LIBRARY OF PARLIAMENT
BIBLIOTHÈQUE DU PARLEMENT

HillStudies

In-depth reads on Canadian topics

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

Publication No. 2015-116-E

Revised 23 September 2021

Julia Nicol

Parliamentary Information, Education and Research Services

AUTHORSHIP

23 September 2021	Julia Nicol	Legal and Social Affairs Division
29 November 2019	Julia Nicol	Legal and Social Affairs Division
23 October 2015	Julia Nicol Marlisa Tiedemann	Legal and Social Affairs Division Legal and Social Affairs Division

ABOUT THIS PUBLICATION

Library of Parliament HillStudies provide in-depth studies of policy issues. They feature historical background, current information and references, and often anticipate the emergence of the issues they examine. They are prepared by Parliamentary Information, Education and Research Services, which carries out research for and provides information and analysis to parliamentarians and Senate and House of Commons committees and parliamentary associations in an objective, impartial manner.

This publication was prepared as part of the Library of Parliament's research publications program, which includes a set of publications, introduced in March 2020, addressing the COVID-19 pandemic.

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

Publication No. 2015-116-E

Ce document est également publié en français.

CONTENTS

EXECUTIVE SUMMARY

Over the last few 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. Since 2015, seven more United States (U.S.) jurisdictions have legalized the practice, as have five Australian states, Canada and other countries. 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 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, U.S. jurisdictions, the five Australian states that allow assisted dying and New Zealand have more restrictive rules in place for assistance in dying than the European jurisdictions that permit the practice. The 10 U.S. jurisdictions where legislation exists generally require a prognosis of six months or less to live and permit only assisted suicide. Only adults are eligible. The Australian states and New Zealand have similar criteria, although with some notable differences, for example, allowing both euthanasia and assisted suicide.

In contrast, in the Benelux countries, and now in Colombia and Spain, 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 these countries and is far more common than assisted suicide.

The three Benelux countries, and now Colombia and Spain, 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, the Netherlands, Belgium and Colombia allow some minors to receive assistance in dying. As in the U.S. jurisdictions that have legalized assisted suicide, Luxembourg, five Australian states New Zealand and Spain only allow 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.

Court decisions have legalized euthanasia in Colombia, Italy, Germany and Peru, but no legislation has been adopted to regulate the practice in those countries.

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(s). Jurisdictions have made different choices regarding which of the two practices has been legalized. All jurisdictions have protection of conscience rights for health care practitioners who do not want to provide assisted dying, although the protections in place vary.

This HillStudy reviews developments surrounding the issue of medical assistance in dying in a range of countries where legislatures or courts have legalized the practice.[1] An appendix provides an overview, in table format, of the current legal status of medical assistance in dying in those jurisdictions with detailed eligibility criteria and safeguards 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, New Jersey and New Mexico are the only ten 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 of this HillStudy outline some of the main constitutional challenges to legislation prohibiting assistance in dying before examining 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 Courts 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. 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[5] have also upheld laws criminalizing assisted suicide, concluding that they do not violate the states' respective constitutions.[6] 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, ten U.S. jurisdictions (nine 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.[7]

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.[8]

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.[9] 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, adult, terminally ill patient so that the patient may commit suicide have a defence against homicide charges in Montana.[10] 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.[11]

2.2 OREGON

In November 1994, Oregon voters approved a ballot initiative, Measure 16,[12] 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 ending their life. Because of a legal challenge, the *Death with Dignity Act* did not come into force until November 1997.[13]

Before a physician can issue such a prescription, certain conditions have to be met, including the following:

- 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, which went into effect in January 2020, that allows certain individuals near death to forego the waiting period of 15 days between requests and the 48-hour waiting period for the prescription.[14]
- 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.[15]

  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.[16]
- 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.[17]

A number of bills have sought to amend the legislation in Oregon, including one that aimed to expand eligibility beyond the period of six months' prognosis. The only bill that passed, however, is the above-noted amendment regarding the 15-day 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*, 1998–2020

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
2004	60	37	1.23
2005	65	38	1.20[b]
2006	65	46	1.47

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
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
2019	290	188	5.19
2020	370	245	6.55

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 United States, Oregon Department of Human Services, Office of Disease Prevention and Epidemiology, *Eighth Annual Report on Oregon's Death with Dignity Act*, 9 March 2006.

Source: Table prepared by the Library of Parliament using data obtained from United States, Oregon Health Authority, Public Health Division, *Death with Dignity Act Annual Reports*.

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 4 million people live in Oregon. In 2020, around 6.55 per 1,000 deaths in Oregon were by physician-assisted suicide.

The annual reports provide aggregate statistics about patients who choose assisted suicide. For 2020,

- 51% were men;
- 81% were aged 65 or older;
- 97% were white;
- 42% had a baccalaureate degree or higher;
- 95% were enrolled in hospice care and 92% died at home;
- 26% had private health insurance and 74% had some form of government health insurance; and

- 66% had cancer, 11% had heart or circulatory disease and 8% had neurological diseases.

The three most common reasons for choosing assisted suicide were concerns about losing autonomy (93%), being less able to engage in activities that make life enjoyable (94%) and experiencing a loss of dignity (72%).[19] Being a burden on family, friends and caregivers was a concern for 53% 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: 6% of those dying from assisted suicide in Oregon expressed such concerns in 2020.[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, and another was referred in 2019.[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. Bill HB 1141, introduced in January 2021, would make a number of changes, but it was not adopted in the most recent legislative session. It may be considered in the next session.[24]

2.3.1 Annual Reports

Table 2 highlights some statistics that reports have provided since Washington's legislation came into force (no reports have been published since 2018). In 2018, the State of Washington had a population of more than 7.4 million, with almost 56,000 total deaths.[25]

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]	65	64
2010	87	87
2011	103	102
2012	121	121
2013	173	169
2014	176	172
2015	215	211
2016	249	242
2017	212	203
2018	267	251

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 Library of Parliament using data obtained from United States, Washington State Department of Health, Disease Control & Health Statistics, Center for Health Statistics, *2018 Death With Dignity Act Report*, July 2019, p. 8.

