminal Code does not require that a physician be the person to assist a suicide, nor does it require the involvement of any physician whatsoever, which is a significant departure from legislation in other countries where assisted suicide is permitted.⁹¹ Nonetheless, at least one canton (region) has approved, by referendum, legislation to regulate the provision of assisted suicide in hospitals and other “socio-medical establishments,” and another has passed legislation on the matter.⁹²

Assisted suicide is also not limited to those with a terminal illness or to Swiss residents. Because of the lack of residency requirements, Switzerland has become a destination for foreigners, predominantly Europeans, seeking assistance in committing suicide.⁹³ Canadian Kathleen (“Kay”) Carter went to Switzerland in 2010 with her daughter, Lee Carter, and son-in-law, Hollis Johnson, to end her life. She suffered from spinal stenosis, a compression of the spinal cord or spinal nerve roots

that was painful but not fatal. Lee Carter and Hollis Johnson were plaintiffs in litigation that successfully challenged Canada's laws on assisted suicide.⁹⁴

In July 2008, the Swiss government called on the Department of Justice and the federal police to prepare a report on the need to update the rules on assisted suicide. That report, as well as consultations undertaken in 2009 and 2010, concentrated primarily on two options: to provide a more detailed legislative framework to regulate assisted suicide or to prohibit organizations that provide assistance to commit suicide altogether.⁹⁵ In the end, there was no consensus on the best course of action, and the Swiss Federal Council (the Swiss cabinet) decided not to make any changes to the law.⁹⁶ Referendums in Zurich to ban assisted suicide or at least to impose a residency requirement also failed.⁹⁷

6.1 CASES

In January 2011, the European Court of Human Rights held that no violation of the *European Convention on Human Rights*' protections of private life occurred when a Swiss man was unable to obtain a lethal substance that was available only by prescription. Ernst G. Haas, who suffered from bipolar disorder, had attempted suicide twice and had been unsuccessful in getting a psychiatrist to prescribe him a lethal dose of a drug. He had also unsuccessfully sought permission from federal and cantonal authorities to receive such a dose without a prescription and had appealed those decisions in the Swiss courts before turning to the European Court of Human Rights. The Court recognized his right to decide to end his own life as protected under the right to privacy in Article 8 of the *European Convention on Human Rights*, but concluded that the state has no obligation to assist someone to access such a drug without a prescription. The Grand Chamber of the European Court of Human Rights refused to hear an appeal.⁹⁸

In May 2013, the European Court of Human Rights heard another case from Switzerland. This time, the case was brought by Alda Gross, who was in her 70s when the case started and, although not ill, did not want to experience the continued decline in mental and physical health that can come with age. She had repeatedly expressed the will to die over a number of years. However, doctors were unwilling to provide a prescription for a lethal substance because of concerns that this would violate professional ethics or lead to prosecution. A split four-to-three decision by the Court distinguished the question at issue from that in the Haas case.⁹⁹ The Court in the Gross case concluded that the lack of clear, legally binding guidelines in Switzerland resulted in a lack of clarity as to the extent of Ms. Gross's right to obtain a lethal drug prescription to commit suicide. As a result, this was a violation of the right to privacy under Article 8 of the *European Convention on Human Rights*.

The Court left it up to the Swiss authorities to develop the necessary guidelines to remedy the Article 8 violation. However, the Swiss government requested the case be

referred to the Grand Chamber of the European Court of Human Rights as a serious question to be decided. It was then discovered that Ms. Gross had died in 2011 and that her death had been hidden from the Court so that her case would go ahead.¹⁰⁰ The Grand Chamber found Ms. Gross's application to be inadmissible in a nine-to-eight decision in 2014, meaning that the earlier decision requiring clarification of the prosecution policy is not binding on Switzerland.¹⁰¹

In October 2019, a Swiss court concluded that a doctor did not have the right to prescribe a lethal dose to a healthy 86-year-old woman who wanted to die with her husband. The physician reportedly received a suspended sentence and a fine. He may be appealing the judgment.¹⁰²

7 COLOMBIA¹⁰³

In Colombia, euthanasia is a criminal offence for which the maximum sentence is less than that for homicide. In a 1997 case, an individual initiated a constitutional challenge to this sentencing distinction on the grounds of the right to life and to equality. One argument was that individuals convicted of euthanasia should not benefit from a lower maximum sentence. Colombia's Constitutional Court rejected the constitutional challenge, concluding that a doctor could not be prosecuted for euthanasia for assisting an individual in ending the person's life if the person had a terminal illness, severe pain and suffering and had consented. Nonetheless, "mercy killing" remains a crime in Colombia if those conditions are not met.¹⁰⁴ The judgment also urged legislative action in this area, but it seems that legislative efforts have not been successful to date, as the issue is quite contentious in this predominantly Catholic country.¹⁰⁵ Given the uncertainty created by a lack of legislation responding to the Constitutional Court decision, few physicians appear to have practised euthanasia openly.¹⁰⁶

In December 2014, the Constitutional Court again addressed the issue of euthanasia, concluding that the fundamental rights of the claimant, who had terminal cancer, had been violated when she was refused euthanasia. She died of natural causes before the proceedings were complete, but the Court nonetheless ordered the Ministry of Health to regulate "dying with dignity," which it did in April 2015.¹⁰⁷ The first person to have a legally assisted death after the regulations were put in place, a man with cancer, died in July 2015.¹⁰⁸ However, news reports state that there are a number of bureaucratic and societal barriers that mean few Colombians have access to euthanasia (officially 40 to date for a population of over 49 million) and others are accessing it outside the public health system (which does not appear to be legal).¹⁰⁹