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
- 75% had cancer, 10% had neurodegenerative diseases, including Amyotrophic Lateral Sclerosis (ALS), and 6% had heart disease.[26]

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.[27]

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.[28] A May 2015 amendment repealed a sunset clause and now requires the collection of information about compliance with the law and the publication of reports by the Vermont Department of Health every two years, starting in 2018.[29] A bill to amend the law to allow for telemedicine consultation and to provide immunity for good faith compliance with the provisions of the assisted dying law was introduced in the Senate in February 2021 but had not been adopted at the time of writing.[30]

Vermont's law on physician-assisted suicide 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.[31]

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.[32] A constitutional challenge to the law was unsuccessful.[33]

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.[34]

This last element with respect to communications with insurance companies may have been included to address some commentators' fears that assisted suicide would be seen by insurers as an economically attractive alternative, in contrast to costly life-sustaining care for the terminally ill. Media have reported that in the past, 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.[35] 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.[36]

California has published five annual reports to date, covering the years 2016 to 2020.[37] Despite having 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.[38]

A bill that removes the sunset clause from the law, making it permanent, and decreases the 15-day waiting period between oral requests to 48 hours, among other changes, passed in September 2021.[39]

2.6 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.[40] As with the other American aid-in-dying laws, Colorado's law is similar to Oregon's law prior to its 2019 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, four reports have been published with statistics. Unlike states such as Oregon, Colorado cannot say, based on the information it collects, 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.[41]

2.7 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.[42] There have been efforts in the U.S. House of Representatives to repeal the law, but none has been successful to date.[43]

2.8 HAWAII

Hawaii's *Our Care, Our Choice Act*, again based on the Oregon law prior to its 2019 amendment, was signed into law on 5 April 2018 and came into force on 1 January 2019.[44] 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.[45] Other bills have also been proposed since then to address access issues and reduce waiting times, among other topics, but none have passed.[46] Two reports have been published to date.[47]

2.9 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 that they refer the patient to a qualified health care professional for that purpose.[48] The law was challenged unsuccessfully.[49] On 6 June 2019, two bills were introduced in the General Assembly, one to make it a crime to coerce a patient to request medical aid in dying or to forge a patient's request and the other to repeal the new act, but neither became law.[50]

2.10 MAINE

The *Maine Death with Dignity Act* was signed into law on 12 June 2019 and came into force on 19 September 2019.[51] 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. Two reports have been published since the law came into force.[52]

2.11 NEW MEXICO

The *Elizabeth Whitefield End-of-life Options Act* was signed into law on 8 April 2021 and came into effect on 18 June 2021. It is similar to Oregon's law but with some important differences. A written request must be made at least 48 hours before the prescription is filled unless the patient may die before then. There does not appear to be any requirement for previous oral requests or a 15-day waiting period. Also, osteopathic doctors, physician assistants and nurses licensed in advanced practice may write the prescription, as long as one of the two health care practitioners assessing the individual is a physician or osteopathic physician.[53]

2.12 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 or assisted suicide by ballot initiative (including an earlier one in Washington State) have been defeated since 1991. According to the council, 284 bills were proposed on the issue between January 1994 and February 2020 in more than 43 states and the District of Columbia.[54]

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. 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.

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 and came into force on 1 April 2002.[55]

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.[56]

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.[57] 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.

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.[58]

3.2.1 Minors

Certain minors are eligible for euthanasia and assisted suicide. The legislation follows the *Netherlands' Medical Treatment Contracts Act*, and parental consent is required for persons aged 12 to 15 to have a physician's assistance to end their life. In principle, 16- and 17-year-olds can decide for themselves, but their parents must be consulted.[59] Fourteen minors received euthanasia between 2002 and 2019.[60] News media reported in October 2020 that the government was considering amending the law to permit children aged one to 11 to make a request, but that change has not yet occurred.[61]

3.2.2 Infants

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.[62] 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.[63]

3.2.3 Advance Directives

Advance directives are permitted for anyone aged 12 or older, although the rules for parental consent or consultation mentioned above apply to minors.[64] Advance directives in the Netherlands do not expire, but they must be updated and discussed regularly by patient and physician.[65] According to studies, it appears that compliance with advance directives for euthanasia in cases of dementia is low in the Netherlands.[66] The euthanasia review committee annual reports only began providing information regarding the use of advance directives in 2017, and from 2017 to 2019 there were two to three cases per year of euthanasia performed on individuals with advanced dementia based on an advance directive.[67]

In 2018, for the first time since the law came into force in 2002, a physician was prosecuted after reporting a case of euthanasia based on an advance directive to the review committee. 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 advance 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; however, the physician was accused of not doing enough to find out if the patient still wanted to die. The patient's advance directive specified that she wanted euthanasia rather than being placed in an institution, among other guidance as to the timing of her death. After losing mental competence, she made inconsistent statements about wanting to die or not and when. She was in an institution for seven weeks prior to her death. When she arrived there, her husband asked the doctor to provide euthanasia for his wife based on the advance directive. The physician decided to wait a month to see how the patient adapted to the nursing home and to observe her. After consulting various people, including the patient's general practitioner, two other assessors (a psychiatrist, and an internist), as well as her family, the physician concluded that the patient was eligible. The two other assessors also found that the due care criteria had been met.

The physician put a sedative in the patient's drink without telling her. During the procedure, the patient tried to get up, so family members held her down. The physician reported the death, as is required, and was found by the review committee to have failed to meet the due care criteria.

The Supreme Court of the Netherlands concluded that an advance directive could replace a voluntary and well-considered request at the time of the euthanasia. However, there is still a requirement that the person be experiencing unbearable suffering to be eligible for euthanasia or assisted suicide; therefore, the person cannot appear to be content in their current situation. The physician in this case was acquitted of the charges and found to have acted in accordance with the advance directive.[68]

3.2.4 Mental Illness as the Sole Underlying Condition

As noted above, the Netherlands does not require a terminal illness or physical suffering for a person to be eligible for euthanasia or assisted suicide. The number of cases of euthanasia or assisted suicide because of a mental illness has increased over time but remains low in comparison with other conditions, at 68 cases out of 6,361 cases of euthanasia or assisted suicide in 2019 (around 1% of the total).[69] This was a decrease from the peak number of cases of euthanasia or assisted suicide because of a mental illness in 2017 when there were 83 such cases out of 6,585 cases of euthanasia/assisted suicide, which represents nonetheless a similar proportion to 2019.[70] Guidelines were published in 2018 by the Netherlands Psychiatric Association to assist physicians in cases where a patient has a psychiatric disorder.[71]

3.2.5 "Completed Life"

There has been some discussion in the Netherlands of allowing euthanasia or assisted suicide for people who are simply "weary of life."[72] 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, although 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."[73]

In 2014, during a parliamentary debate, the health minister was asked to set up a commission to study the scope for euthanasia or assisted suicide where a person feels their life is complete. The government agreed, and the Schnabel Commission (named after the chair of the commission) studied whether to expand eligibility for euthanasia/assisted suicide 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 in its 2016 report, although it concluded that the euthanasia legislation already permits cases of "completed life" since that is equivalent to "the symptoms of old age," which could satisfy the eligibility requirements.[74] The government nonetheless stated an intent to develop legislation to assist people who conclude that their life is complete, but who do not have medical justification, to die.[75] However, no such legislation appears to have been passed.