The 2014 Constitutional Court decision also urged Congress to legislate on this issue. As a result, at least one bill to regulate euthanasia and assisted suicide was tabled but it did not pass.¹¹⁰

A further judgment of the Constitutional Court in 2017 is reported to have required the government to regulate the practice for minors as well, which it did in 2018. As is required for adults, a committee consisting of a physician, a psychiatrist and a lawyer must assess the case. The patient must be at least six- or seven-years-old and have a prognosis of less than six months, among other criteria.¹¹¹

8 AUSTRALIA

The Northern Territory of Australia was the first jurisdiction to make euthanasia and assisted suicide legal in 1996, but the law was quickly overturned by federal legislation. Not until 2017 was assisted dying again legal in an Australian state. That year, the State of Victoria legalized assisted dying, though the law only came into force on 19 June 2019.¹¹²

The Victorian legal framework is closer to that in the U.S. jurisdictions where assisted suicide is legal, with a requirement to have six months or less to live, though there are some differences. Both euthanasia (known as practitioner administration) and assisted suicide (known as self-administration) are allowed. Individuals who have twelve months to live or less and suffer from a neurodegenerative condition are also eligible. Patients must also be 18 years of age or older, have lived in Victoria for at least 12 months and have mental capacity, among other requirements. As with other jurisdictions, two physicians must assess the patient, who needs to have made two oral requests and a written one. The final request must be made at least nine days after the first and at least a day after the second assessment, unless the patient is likely to die before those deadlines.¹¹³

In addition, the patient must be the one to initiate discussion of voluntary assisted dying, as it is called in Victoria. Physicians must undergo specific online training prior to completing an assessment of a patient for assistance in dying. All training must be approved by the Head of the Department of Health and Human Services and may include information about the requirements under the law, assessment of eligibility criteria and identifying and assessing risk factors for abuse and coercion. Physicians also have an obligation to refer the patient to a specialist if they are unsure whether the patient meets one or more of the eligibility criteria.¹¹⁴

The physician must request a voluntary assisted dying permit, which specifies if the death will be practitioner- or self-administered (physicians can apply for a practitioner-administered permit if they have a self-administration permit and the patient becomes incapable of self-administering). The patient also needs to designate a contact person who is responsible for returning any unused drugs.¹¹⁵

9 GERMANY

In 2015, Germany explicitly outlawed prescribing drugs for the purpose of ending a life. In 2017, a federal court case concluded that assisted dying was legal in certain cases. That judgment, however, has been reported to have largely been ignored by the government and requests for such drugs have apparently all been rejected. In April 2019, Germany's Federal Constitutional Court heard arguments challenging the 2015 law. The judgment in that decision does not appear to have come out at the time of writing.¹¹⁶

10 ITALY

In November 2019, Italy's Constitutional Court concluded that assisted dying should be permitted by law in certain circumstances. A parliamentary debate is expected on the topic.¹¹⁷

11 UNITED KINGDOM

11.1 ENGLAND AND WALES

11.1.1 Court Cases

End-of-life decisions have caused considerable controversy in the U.K. Euthanasia is illegal throughout the U.K. Although assisted suicide also remains illegal, because of the developments discussed in this section, a person who assists the suicide of another person will not necessarily be prosecuted.¹¹⁸

In a 2002 European Court of Human Rights case, Diane Pretty unsuccessfully challenged the law prohibiting assisted suicide and sought assurances from the Director of Public Prosecutions (DPP) that her husband would not be prosecuted if he assisted her suicide. The Court found that the DPP's refusal of her request and the U.K.'s prohibition of assisted suicide did not infringe on any of her rights under the *European Convention on Human Rights*.¹¹⁹

In the mid-2000s, Debbie Purdy, who suffered from multiple sclerosis, made it known that she wanted to obtain the assistance of a Swiss clinic to end her life. She was afraid, however, that her husband, Omar Puente, would be prosecuted in the U.K. if he accompanied her to Switzerland. She wanted to determine the DPP's official policy in this regard and to clarify whether it was legal under British law for a British citizen to assist someone to commit suicide in a country, such as Switzerland, where assisted suicide is legal.

The House of Lords concluded that the DPP should be required to clarify its policy in dealing with such cases for the public.¹²⁰ The resulting updated policy, published in

February 2010, stated clearly that assisted suicide remains a criminal offence. However, it outlined a two-stage process to determine whether charges will be brought: first, it must be determined whether there is sufficient evidence of an offence having been committed and, second, it must be decided whether a prosecution is in the public interest. Specific factors, such as whether the person who committed suicide clearly stated the intention to do so, and the motivation of the person who assisted, are to be considered.

In 2014, the policy was clarified again with respect to the risk of prosecution for health care workers. This was done to make it clear that it is the relationship with the patient that matters in assessing whether prosecution is more likely to be required (that is, whether the victim was in the health professional's care and at risk of undue influence). The intent is not for the listed types of professionals to be at greater risk of prosecution simply because of their profession.¹²¹ This clarification arose from the Nicklinson case, in which Tony Nicklinson and another person known as AM or Martin, both of whom had locked-in syndrome,¹²² challenged the law on assisted suicide and euthanasia in England and Wales. Paul Lamb, another plaintiff with the same syndrome, joined the challenge later. None of the men appears to have had a terminal illness. When Mr. Nicklinson died shortly after a lower-level court decision was released, his wife also became a plaintiff. As part of that case, the U.K. Supreme Court (previously the House of Lords) concluded that the policy lacked clarity with respect to the likelihood of prosecution of health care professionals but left the DPP to clarify the policy.

The Supreme Court handed down a divided decision on 25 June 2014 in which each justice wrote a judgment. The appellants (Mr. Nicklinson and others) lost the appeal, with seven of nine judges dismissing their claims. Four judges concluded that the Court should defer to Parliament on this topic. Five of the justices concluded that the “court has the constitutional authority to make a declaration that the general prohibition on assisted suicide in Section 2 is incompatible with Article 8” (the right to privacy and family life in the *European Convention on Human Rights*). However, three of those justices found that Parliament should be given the opportunity to address the issue first. Only two justices concluded that such a declaration should be issued at the time of judgment.¹²³ An application to the European Court of Human Rights by Mrs. Nicklinson and Mr. Lamb challenging the decision was deemed inadmissible.¹²⁴

AM also unsuccessfully challenged the General Medical Council's (the regulatory body for doctors in the U.K.) guidance for doctors with respect to assisted suicide.¹²⁵

The *Suicide Act 1961* was unsuccessfully challenged in 2017 for being incompatible with certain articles of the *European Convention on Human Rights*. The High Court of Justice concluded that Parliament had decided not to change the

law in 2015 and that this must be respected. Appeals of that decision were unsuccessful.¹²⁶

11.1.2 Legislative Proposals

Bills have been introduced in the House of Commons and the House of Lords to legalize “assisted dying” in England and Wales. The most recent bill was introduced in 2015.¹²⁷

The bills introduced in the U.K. Parliament were similar to the laws in the U.S., requiring a person seeking assistance with dying to have a terminal illness with less than six months to live, be 18 years of age or older, have the capacity to make the decision and be a resident of the jurisdiction in question (in this case, England and Wales). One key difference is that participants would have needed the authorization of the High Court (Family Division), whereas judicial involvement is not required in the U.S. states where assisted suicide is legal. The bills would have allowed a doctor or a nurse to “assist [the] person to ingest or otherwise self-administer the medicine; but the decision to self-administer the medicine and the final act of doing so must be taken by the person for whom the medicine has been prescribed.”¹²⁸ The assisting health professional would have also needed to remain near the patient until the person either dies or decides not to administer the medicine.

A debate about the impact of the current laws prohibiting assisted dying took place in the House of Commons on 4 July 2019, but there do not appear to be plans to introduce any new legislation on assisted dying for now.¹²⁹

11.2 NORTHERN IRELAND

The DPP’s jurisdiction is limited to England and Wales, but Northern Ireland has a similar policy, developed in collaboration with the DPP. Unlike the policy in place in England and Wales, this policy does not appear to have been updated to clarify the situation with respect to health care workers.¹³⁰

11.3 SCOTLAND

Unlike England, Wales and Northern Ireland, Scotland does not have a statutory offence of assisted suicide. Depending on the facts, a case of assisted suicide could be addressed through homicide laws.¹³¹ In an attempt to eliminate this risk, Margo MacDonald, an independent member of the Scottish Parliament living with Parkinson’s disease, introduced a bill in the Scottish Parliament in 2010 that would have legalized assisted suicide. The bill was defeated later that year.¹³²

Ms. MacDonald introduced a bill on the same topic in November 2013. When she died in 2014, another member of the Scottish Parliament took responsibility for the bill. In May 2015, the bill failed to pass the stage 1 debate in the Scottish Parliament and died on the *Order Paper*. That bill would have allowed individuals who were at least 16 years old with a terminal illness or a life-shortening condition to request assistance in committing suicide. It would have introduced a role for “licensed facilitators” in giving practical assistance to the patient and would have provided for a licensing scheme for such facilitators. Unlike the assisted suicide legislation in the U.S., the bill did not require the prognosis to be six months or less.¹³³

The Scottish courts have also addressed the issue of assisted suicide recently. A September 2015 trial-level decision addressed the petition of Gordon Ross. Similar to the appellant in the decision handed down by the House of Lords in the *Purdy* decision, Mr. Ross sought judicial review to clarify the circumstances in which a person who helps another to commit suicide would be prosecuted. The Scottish Court of Session dismissed the petition. Among other conclusions, the Court found that Article 8 of the *European Convention on Human Rights* was engaged but distinguished the *Purdy* decision because of the differences in the laws and prosecutorial practice between Scotland and England and Wales. The Court concluded that the Scottish policy was in accordance with the law and that Article 8 of the European Convention was not violated.¹³⁴ Mr. Ross’s appeal of the decision was unsuccessful.¹³⁵