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 most years in the Netherlands (by as much as 19% year over year between 2009 and 2010, with lower increases in more recent years and a reduction in 2018). Although regional euthanasia 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.[76] 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.[77]

2018 was the first year that saw a reduction in the number of euthanasia and assisted suicide deaths since 2006, possibly due to an influenza epidemic that year or the announcement of the prosecution mentioned above.[78] 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.[79] Failure to meet the statutory standard of due care is found in very few cases: between 2013 and 2019, four to 12 cases each year have failed to meet that standard out of thousands of cases.[80]

In 2018, for the first time in more than 10 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 the law came into force in 2002 (see the case mentioned in section 3.2.3 of this HillStudy).[81] 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, although in at least two of those cases, the board decided not to prosecute.[82]

The 2012 review of the system 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.[83] The majority of cases of assisted suicide or euthanasia over the period addressed by the review (2007 to 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.[84] 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.[85]

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.[86]

In 2019, 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.[87]

Tables 3 and 4 highlight some further statistics from regional euthanasia review committee annual reports in recent years. The Netherlands had a population of more than 17 million people and over 150,000 deaths in 2019.

Table 3 – Annual Statistics Regarding the Netherlands' Law Relating to Euthanasia and Assisted Suicide, 2003–2019

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
2019	6,092	245	24	6,361

Source: Table prepared by the Library of Parliament using 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 2019

Disorder or Illness	Number of Patients	Percentage of Reported Deaths
Cancer	4,100	64.5
Combination of disorders	846	13.3
Neurological disorders	408	6.4
Cardiovascular disease	251	3.9
Pulmonary disorders	187	2.9
Multiple geriatric syndromes	172	2.7
Other conditions	167	2.6
Dementia[a]	162	2.5
Psychiatric disorders	68	1.1
Total	6,361	100.0

Note: a. 160 patients were in the early stages of dementia when they died and two were at advanced stages.

Source: Table prepared by the Library of Parliament using data obtained from The Netherlands, RTE Regional Euthanasia Review Committees, *Annual report 2019*.

4 BELGIUM

Belgium conditionally decriminalized euthanasia in 2002.[88] 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 who intentionally ends the life of another person at that person's request. The Belgian oversight body for euthanasia argues that euthanasia, as defined in the law, encompasses assisted suicide.[89]

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. While the law does not require a patient to be a resident or citizen of Belgium, the requirements make it rare for non-residents to be eligible.[90] As noted in section 4.1 of this HillStudy, in 2014, the law was expanded to include more minors, albeit with more restrictive criteria.

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.[91] 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.

4.1 MINORS

In 2014, the legislation on euthanasia 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.[92]

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.[93]

Since the change to permit minors to request euthanasia, the number of minors who received euthanasia in Belgium per year ranged from zero to two.[94]

4.2 ADVANCE DIRECTIVES

Individuals who are 18 years old or more 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 irreversibly 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. The directive was only valid for five years until amendments to the law in 2020 removed that time limit, making them valid indefinitely.[95]

From 2016 to 2020, 1% of individuals who received euthanasia in Belgium did so based on an advance directive (from 22 to 33 people per year).[96]

4.3 MENTAL ILLNESS AS THE SOLE UNDERLYING CONDITION

As in the Netherlands, there is no requirement to have a terminal illness or for there to be physical suffering for adults or emancipated minors, meaning that a person can have euthanasia performed in Belgium due to a mental illness. The number of cases of euthanasia due to mental illness increased over time until it peaked in 2015 with 63 such cases. In 2020, there were 21 cases due to mental illness out of 2,444 total cases of euthanasia (less than 1%).[97] As outlined in more detail in section 4.4 of this HillStudy, the cases that have caused the most controversy in Belgium have largely been cases based on mental illness.

4.4 BIANNUAL REPORTS AND REVIEW OF CASES

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.[98] 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 (the commission does not agree with this interpretation).[99]

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).[100]

Another criminal case was the result of a family's complaint in 2011 rather than a referral by the commission. Tine Nys died by euthanasia in 2010 at age 38. She reportedly had been suicidal, had addiction issues for many years and had recently been diagnosed with autism. The three doctors involved were acquitted by a jury in 2020, but a civil suit by Ms. Nys's family began in May 2021.[101]

Tom Mortier, a Belgian man whose mother received euthanasia in 2012 because of long-standing depression, has brought a case before the European Court of Human Rights. The doctor who provided euthanasia in that case is reportedly one of the three doctors in Ms. Nys's death.[102]

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 explicitly regulating assisted suicide. The 2020 amendments that changed the validity period for advance directives also included requirements to refer, but the other bills have not been adopted.[103]

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.[104] Belgium's Commission publishes biannual reports that aggregate statistics about those who choose euthanasia. For 2020, statistics for individuals who died by euthanasia showed that

- 50% were men;
- 87.7% were aged 60 or older;[105] and
- 54.2% died at home.[106]

This is the first time the number of reported euthanasia deaths decreased (from 2,656 in 2019 to 2,444 in 2020). Tables 5 and 6 highlight some statistics from Belgium's biannual reports in recent years.

Table 5 – Annual Statistics Concerning Belgium's Law Relating to Euthanasia, 2002–2020

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

Year	Reported Deaths by Euthanasia	Deaths by Euthanasia per 1,000 Deaths
2014	1,928	18.0
2015	2,022	18.0
2016	2,028	Not reported
2017	2,309	Not reported
2018	2,359	Not reported
2019	2,656	Not reported
2020	2,444	Not reported

Source: Table prepared by the Library of Parliament using data obtained from biannual reports from Belgium, Service public fédéral, Santé publique, Sécurité de la chaîne alimentaire et Environnement, *Commission fédérale de contrôle et d'évaluation de l'euthanasie*. Click on "Consultez tous les documents." See also Belgium, Commission fédérale de contrôle et d'évaluation de l'euthanasie, *EUTHANASIE – Chiffres de l'année 2020*, News release, 2 March 2021.

Table 6 – Disorder or Illness of Patients in Belgium Who Died by Euthanasia or Assisted Suicide in 2020

Disorder or Illness	Number of Patients	Percentage of Reported Deaths
Tumours (cancers)	1,569	64.2
Multiple diseases	421	17.2
Diseases of the nervous system	187	7.7
Cardiovascular disease	84	3.4
Diseases of the respiratory system	65	2.7
Cognitive impairment (dementia syndromes)	22	0.9
Mental and behavioural disorders	21	0.9
Diseases of the joints, muscles and connective tissues	17	0.7
Digestive diseases	15	0.6
Traumatic injuries, poisonings and other complications due to external causes	11	0.5
Genitourinary diseases	8	0.3
Certain infectious and parasitic diseases	6	0.2
Abnormal symptoms, signs and results of clinical examinations and laboratory tests not classified elsewhere	5	0.2
Diseases of the eye and associated tissues	4	0.2
Endocrine, nutritional and metabolic diseases	3	0.1
Diseases of the blood and hematopoietic organs and certain disorders of the immune system	2	0.1
Diseases of the skin and subcutaneous tissue	2	0.1
Diseases of the ear and mastoid process	1	0.0
Congenital malformations and chromosomal anomalies	1	0.0

Source: Table prepared by the Library of Parliament using data obtained from Belgium, Commission fédérale de contrôle et d'évaluation de l'euthanasie, *EUTHANASIE – Chiffres de l'année 2020*, News release, 2 March 2021.

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.[107] 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*.[108] 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. 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 2021, the law was amended to clarify that a death by euthanasia or assisted suicide is a natural death for insurance purposes.[109]

5.1 BIANNUAL REPORTS

Luxembourg's Commission nationale de contrôle et d'évaluation de l'application 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 or assisted suicide. 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).[110]

Table 7 provides information on the number of reported deaths by euthanasia or assisted suicide per year. The country has a population of over 600,000 and registered 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 Advance 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 Library of Parliament using data obtained from 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 to be 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 and there is no age limit, although it appears that organizations offering assisted suicide generally require the person to be an adult to receive assisted suicide.[111]

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.[112] Nonetheless, at least one canton (region) has approved, by referendum, legislation to require hospitals and other public interest "socio-medical establishments" to permit assisted suicide and outlined under which conditions, and another has passed legislation on the matter.[113]

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.[114] 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.[115]

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.[116] 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.[117] Referenda in Zurich to ban assisted suicide or at least to impose a residency requirement also failed.[118]

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 also had 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.[119]

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.[120] 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.[121] 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.[122]

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 lost his appeal.[123]

7 COLOMBIA

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.[124] 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.[125] Given the uncertainty created by a lack of legislation responding to the Constitutional Court decision, few physicians appear to have practised euthanasia openly.[126]

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.[127] The first person to have a legally assisted death after the regulations were put in place, a man with cancer, died in July 2015.[128] However, news reports state that there are a number of bureaucratic and societal barriers that mean few Colombians have access to euthanasia (reportedly 124 individuals in total had received euthanasia as of 12 July

2021 had received euthanasia for a population of over 51 million), and others are accessing it outside the public health system (which does not appear to be legal).[129]

The 2014 Constitutional Court decision also urged Congress to legislate on this issue. Multiple bills to regulate euthanasia and assisted suicide have been tabled but not passed.[130] The most recent effort to legislate was in the spring of 2021 but was unsuccessful as well.[131] 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 or psychologist 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 (the rules vary somewhat depending on age).[132] On 1 July 2021, the government issued Resolution 971 to provide further guidelines on euthanasia procedures. The guidelines permit advance directives.[133] On 22 July 2021, the Constitutional Court decided a case challenging the requirement that an individual be terminally ill. The Court's decision allows non-terminal individuals experiencing intense suffering from bodily injury or serious and incurable disease to receive euthanasia.[134] The judgment does not appear to exclude mental illness as a sole underlying condition.[135]

8 AUSTRALIA

The Northern Territory of Australia was the first jurisdiction in the world 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, although the law only came into force on 19 June 2019.[136] Since then, the states of Western Australia, Tasmania, South Australia and Queensland have legalized assisted dying for adults with the mental capacity to make the decision and who have a terminal illness. No advance directives are permitted in any of those jurisdictions.

8.1 VICTORIA

The Victorian legal framework is closer to that of the U.S. jurisdictions where assisted suicide is legal, with a requirement to have six months or less to live, although there are some differences. Both euthanasia (known as practitioner administration) and assisted suicide (known as self-administration) are allowed, although euthanasia is only allowed in narrow circumstances where self-administration is not possible. Individuals who have twelve months to live or less and who 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.[137]

In addition, the individual 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.[138]

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 only if the individual is incapable of self-administering or digesting the substance). The individual also needs to designate a contact person who is responsible for returning any unused drugs.[139]

8.1.1 Biannual Reports and Review of Cases

Statistics are available for the period from 19 June 2019 to December 2020. In 2019, 37 people self-administered and nine received euthanasia.[140] In 2020, there were 184 and 40, respectively.[141] The state had a population of almost 6.7 million people and over 41,000 deaths in 2020 (3 deaths by euthanasia or assisted suicide per 1,000 deaths).

Seventy-seven percent of those who received assistance in dying had cancer and 52.4% were male (0.2% self-described their gender and the rest were women). The average age was 71. While four reports have been published, only the most recent report has demographic information, and it does not share as much information about age, place of death and type of disease or condition as in other jurisdictions. However, information not published elsewhere, such as language spoken at home, country of birth and whether the patient lived in a metropolitan area or a regional/rural area, is included.[142]

One case was referred to the Australian Health Practitioner Regulation Agency for a failure to comply with the procedural requirements.[143] There were six other cases where non-compliance with the *Voluntary Assisted Dying Act 2017* was identified by the Voluntary Assisted Dying Review Board; however, the board found that the issues in those six cases were not related to eligibility and were due to misunderstandings, so the cases were not referred for further consideration to the regulator or police.[144]

8.2 WESTERN AUSTRALIA

Western Australia adopted a law in 2019 that came into effect 1 July 2021 and is similar to Victoria's law in many respects. There are some differences, however, including the following:

- A nurse practitioner may administer the substance (although physicians must do the assessments).
- The nurse practitioner may administer the substance in a broader set of circumstances (as opposed to the patient administering).
- No permit is required from the government.
- A physician or nurse practitioner can raise the option of assisted dying with a patient if certain other information about treatments and palliative care is also provided, although other health care workers are not permitted to do so.[145]

An annual report must be prepared within six months of the end of each year.

8.3 TASMANIA

Tasmania passed a law in March 2021 that permits assisted dying as of 22 October 2022.[146] As in the other Australian states that have assisted dying laws, only adults with capacity are eligible, and there is a residency requirement. As in Victoria, there is a requirement for state approval, although from the Assisted Dying Commission in Tasmania instead of the health department. The Tasmanian law allows the broader circumstances for physician administration that are permitted in Western Australia and permits physicians to raise the option of assisted dying as well. There are also some new elements that differ from the existing legislation in Victoria and Western Australia, including the following:

- The commission can exempt an individual from the requirement to have six to 12 months or less to live.
- There must be 48 hours between requests unless the patient is likely to die within seven days or lose capacity within 48 hours.
- The physician assessing or administering must have at least five years' experience as a physician, among other requirements; and
- Registered nurses (not only nurse practitioners) may administer the substance (although physicians must do the assessments).[147]

An annual report must be prepared within four months of the end of each fiscal year.