NOTES

1. The law in a number of countries is silent with respect to assisted suicide, meaning that the practice is technically legal in those jurisdictions. Countries in such situations are not discussed in this paper, as the focus here is on legislative initiatives and court rulings. Not all countries where bills have been proposed but not yet passed, such as Spain, are discussed. While New Zealand recently passed legislation on medical assistance in dying, a referendum is required for it to come into law. Because there is no legislation currently in force, that country is not discussed either. In addition, the policies of medical associations that regulate professions such as medical practice and nursing have not been examined. Finally, the topic of withholding or withdrawing treatment appears to be less controversial in Canada than euthanasia or assisted suicide, although there are some outstanding challenges to the application of the law in Canada. Withholding or withdrawing treatment is contentious in some other countries. However, that issue is beyond the scope of this paper.
2. Martha Butler and Marisa Tiedemann, [*Carter v. Canada: The Supreme Court of Canada’s Decision on Assisted Dying*](#), Publication no. 2015-47-E, Parliamentary Information and Research Service, Library of Parliament, Ottawa, 29 December 2015; Julia Nicol and Marisa Tiedemann, [*Legislative Summary of Bill C-14: An Act to amend the Criminal Code and to make related amendments to other Acts \(medical assistance in dying\)*](#), Publication no. 42-1-C14-E, Parliamentary Information and Research Service, Library of Parliament, Ottawa, 27 September 2018; and Marisa Tiedemann, *Assisted Dying in Canada After Carter v. Canada*, Publication no. 2019-43-E, Parliamentary Information and Research Service, Library of Parliament, Ottawa, 29 November 2019.
3. Mary J. Shariff, “Immortal Beloved and Beleaguered: Towards the Integration of the Law on Assisted Death and the Scientific Pursuit of Life Extension,” *Health Law in Canada*, Vol. 31, No. 1, 2010, p. 6.

4. United States, [Washington v. Glucksberg](#), 521 U.S. 702 [Supreme Court of the United States, 1997] (Court Listener); and United States, [Vacco v. Quill](#), 521 U.S. 793 [Supreme Court of the United States, 1997] (Court Listener).
5. United States, [Sampson v. State](#), 31 P.3d 88 [Alaska Supreme Court, 2001] (Court Listener); and United States, [Sanderson v. People](#), 12 P.3d 851 [Colorado Court of Appeals, 2000] (Court Listener).
6. United States, Oregon, State Legislature, [The Oregon Death with Dignity Act](#), Oregon Revised Statutes, c. 127. Although the legislation was not struck down as a result of the legal challenge, the Oregon legislature then voted to have another citizen vote on the law. Oregon voters reaffirmed their support by a 60% majority, and the Act came into effect in November 1997. Opponents of the *Death with Dignity Act* quickly began to lobby for federal intervention against the state initiative. They initially appeared unsuccessful, but with a change in government at the federal level in 2001, an Interpretive Rule was issued to clarify the legal situation in federal law for doctors who might assist a patient to commit suicide.

The Interpretive Rule stated that physicians who prescribed, dispensed or administered federally controlled substances to assist a suicide would be violating the federal *Controlled Substances Act*. However, in January 2006, the Supreme Court of the United States ruled in *Gonzales v. Oregon* that the Interpretive Rule was invalid because it went beyond the federal Attorney General's authority under the *Controlled Substances Act*. United States, [Gonzales v. Oregon](#), 546 U.S. 243 [Supreme Court of the United States, 2006] (Court Listener).
7. United States, [Baxter v. State](#), 2009 MT 449 [Montana Supreme Court], para. 7 (Court Listener).
8. *Ibid.*, para. 13.
9. *Ibid.*
10. For a bill seeking to make assisted suicide illegal, see, for example, United States, Montana, State Legislature, "[HB 284](#)," *Montana Legislature: Detailed Bill Information*. For a bill seeking to regulate the practice, see United States, Montana, State Legislature, "[SB 202](#)," *Montana Legislature: Detailed Bill Information*.
11. A ballot initiative is "a form of direct democracy ... by which citizens exercise the power to place measures otherwise considered by state legislatures or local governments on statewide and local ballots for a public vote." See Robert Longley, "[Understanding the Ballot Initiative Process](#)," *ThoughtCo.com*.
12. See endnote 6.
13. United States, Oregon, State Legislature, [Senate Bill 579](#), 80th Oregon Legislative Assembly, 2019 Regular Session.
14. *Oregon Death with Dignity Act*, 127.800, s. 1.01(3).
15. *Ibid.*, 127.800, s. 1.01(7)(e).
16. *Ibid.*, 127.855, s. 3.09 ("Medical record documentation requirements"); 127.865, s. 3.11 ("Reporting requirements").
17. *Ibid.*, 127.855, s. 4.01(4).
18. See, for example, United States, Oregon, State Legislature, [House Bill 2232](#), 80th Oregon Legislative Assembly, 2019 Regular Session; United States, Oregon, State Legislature, [House Bill 2217](#), 80th Oregon Legislative Assembly, 2019 Regular Session; and United States, Oregon, State Legislature, [House Bill 2903](#), 80th Oregon Legislative Assembly, 2019 Regular Session.
19. United States, Oregon, Oregon Health Authority, Public Health Division, [Oregon Death with Dignity Act: 2018 Data Summary](#), 25 April 2019, p. 12.
20. *Ibid.*
21. *Ibid.*; and "[SF Judge Upholds Law Prohibiting Physician-Assisted Suicide](#)," *NBC Bay Area*, 14 August 2015.
22. United States, Oregon, Oregon Health Authority, Public Health Division, [Death with Dignity Act Annual Reports](#). See annual reports for 2011–2018. No further information was found regarding the referral of two doctors to the Oregon Medical Board.
23. United States, Washington, Washington State Department of Health, [Death with Dignity Act](#). For information about the ballot initiative, see Washington Secretary of State, "Initiative Measure No. 1000," [Initiatives to the People](#).