8.4 SOUTH AUSTRALIA

South Australia passed its assisted dying law on 24 June 2021. There will be an 18- to 24-month implementation phase.[148] The law is based on Victoria's legislation, with some differences in areas such as conscience rights of institutions.[149]

8.5 QUEENSLAND

Queensland's Parliament passed legislation to permit assisted dying on 16 September 2021, which will come into effect in January 2023. The legislation takes different aspects of the various other laws in Australian jurisdictions, including a requirement for death to be expected within 12 months and that there be nine days between the first and final requests.[150]

9 GERMANY

In 2015, Germany explicitly outlawed assisting suicide. That law was challenged before the Federal Constitutional Court, which found in February 2020 that the law was unconstitutional.[151] Bills were proposed to regulate the practice in response to the judgment, but it does not appear that they have passed.[152]

10 ITALY

In November 2019, Italy's Constitutional Court concluded that assisted dying should be permitted by law in very limited circumstances. The Court then outlined the broad circumstances where assisted dying would be permitted. The patient must be suffering from an incurable illness and experiencing intolerable physical or psychological suffering while being kept alive on life support. The patient must also remain capable of making free and informed decisions. Parliament had one year to legislate additional detailed regulations but did not do so. The Court then outlined rules based on procedures in the country's advance directives law.[153]

11 NEW ZEALAND

Legislators in New Zealand passed a law legalizing euthanasia and assisted suicide in 2019, which required approval by referendum.[154] The law was approved with 65% of the vote in 2020.[155] Assisted dying will be legalized on 7 November 2021.[156]

Both euthanasia and assisted suicide are permitted. Among other requirements, the person must be 18 or older, a citizen or permanent resident of New Zealand and have a terminal illness with six months or less to live. Assistance in dying is not available due solely to a mental disorder or condition, or by advance directive.

A health practitioner is not permitted to discuss assisted dying unless the patient is the one to raise it. Two physicians must assess the person, and if either is unsure of the individual's competence to make the decision, a psychiatrist must also assess eligibility. A physician or nurse practitioner may administer the substance or supervise an assisted suicide. Annual reports are required.[157]

12 PERU

In February 2021, a judge allowed a woman to receive euthanasia. The Peruvian legal system requires the decision to be considered by the country's Supreme Court, which has not yet issued a judgment to uphold or reverse the trial decision. A bill was introduced in Parliament but did not pass before the dissolution of the most recent Parliament in the summer of 2021.[158]

13 SPAIN

In March 2021, Spain's parliament adopted a law to permit euthanasia and assisted suicide for adults who meet residency requirements and have a serious and incurable disease or a serious, chronic and incapacitating condition, among other criteria. This definition appears to include mental illness, although that is not explicit in the law. Advance directives are permitted. The law came into force in June 2021.[159]

Two written requests made 15 days apart are required unless there is a risk of imminent loss of capacity. After the 15 days, the physician must wait 24 hours and confirm whether the patient wants to proceed. Then a second physician does an assessment and, if the person is eligible, the file is sent to the Guarantee and Evaluation Commission where a medical professional and a lawyer review it. There are timelines in which each step is to be completed, with the entire process likely taking more than a month. Annual reports will be published.[160]

NOTES

* Several sections of this HillStudy reference primary or secondary sources in a language other than English or French. For this reason, in cases where translations are unavailable, it has not always been possible to confirm the statements contained in these foreign-language sources.

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 are discussed. 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 HillStudy.

2. Julia Nicol and Marlisa 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, Library of Parliament, 27 September 2018; Marlisa Tiedemann, *Assisted Dying in Canada After* Carter v. Canada, Publication no. 2019-43-E, Library of Parliament, 29 November 2019; and Julia Nicol and Marlisa Tiedemann, *Legislative Summary of Bill C-7: An Act to amend the Criminal Code (medical assistance in dying)*, Publication no. 43-2-C-7-E, Library of Parliament, 19 April 2021. For historical information, see Julia Nicol and Marlisa Tiedemann, *Euthanasia and Assisted Suicide in Canada*, Publication no. 2015-139-E, Library of Parliament, 15 December 2015.

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. Note that, since then, assisted suicide has been legalized in New Mexico.

6. 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).

7. United States, Oregon, *The Oregon Death with Dignity Act*, O.R.S., 127.800–127.995. Although the legislation was not struck down as a result of the legal challenge, the Oregon legislature then voted to have another referendum 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).

8. United States, *Baxter v. State*, 2009 MT 449 (Montana Supreme Court) (Court Listener), para. 7.

9. Ibid., para. 13.

10. Ibid.

11. For a bill seeking to make assisted suicide illegal, see, for example, United States, Montana, *Senate Bill No. 290*, 2021 Montana Legislature. For a bill seeking to regulate the practice, see United States, Montana, *Senate Bill No. 202*, 2015 Montana Legislature.

12. A ballot initiative is "a form of direct democracy … through 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*.

13. See endnote 7.

14. United States, Oregon, *Enrolled Senate Bill 579*, 80th Oregon Legislative Assembly, 2019 Regular Session.

15. United States, Oregon, *Oregon Death with Dignity Act*, O.R.S. 127.800, s. 1.01(3).

16. Ibid., O.R.S. 127.800, s. 1.01(7)(e).

17. Ibid., O.R.S. 127.855, s. 3.09 ("Medical record documentation requirements"); and Ibid., O.R.S. 127.865, s. 3.11 ("Reporting requirements").

18. See, for example, United States, Oregon, *House Bill 2232*, 80th Oregon Legislative Assembly, 2019 Regular Session; United States, Oregon, *A-Engrossed House Bill 2217*, 80th Oregon Legislative Assembly, 2019 Regular Session; and United States, Oregon, *House Bill 2903*, 80th Oregon Legislative Assembly, 2019 Regular Session.

19. United States, Oregon Health Authority, Public Health Division, *Oregon Death with Dignity Act: 2020 Data Summary*, 26 February 2021, 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 Health Authority, Public Health Division, *Death with Dignity Act Annual Reports*. See annual reports for 2011 to 2020. No further information was found regarding the outcome of the referral of two doctors to the Oregon Medical Board.

23. United States, Washington State Legislature, *The Washington Death With Dignity Act*, c. 70.245, R.C.W. For information about the ballot initiative, see United States, Washington Secretary of State, *Initiative Measure No. 1000: The Washington Death with Dignity Act*.

24. United States, Washington State Legislature, *HB 1141 – 2021-22: Increasing access to the death with dignity act*; and Sarah Gentzler, "A revision to Washington state's Death with Dignity Act stalls in the Senate," *The News Tribune* (Tacoma, Washington), 17 April 2021 [SUBSCRIPTION REQUIRED].

25. Data for 2020 are not available on the state's death statistics web page. See United States, Washington State Department of Health, *All Deaths – County and State Dashboards*.

26. Katherine Hutchinson and Zachary Smithingell, "*Table 1.* Characteristics of participants who died, 2016–2018," *2018 Death with Dignity Act Report*, Washington State Department of Health, Disease Control & Health Statistics, Center for Health Statistics, July 2019, p. 9; and "*Table 4.* Circumstances and Complications Related to Ingestion of Medication Prescribed for Participants Who Died, 2016–2018," *2018 Death with Dignity Act Report*, Washington State Department of Health, Disease Control & Health Statistics, Center for Health Statistics, July 2019, p. 13.

27. Ibid., "*Table 2.* End of Life Concerns of Participants Who Died, 2016–2018," *2018 Death with Dignity Act Report*, Washington State Department of Health, Disease Control & Health Statistics, Center for Health Statistics, July 2019, p. 11.

28. United States, Vermont General Assembly, *S.77 (Act 39): An act relating to patient choice and control at end of life*, 20 May 2013.

29. United States, 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 Department of Health, *Chapter 2: Hospital & Medication Rules – Subchapter 7: Rule Governing Compliance with Patient Choice at the End of Life*. Two reports have been published to date: David C. Englander, Esq., Vermont Department of Health, *Report Concerning Patient Choice at the End of Life*, Report to the Vermont Legislature, 15 January 2018; and David C. Englander, Esq., Vermont Department of Health, *Report Concerning Patient Choice at the End of Life*, Report to the Vermont Legislature, 15 January 2020.

30. United States, Vermont General Assembly, *S74, An act relating to modifications to Vermont's patient choice at the end of life laws*, 9 February 2021.

31. 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.

32. United States, 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.

33. United States, *Sang-Hoon Ahn v. Hestrin*, Court of Appeal of the State of California, Fourth Appellate District, Division 2, Case No. E073530, 3 December 2020 [SUBSCRIPTION REQUIRED]; United States, *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, Appellate Courts Case Information, *Supreme Court: Disposition* – Becerra v. S.C. (Ahn), Division SF, Case No. S253424, 27 February 2019. For further details about the case, see Death with Dignity, *California*.

34. For a list of other differences, see Death with Dignity, *The California End of Life Option Act and Death with Dignity*, 22 January 2016.

35. Medicaid is state-funded health care for low-income residents.

36. Susan Harding and KATU Web staff, "Letter noting assisted suicide raises questions," *Katu.com* (Portland, Oregon), 30 July 2008; and Dan Springer, "Oregon Offers Terminal Patients Doctor-Assisted Suicide Instead of Medical Care," *Fox News*, 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," *The 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.

37. United States, California Department of Public Health, Center for Health Statistics and Informatics, *End of Life Option Act*.

38. 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.

39. United States, California Legislative Information, *An act to amend Sections 443.1, 443.3, 443.4, 443.5, 443.11, 443.14, 443.15, and 443.17 of, and to repeal* and add *Section 443.215 of the Health and Safety Code, relating to end of life*, S.B. 380, c. 542, 2021–2022 Legislative Session.

40. United States, Colorado, *Colorado End-of-Life Options Act*, C.R.S., Title 25, art. 48.

41. United States, Colorado Department of Public Health & Environment, "Annual statistical report," *Medical Aid in Dying*; and Sawyer D'Argonne, "69 Coloradoans seek assisted suicide in first year of program," *Sky-Hi News*, 2 March 2018.

42. United States, District of Columbia, *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: 2017 Summary*; and United States, District of Columbia, DC Health, *District of Columbia Death with Dignity Act: 2018 Data Summary*. Reports for more recent years do not appear to have been published.

43. Congress can review and repeal laws passed by the Council of the District of Columbia. See Compassion & Choices, *District of Columbia*; Death with Dignity, *District of Columbia*; and Patients Rights Council, *District of Columbia*.

44. United States, Hawaii, House of Representatives, *A Bill for an Act Relating to Health* (*Our Care, Our Choice Act*), H.B. 2739, H.D. 1, 29th Legislature, 5 April 2018.

45. United States, Hawaii, Senate, *A bill for an Act relating to prescriptions*, S.B. 536, S.D. 2, H.D. 1, C.D. 1, 30th Legislature, 2019.

46. Patients Rights Council, *Hawaii*.

47. United States, Hawaii, Department of Health, *Report to the Thirtieth Legislature, State of Hawaii, 2020, Pursuant to Act 2, Session Laws of Hawaii 2019 (HB2739 H.D. 1)*, 1 July 2020; and United States, Hawaii, Department of Health, *Report to the Thirty-first Legislature, State of Hawaii, 2021, Pursuant to Act 2, Session Laws of Hawaii 2019, HB2739 H.D. 1, HRS 327L: Establishes the Our Care Our Choice Act*, 1 July 2021.

48. United States, New Jersey, *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*, 12 April 2021.

49. Patients Rights Council, *New Jersey*; United States, *Glassman v. Grewal*, Supreme Court of New Jersey, 27 August 2019; and Compassion & Choices, *Glassman v. Grewal*.

50. Both bills were referred to the judiciary committee of the New Jersey General Assembly but went no further. See 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.

51. United States, Maine, *An Act to Enact the Maine Death with Dignity Act*, H.P. 948 – L.D. 1313, Public Law, c. 271, 129th Maine Legislature, 12 June 2019; and Death with Dignity, *Maine Death with Dignity Act Goes into Effect*, 19 September 2019.

52. Maine Death with Dignity, *State Reports*.

53. United States, New Mexico Legislature, *Elizabeth Whitefield End-of-Life Options Act*, HB 47, 2021 Regular Session, 8 April 2021; and Associated Press, "New Mexico becomes latest state to legalize medically assisted suicide for terminally ill patients," *KTLA5* (Los Angeles), 8 April 2021. An osteopathic physician is a trained and licensed doctor who may use manual medicine therapies such as spinal manipulation or massage therapy in their treatment of patients. See Brent A. Bauer, "What kind of doctor is a D.O.? Does a D.O. have the same training as an M.D.?," *Mayo Clinic*.

54. Patients Rights Council, *Attempts to Legalize Euthanasia/Assisted-Suicide in the United States*.

55. The Netherlands' Termination of Life on Request and Assisted Suicide (Review Procedures) Act came into effect on 1 April 2002. An unofficial English translation of the law has been provided by the Institut Européen de Bioéthique. See The Netherlands, *Termination of Life on Request and Assisted Suicide (Review Procedures) Act*.