24. Data for 2018 is not available on the state's death statistics web page. See United States, Washington, Washington State Department of Health, [All Deaths – County and State Dashboards](#).
25. United States, Washington, Washington State Department of Health, Disease Control & Health Statistics, Center for Health Statistics, "Table 2. End of Life Concerns of Participants Who Died, 2016–2018," [2018 Death with Dignity Act Report](#), Chapter 70.245 RCW, July 2019, p. 11.
26. United States, Vermont, Vermont General Assembly, [S.77 \(Act 39\): An act relating to patient choice and control at end of life](#), 20 May 2013.
27. United States, Vermont, Vermont General Assembly, [S.108 \(Act 27\): An act relating to repealing the sunset on provisions pertaining to patient choice at end of life](#), 20 May 2015. Rules for the collection of data are found in United States, Vermont, Vermont Department of Health, [Rule Governing Compliance with Patient Choice at the End of Life](#).
28. David C. Englander, Esq., Vermont Department of Health, [Report Concerning Patient Choice at the End of Life \(January 15, 2018\)](#), Report to the Vermont Legislature.
29. United States, [Vermont Alliance for Ethical Healthcare, Inc. et al. v. Hoser et al.](#), United States District Court for the District of Vermont, 5 April 2017.
30. United States, California, California Legislative Information, [Assembly Bill No. 15: An act to add and repeal Part 1.85 \(commencing with Section 443\) of Division 1 of the Health and Safety Code, relating to end of life \(AB-15 End of Life Option Act\)](#), c. 1, 5 October 2015.
31. April Dembosky, "California Approves Physician-Assisted Suicide; Bill Heads to Governor's Desk," *NPR*, 12 September 2015; and Alexei Koseff, "Which bills will Jerry Brown sign?," *Sacramento Bee*, 17 September 2015.
32. United States, California, [People v. Superior Court \(Ahn\)](#), Court of Appeal of the State of California, Fourth Appellate District, Division 2, Case no. E070545, 27 November 2018. On 27 February 2019, California's Supreme Court refused to review the decision of the appeals court. See California Courts, "Supreme Court: Disposition – *Becerra v. S.C. (Ahn)*," [Appellate Courts Case Information](#). For further details about the case, see Death with Dignity, [California](#).
33. For a list of other differences, see Death with Dignity, [The California End of Life Option Act and Death with Dignity](#), 22 January 2016.
34. Medicaid is state-funded health care for low-income residents.
35. Susan Harding and KATU Web staff, "Letter noting assisted suicide raises questions," *Katu.com* [Portland], 30 July 2008; and Dan Springer, "Oregon Offers Terminal Patients Doctor-Assisted Suicide Instead of Medical Care," *FoxNews*, 28 July 2008. For a case reported after the law was put in place, see Bradford Richardson, "Assisted-suicide law prompts insurance company to deny coverage to terminally ill California woman," *Washington Times*, 20 October 2016. Similar concerns were raised by the (U.S.) National Council on Disability in [The Danger of Assisted Suicide Laws: Part of the Bioethics and Disability Series](#), 9 October 2019.
36. United States, State of California, California Department of Public Health, "End of Life Option Act," [Center for Health Statistics and Informatics](#).
37. Sammy Caiola, "California's Aid in Dying Law Is Mostly Used By White People. Here's Why," *Capital Public Radio*, 12 July 2019. For an academic article regarding perceptions of medical aid in dying in different racial and ethnic groups, see Cindy L. Cain and Sara McCleskey, "Expanded definitions of the 'good death'? Race, ethnicity and medical aid in dying," *Sociology of Health and Illness*, Vol. 41, No. 6, 2019, pp. 1175–1191.
38. United States, Colorado, Colorado Department of Public Health & Environment, [Medical Aid in Dying](#); and Sawyer D'Argonne, "69 Coloradoans seek assisted suicide in first year of program," *Sky-Hi News*, 2 March 2018.
39. Amanda Pampuro, "Terminally Ill Man Sues Hospital Over Aid-in-Death Medication," *Courthouse News Service*, 22 August 2019. For the pleadings, see [Mahoney et al. v. Centura Health Corporation](#), United States District Court, District of Colorado, Arapahoe County, 21 August 2019.
40. United States, District of Columbia, DC.gov, [Death with Dignity Act of 2016](#), D.C. Law 21-182; United States, District of Columbia, DC Health, [District of Columbia Death with Dignity Act: 2018 Data Summary](#); and United States, District of Columbia, DC Health, [District of Columbia Death with Dignity Act: 2017 Summary](#).