56. Ibid., s. 2.

57. The Netherlands, "Is euthanasia allowed?," *Euthanasia*.

58. The Netherlands, Regional Euthanasia Review Committees (RTE), *Euthanasia Code 2018: Review Procedures in Practice*, p. 60.

59. The Netherlands, *Termination of Life on Request and Assisted Suicide (Review Procedures) Act*, ss. 2(3) and 2(4) [UNOFFICIAL TRANSLATION].

60. The total of 14 minors receiving euthanasia was calculated by the author based on information in the 2015 to 2019 annual reports of the euthanasia review committees. See The Netherlands, Regional Euthanasia Review Committees (RTE), *Annual reports*. At the time of writing, the 2020 report had not been translated into English.

61. See, for example, "Euthanasia proposal readied for children aged 1 to 12," *NL Times*, 13 October 2020.

62. 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.

63. 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.

64. The Netherlands, *Termination of Life on Request and Assisted Suicide (Review Procedures) Act*, ss. 2(3) and 2(4) [UNOFFICIAL TRANSLATION].

65. Liselotte Postma, Erasmus School of Law, Erasmus University Rotterdam, *Advance directives requesting euthanasia in the Netherlands*, p. 10.

66. Council of Canadian Academies, *The State of Knowledge on Advance Requests for Medical Assistance in Dying: The Expert Panel Working Group on Advance Requests for MAID*, 2018, p. 109.

67. See annual reports from 2017 to 2019. The Netherlands, Regional Euthanasia Review Committees (RTE), *Annual reports*.

68. 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; David Gibbes Miller, Rebecca Dresser and Scott Y. H. Kim, "Advance euthanasia directives: a controversial case and its ethical implications," *Journal of Medical Ethics*, Vol. 45, No. 2, February 2019, pp. 84–89; and Eva C. A. Asscher and Suzanne van de Vathorst, "Supreme Court rules on the first prosecution of a Dutch doctor since the euthanasia act," *Journal of Medical Ethics Blog*, 28 April 2020.

69. The Netherlands, Regional Euthanasia Review Committees (RTE), *Annual report 2019*, pp. 10 and 12.

70. The Netherlands, Regional Euthanasia Review Committees (RTE), *Annual report 2017*, pp. 9 and 12.

71. The Netherlands, Regional Euthanasia Review Committees (RTE), *Annual report 2018*, p. 5.

72. 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, 1 December 2013, pp. 466–468.

73. Tony Sheldon, "Being 'tired of life' is not grounds for euthanasia," *The BMJ* (British Medical Journal), Vol. 326, No. 7380, 11 January 2003; and 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. 7.

74. Bioethics Research Library, *Bioethics news: A Dutch report applies the brakes on euthanasia*, Georgetown University, Kennedy Institute of Ethics.

75. The Netherlands, *Letter of the government position on 'completed life'*, 12 October 2016. For the Dutch medical association response, see Royal Dutch Medical Association (KNMG), *Reflections by the Royal Dutch Medical Association (KNMG) on the 'Government Response and Vision on Completed Life'*, 29 March 2017.

76. See, for example, the English summary of Bregje 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), 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), 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.

77. 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), 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, October 2017.

78. The Netherlands, Regional Euthanasia Review Committees (RTE), *Annual report 2018*, p. 11; and the Netherlands, Regional Euthanasia Review Committees (RTE), *Annual report 2019*, p. 10.

79. 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.

80. 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, Regional Euthanasia Review Committees (RTE), *Annual reports*. The second review 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 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), December 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, No. 2, August 2014, p. 198 (copy provided by *De Gruyter Open*).

81. The Netherlands, Regional Euthanasia Review Committees (RTE), *Annual report 2018*, pp. 5–6.

82. It is not clear from the *2018 Annual Report* what the final result was for the other two cases. Ibid., p. 8.

83. 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), December 2012, pp. 20–21.

84. Johan Legemaate and Ineke Bolt, "The Dutch Euthanasia Act: Recent Legal Developments," *European Journal of Health Law*, Vol. 20, No. 5, 1 December 2013, p. 455.

85. 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), December 2012, pp. 20–21.

86. The Netherlands, Regional Euthanasia Review Committees (RTE), *Euthanasia Code 2018: Review Procedures in Practice*; The Netherlands, Regional Euthanasia Review Committees (RTE), *Annual report 2014*, p. 6; and the Netherlands, Regional Euthanasia Review Committees (RTE), *Annual report 2017*, p. 22.

87. The Netherlands, Regional Euthanasia Review Committees (RTE), *Annual report 2019*, pp. 13–14 and 17.

88. 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," *Moniteur belge*, 22 June 2002, art. 3, §2, p. 28515.

89. Belgium, Commission fédérale de contrôle et d'évaluation de l'euthanasie (CFCEE), *Neuxième rapport aux Chambres législatives 2018-2019*, p. 25.

90. As in the Netherlands, there is no requirement of residency in the Belgian law but the conditions create a practical limitation because the doctor providing euthanasia must know the patient well. See Union nationale des mutualités socialistes, *Question de droit : La loi dépénalisant l'euthanasie*, January 2004, p. 14.

91. The commission has interpreted this to mean that if death is expected in the coming days, weeks or months, then one consulting physician is enough, whereas two are required when death is expected on a longer time frame. See Belgium, CFCEE, *Brochure à l'intention du corps medical*, p. 7.

92. 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*, cl. 2(d), 7 February 2014.

93. Belgium, Constitutional Court, *Arrêt n° 153/2015 du 29 octobre 2015*; and Belgium, Constitutional Court, *Note informative relative à l'arrêt n° 153/2015*.

94. See annual reports of the CFCEE for 2014 to 2019. Belgium, Service public fédéral, Santé publique, Sécurité de la chaîne alimentaire et Environnement, *Commission fédérale de contrôle et d'évaluation de l'euthanasie*. Click on "Consultez tous les documents."

95. Belgium, Belgian Federal Parliament, "28 Mai 2002. – Loi relative à l'euthanasie," *Moniteur belge*, 22 June 2002, art. 4, pp. 28516–28517; and Belgium, Chambre des représentants de Belgique, "15 mars 2020. – Loi visant à modifier la législation relative à l'euthanasie," *Moniteur belge*, 23 March 2020.

96. Belgium, CFCEE, *Huitième rapport aux Chambres législatives : années 2016-2017*, p. 3; Belgium, CFCEE, *Neuvième rapport aux Chambres législatives 2018-2019*, p. 3; and Belgium, CFCEE, *EUTHANASIE – Chiffres de l'année 2020*, News release, 2 March 2021.