41. Congress can review and repeal laws passed by the Council. See Compassion & Choices, [District of Columbia](#); Death with Dignity, [District of Columbia](#); and Patients Rights Council, [District of Columbia](#).
42. United States, Hawaii, House of Representatives, [A Bill for an Act Relating to Health](#) (Our Care, Our Choice Act), H.B. no. 2739, 29th Legislature, 5 April 2018.
43. United States, Hawaii, State Legislature, [SB536 SD2 HD1 CD1](#), 30th Legislature, 2019.
44. United States, State of Hawaii, Department of Health, [Hawaii Department of Health \(DOH\): 2019 Our Care Our Choice Annual Report](#), 1 July 2019.
45. United States, New Jersey, State Legislature, [An Act concerning medical aid in dying for the terminally ill, supplementing Titles 45 and 26 of the Revised Statutes, and amending P.L. 1991, c.270 and N.J.S.2C:11-6](#), P.L. 2019, c. 59, 12 April 2019; and United States, New Jersey, [New Jersey Medical Aid in Dying for the Terminally Ill Act: Frequently Asked Questions](#).
46. Patients Rights Council, [New Jersey](#); Compassion and Choices, [New Jersey](#); United States, New Jersey, [Glassman v. Grewal](#), Supreme Court of New Jersey, 27 August 2019; and [Glassman v. Grewal](#), Superior Court of New Jersey Appellate Division, 27 August 2019.
47. Both bills have been referred to the judiciary committee of the New Jersey Assembly. United States, New Jersey, General Assembly, [A5469: An Act concerning medical aid in dying and amending P.L. 2019, c.59](#), 218th Legislature, 6 June 2019; and United States, New Jersey, General Assembly, [A5525: An Act concerning medical aid in dying for the terminally ill, amending P.L. 1991, c.270 and N.J.S.2C:11-6, and repealing sections 1 through 26 of P.L. 2019, c.59](#), 218th Legislature, 6 June 2019.
48. United States, Maine, State Legislature, [An Act to Enact the Maine Death with Dignity Act](#), Public Law, c. 271, 12 June 2019; and Death with Dignity, [Maine Death with Dignity Act Goes into Effect](#), 19 September 2019.
49. Patients Rights Council, [Attempts to Legalize Euthanasia/Assisted-Suicide in the United States](#)."
50. Eduard Verhagen and Pieter J.J. Sauer, [The Groningen Protocol – Euthanasia in Severely Ill Newborns](#)," *The New England Journal of Medicine*, Vol. 352, 10 March 2005, pp. 959–962.
51. Ibid.; and Hilde Lindemann and Marian Verkerk, "Ending the Life of a Newborn: The Groningen Protocol," *Hastings Center Report*, Vol. 38, No. 1, 2008, pp. 42–51.
52. The Netherlands' Termination of Life on Request and Assisted Suicide (Review Procedures) Act came into effect on 1 April 2002. For an English translation of the law, see Institut Européen de Bioéthique, [Review procedures for the termination of life on request and assisted suicide and amendment of the Criminal Code and the Burial and Cremation Act \(Termination of Life on Request and Assisted Suicide \(Review Procedures\) Act\)](#).
53. Ibid., section 2.
54. Government of the Netherlands, [Is euthanasia allowed?](#)," *Euthanasia*.
55. The Netherlands, RTE Regional Euthanasia Review Committees, [Euthanasia Code 2018: Review Procedures in Practice](#), p. 60.
56. Scott Kim, [How Dutch Law Got a Little Too Comfortable with Euthanasia](#)," *The Atlantic*, 8 June 2019.
57. The Netherlands, RTE Regional Euthanasia Review Committees, [Annual report 2018](#), p. 5.
58. At least one group has lobbied for older people who feel their life is "completed" to receive euthanasia without any underlying illness being required. Folkert Jensma, NRC International, ["Right to die" for elderly back at centre of Dutch debate](#)," *Radio Netherlands Worldwide*, 9 February 2010; and Johan Legemaate and Ineke Bolt, "The Dutch Euthanasia Act: Recent Legal Developments," *European Journal of Health Law*, Vol. 20, No. 5, 2013, pp. 466–468.
59. Tony Sheldon, ["Being 'tired of life' is not grounds for euthanasia](#)," *The BMJ* [British Medical Journal], Vol. 326, No. 7380, 11 January 2003; and Shariff (2010), p. 7.
60. Bioethics Research Library, [Bioethics news: A Dutch report applies the breaks on euthanasia](#), Georgetown University Kennedy Institute of Ethics.

61. See, for example, the English summary of Bregje D. Onwuteaka-Philipsen et al., [Evaluatie: Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding](#) [Review of the Termination of Life on Request and Assisted Suicide Act], ZonMw, The Hague, May 2007, pp. 13–21. See also the English summary of Agnes van der Heide et al., [Tweede evaluatie: Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding](#) [Second Review of the Termination of Life on Request and Assisted Suicide Act], ZonMw, The Hague, December 2012, pp. 19–25. Other reviews of the Dutch experience available in English include Bernard Lo, “Euthanasia in the Netherlands: what lessons for elsewhere?,” *The Lancet*, Vol. 380, No. 9845, 8 September 2012, pp. 869–870; Bregje D. Onwuteaka-Philipsen et al., “Trends in end-of-life practices before and after the enactment of the euthanasia law in the Netherlands from 1990 to 2010: a repeated cross-sectional survey,” *The Lancet*, Vol. 380, No. 9845, 8 September 2012, pp. 908–915; and Judith A.C. Rietjens et al., [“Two Decades of Research on Euthanasia from the Netherlands. What Have We Learnt and What Questions Remain?”](#), *Bioethical Inquiry*, Vol. 6, 2009, pp. 271–283.
62. See the English summary of Bregje Onwuteaka-Philipsen et al., [Derde evaluatie: Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding](#) [Third Review of the Termination of Life on Request and Assisted Suicide Act], ZonMw, The Hague, May 2017, pp. 19–25. A 2017 article in *BMJ Open* reviewed a smaller number of online cases and found that the review committees are focused on whether physicians were thorough and professional in providing euthanasia and assisted suicide, rather than assessing whether the patient should have received assistance in dying. See David Gibbes Miller and Scott Y.H. Kim, [“Euthanasia and physician-assisted suicide not meeting due care criteria in the Netherlands: a qualitative review of review committee judgements,”](#) *BMJ Open*, Vol. 7, No. 10.
63. The Netherlands, RTE Regional Euthanasia Review Committees, *Annual report 2018*, p. 11.
64. Annette J. Berendsen et al., “Physician-assisted death is less frequently performed among women with a lower education: A survey among general practitioners,” *Palliative Medicine*, Vol. 28, No. 9, 2014, p. 1161.
65. For detailed information regarding cases where physicians were found not to have acted with due care, see each of the annual reports found at The Netherlands, RTE Regional Euthanasia Review Committees, [Annual reports](#). The Second Review (*Tweede evaluatie*) in 2012 found that, of the 14,000 cases from 2007 to 2011, there were 36 cases with a lack of due care. Although it was determined that criminal proceedings were not necessary in these cases, this was a conditional decision in six cases. See van der Heide et al. (2012), p. 21. An academic article states that approximately one in 600 cases does not meet the criteria, and that this is usually for procedural reasons more than actual concerns about the patient’s intentions to die. Theo A. Boer, [“Euthanasia, Ethics and Theology: A Dutch Perspective,”](#) *Ecumenical Review Sibiu / Revista Ecumenica Sibiu*, Vol. 6, Issue 2, August 2014, p. 198 (copy provided by De Gruyter Open).
66. The Netherlands, RTE Regional Euthanasia Review Committees, *Annual report 2018*, pp. 6–8.
67. Raf Casert and Aleksandar Furtula, Associated Press, “Dutch euthanasia case puts law on trial,” *Toronto Star*, 29 August 2019; Stephanie van den Berg, [“Dutch doctor acquitted in case of euthanasia of patient with dementia,”](#) *Reuters*, 11 September 2019; and Stephanie van den Berg, [“Dutch prosecutors seek Supreme Court ruling on euthanasia for incapacitated patients,”](#) *Reuters*, 26 September 2019.
68. It is not clear from the 2018 *Annual Report* what the final result was for the other two cases. The Netherlands, RTE Regional Euthanasia Review Committees, *Annual report 2018*, pp. 6–8.
69. van der Heide et al. (2012), pp. 20–21.
70. Legemaate and Bolt (2013), p. 455.
71. van der Heide et al. (2012), pp. 20–21.
72. The Netherlands, RTE Regional Euthanasia Review Committees, *Euthanasia Code 2018: Review Procedures in Practice*; The Netherlands, Regional Euthanasia Review Committees, [Annual report 2014](#), p. 6; and The Netherlands, RTE Regional Euthanasia Review Committees, [Annual report 2017](#), p. 22.
73. The Netherlands, RTE Regional Euthanasia Review Committees, *Annual report 2018*, pp. 13–14 and 17.
74. Belgian Advisory Committee on Bioethics, [Opinion no. 59 of 27 January 2014 on ethical aspects of the application of the Law of 28 May 2002 on euthanasia](#), p. 6; and Belgium, Belgian Federal Parliament, [28 Mai 2002. – Loi relative à l’euthanasie](#) [Law relating to euthanasia], F. 2002-2141 [C-2002/09590] (Moniteur Belge), 22 June 2002.
75. [Carter v. Canada \(Attorney General\)](#), 2012 BCSC 886 (CanLII), para. 508; and Sigrid Sterckx, [Une faille dans la loi euthanasie : l’aide au suicide comme échappatoire au contrôle de l’euthanasie](#), Institut Européen de Bioéthique, 30 April 2019.

76. As in the Netherlands, there is no requirement of residency in the Belgian law but the conditions create a practical limitation because the doctor must know the patient well. Union nationale des mutualités socialistes, [Question de droit : La loi dépénalisant l'euthanasie](#), Brussels, January 2004, p. 14.
77. Belgium, Chambre des représentants de Belgique, [Projet de Loi modifiant la loi du 28 mai 2002 relative à l'euthanasie en vue de l'étendre aux mineurs](#), section 2(d), 7 February 2014.
78. Belgium, Constitutional Court, [Arrêt n° 153/2015 du 29 octobre 2015](#); and Belgium, Constitutional Court, [Note informative relative à l'arrêt n° 153/2015](#).
79. Belgium, Commission fédérale de contrôle et d'évaluation de l'euthanasie, [Sixième rapport aux Chambres législatives \(Années 2012-2013\)](#).
80. Graeme Hamilton, "[Belgian doctor facing possible murder charge for euthanizing senior seen as warning for Canada](#)," *National Post*, 29 October 2015; and The World Federation of Right to Die Societies, [Belgian physician dismissed of legal proceedings](#), 6 May 2019.
81. Belgium, Commission fédérale de contrôle et d'évaluation de l'euthanasie, [Huitième rapport aux Chambres législatives années 2016-2017](#), p. 30.
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86. Note that the reports in various jurisdictions use different age groupings (e.g., "60 years and over" or "65 years and over") and so cannot be compared directly.
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92. "[Un canton suisse légalise le suicide assisté](#)," Radio-Canada, 17 June 2012; and "[Le Parlement valaisan réglemente le suicide assisté en EMS](#)," *Radio Télévision Suisse*, 9 May 2019.
93. Imogen Foulkes, "[Switzerland plans new controls on assisted suicide](#)," *BBC News Europe*, 2 July 2010; and Shariff (2010), pp. 6–7.
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97. "[Zurich voters reject ban on 'suicide tourism'](#)," *Reuters*, 16 May 2011.
98. "[Judgment Haas v. Switzerland \(31322/07\), refusal to deliver lethal drug without prescription: no violation of article 8](#)," *European Court of Human Rights News*, 3 July 2011.
99. European Court of Human Rights [ECHR], [Gross v. Switzerland - 67810/10](#), Article 8, Information Note on the Court's case-law No. 163, May 2013.
100. Ms. Gross communicated with her lawyer through an intermediary, a retired pastor, and had asked him not to notify the lawyer of her death. The pastor felt that, as a spiritual adviser, he had a duty not to disclose the information.
101. ECHR, *Gross v. Switzerland* (2013); and ECHR, [Case of Gross v. Switzerland](#), Grand Chamber, Application no. 67810/10, 30 September 2014. Note that this was not an appeal to the Grand Chamber. Judgments of the ECHR are only final once either the Grand Chamber provides judgment or, for one of a number of reasons, does not hear the case.
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111. It should be noted that some sources say a child must be at least six years old, while others say they must be seven. See María Alejandra Triviño, "[Colombia has regulated euthanasia for children and adolescents](#)," *Latin American Post*, 13 March 2018. Also see links to primary sources in Australian Care Alliance, [Colombia: Court ordered euthanasia](#); and Stephanie Nolen (2019).
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115. *Ibid.*, s. 39, p. 36.
116. "[Top German court to decide legality of assisted suicide](#)," *DW* (Germany), 15 April 2019; and Adelheid Müller-Lissner, "[Euthanasia: 'Germany has found a moderate solution'](#)," *Goethe Institut*, February 2017.
117. The World Federation of Right to Die Societies, [Italian Constitutional Court now officially rules that aid in suicide is, under certain conditions, not punishable](#), 22 November 2019.

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120. United Kingdom, House of Lords, [R \(on the application of Purdy\) \(Appellant\) v Director of Public Prosecutions \(Respondent\)](#), [2009] UKHL 45, House of Lords, 30 July 2009.
121. United Kingdom, CPS (Crown Prosecution Service), [Suicide: Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide](#), October 2014.
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127. United Kingdom, House of Commons, [Assisted Dying \(No. 2 Bill\) 2015-16](#); and United Kingdom, House of Lords, [Assisted Dying Bill \[HL\] 2015-16](#).
128. United Kingdom, House of Commons, [Assisted Dying \(No. 2\) Bill 2015-16](#), section 4(5)(c); and United Kingdom, House of Lords, [Assisted Dying Bill \[HL\] 2015-16](#), section 4(4)(c).
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131. Email responses to the author from the Crown Office in Scotland, 6 and 8 September 2013.
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133. United Kingdom, Scottish Parliament, [Assisted Suicide \(Scotland\) Bill](#).
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APPENDIX A –THE LAW ON MEDICAL ASSISTANCE IN DYING: COMPARISON OF SELECTED JURISDICTIONS OUTSIDE CANADA

**Table A.1 – Current Legal Status of Euthanasia and Assisted Suicide
in Selected Jurisdictions Outside Canada**

Criteria	United States	The Netherlands	Belgium	Luxembourg	Australia
Euthanasia (E)/ assisted suicide (AS) allowed?	AS allowed (Oregon, Washington State, Vermont, California, Colorado, District of Columbia, Hawaii, Maine, New Jersey and Montana only)	E and AS allowed	E and AS allowed	E and AS allowed	E and AS allowed in state of Victoria
Terminal illness required?	Yes	No	No	No	Yes
Residency required?	Yes	Yes, although not explicitly in the law	Yes, although not explicitly in the law	Yes, although not explicitly in the law	Yes
Advance directives permitted?	No	Yes	Yes (only for unconscious persons)	Yes (only for unconscious persons)	No
Permitted for minors?	No	Yes (12 years and older or newborn)	Yes	No	No
Permitted for persons with dementia/psychiatric illness not capable of making decisions?	No	Yes, if there is a signed advance directive	Yes, but the person must be competent at time of request	Yes, but the person must be competent at time of request	No
Psychological suffering sufficient?	No	Yes	Yes	Yes	No

Note: This table includes a number of elements to highlight the differences between jurisdictions but does not include all criteria that must be met to satisfy the conditions in each jurisdiction. The table does not include Colombia because of a lack of sufficient information in English or French and does not include the U.K. because that country has no legislation regulating euthanasia or assisted suicide. Switzerland, Italy and Germany are not included in the table because they do not have a detailed regulatory regime.

Sources: Table prepared by the author based on information obtained from United States, Oregon, Oregon Health Authority, [Oregon Revised Statute: Oregon's Death with Dignity Act](#); United States, Washington, Washington State Department of Health, [Death with Dignity Act](#); United States, Vermont, Vermont General Assembly, [S.77 \(Act 39\): An act relating to patient choice and control at end of life](#), 20 May 2013; United States, California, California Legislative Information, [Assembly Bill No. 15. An act to add and repeal Part 1.85 \(commencing with Section 443\) of Division 1 of the Health and Safety Code, relating to end of life](#), (AB-15 End of Life Option Act), c. 1, 5 October 2015; Institut Européen de Bioéthique, [Review procedures for the termination of life on request and assisted suicide and amendment of the Criminal Code and the Burial and Cremation Act \(Termination of Life on Request and Assisted Suicide \[Review Procedures\] Act\)](#); Belgium: Belgian Federal Parliament, [28 Mai 2002. – Loi relative à l'euthanasie](#), F. 2002-2141 [C-2002/09590] (Moniteur Belge), 22 June 2002; Luxembourg, Gouvernement du Grand-Duché de Luxembourg, [Loi du 16 mars 2009 sur l'euthanasie et l'assistance au suicide](#) (Journal officiel du Grand-Duché de Luxembourg); and Australia, Parliament of Victoria, [Voluntary Assisted Dying Act 2017](#), No. 61 of 2017.