97. See the annual reports of the CFCEE. Belgium, Service public fédéral, Santé publique, Sécurité de la chaîne alimentaire et Environnement, *Commission fédérale de contrôle et d'évaluation de l'euthanasie*. Click on "Consultez tous les documents."

98. Belgium, CFCEE, *Sixième rapport aux Chambres législatives (Années 2012-2013)*.

99. Graeme Hamilton, "Belgian doctor facing possible murder charge for euthanizing senior seen as warning for Canada," *National Post*, 29 October 2015; World Federation of Right to Die Societies, *Belgian physician dismissed of legal proceedings*, 6 May 2019; and Belgium, CFCEE, *Neuvième rapport aux Chambres législatives 2018-2019*, pp. 29–30.

100. Belgium, CFCEE, *Huitième rapport aux Chambres législatives : années 2016-2017*, p. 30.

101. Christian Rioux, "Un procès sur l'aide à mourir déchire la Belgique," *Le Devoir* (Montréal), 30 January 2020; and Alan Hope, "New trial for doctor who carried out euthanasia on Tine Nys," *The Brussels Times*, 12 May 2021.

102. Bruno Waterfield, "Son challenges Belgian law after mother's 'mercy killing'," *The Telegraph* (United Kingdom) [SUBSCRIPTION REQUIRED], 2 February 2015; European Court of Human Rights (ECHR), "Belgium," *Press country profile*; and Maria Cheng, "Europe's top rights court to hear Belgian euthanasia case," *AP News*, 8 January 2019.

103. Belgium, Chambre des représentants de Belgique, *Proposition de loi modifiant la loi du 28 mai 2002 relative à l'euthanasie en ce qui concerne l'auto-euthanasie assistée*, Doc. 53 2635/001, 53rd Parliament, 4th Session, 7 February 2013; Belgium, Chambre des représentants de Belgique, *Proposition de loi modifiant la loi du 28 mai 2002 relative à l'euthanasie en ce qui concerne les personnes atteintes d'une affection cérébrale et devenues incapables d'exprimer leur volonté*, Doc 54 1013/001, 54th Parliament, 2nd Session, 10 April 2015; Belgium, Chambre des représentants de Belgique, *Proposition de loi portant modification de la loi du 28 mai 2002 relative à l'euthanasie en ce qui concerne l'obligation de renvoi*, Doc 54 1015/001, 54th Parliament, 2nd Session, 10 April 2015; and Belgium, Chambre des représentants de Belgique, "15 mars 2020. – Loi visant à modifier la législation relative à l'euthanasie," *Moniteur belge*, 23 March 2020.

104. Naftali Bendavid, "In Depth: Some Belgians Are Opting for the Euthanasia Escape – Twins Request Highlights Fight Over Expanding Law and Reverberates in End-of-Life Debate in U.S.," *The Wall Street Journal Asia*, 17 June 2013. See other examples discussed in Alliance VITA, *Euthanasie en Belgique : bilan de 15 ans de pratique*, 7 June 2017.

105. 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.

106. Belgium, CFCEE, *EUTHANASIE – Chiffres de l'année 2020*, News release, 2 March 2021.

107. Lyn Carson and Brette Blakely, "What Can Oregon Teach Australia About Dying?," *Journal of Politics and Law*, Vol. 6, No. 2, 2013, p. 38.

108. Luxembourg, "Loi du 16 mars 2009 sur l'euthanasie et l'assistance au suicide," *Journal officiel du Grand-Duché de Luxembourg*, 16 March 2009.

109. Luxembourg, *Le décès suite à un acte d'euthanasie ou d'assistance au suicide sera considéré à l'avenir comme une mort de cause naturelle*, News release, 11 July 2019; and Luxembourg, "Loi du 2 mars 2021 modifiant : 1° la loi du 16 mars 2009 sur l'euthanasie et l'assistance au suicide; 2° la loi modifiée du 24 juillet 2014 relative aux droits et obligations du patient," *Journal officiel du Grand-Duché de Luxembourg*, 3 March 2021.

110. Luxembourg, *Cinquième rapport de la loi du 16 mars 2009 sur l'euthanasie et l'assistance au suicide (années 2017 et 2018)*, 2019. Note that, while there is a report for 2019–2020, the numbers do not add up in several of the tables in the report. Therefore, those more recent numbers have not been used in this publication.

111. Sarah Mroz et al., "Assisted dying around the world: a status quaestionis," *Annals of Palliative Medicine*, Vol. 10. No. 3, March 2021.

112. Switzerland, The Federal Council, *311.0: Swiss Criminal Code of 21 December 1937 (Status as of 1 July 2021);* and *Christian Schwarzenegger and Sarah J. Summers, Criminal Law and Assisted Suicide in Switzerland,* Submission to the Select Committee on the Assisted Dying for the Terminally Ill Bill, House of Lords, Zurich, 3 February 2005.

113. "Un canton suisse légalise le suicide assisté," *Radio-Canada*, 17 June 2012; Canton of Vaud, *Loi sur la santé publique du 29 mai 1985*, s. 27(d); and "Le Parlement valaisan réglemente le suicide assisté en EMS," *RTS Info* (Radio Télévision Suisse), 9 May 2019.

114. Imogen Foulkes, "Switzerland plans new controls on assisted suicide," *BBC News Europe*, 2 July 2010; and 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, pp. 6–7.

115. *Carter v. Canada (Attorney General)*, 2015 SCC 5.

116. Switzerland, Federal Office of Justice, *Euthanasia*.

117. Switzerland, The Federal Council, *Assisted suicide: strengthening the right of self-determination; The Federal Council continues to support suicide prevention and palliative care*, News release, 29 June 2011.

118. "Zurich voters reject ban on 'suicide tourism'," *Reuters*, 16 May 2011.

119. "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.

120. ECHR, Second Section, *Case of Gross v. Switzerland*, Application No. 67810/10, 14 May 2013. At paragraph 63, the judgment states:

> In the *Haas* case, the Court considered that it was appropriate to examine the applicant's request to obtain access to sodium pentobarbital without a medical prescription from the perspective of a positive obligation on the State to take the necessary measures to permit a dignified suicide. In contrast, the Court considers that the instant case primarily raises the question whether the State had failed to provide sufficient guidelines defining if and, in the case of the affirmative, under which circumstances medical practitioners were authorised to issue a medical prescription to a person in the applicant's condition.

121. 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.

122. ECHR, Second Section, *Case of Gross v. Switzerland*, Application No. 67810/10, 14 May 2013; and ECHR, Grand Chamber, *Case of Gross v. Switzerland*, Application No. 67810/10, 30 September 2014. Note that this was not an appeal to the Grand Chamber but rather a referral by the government. Cases brought to ECHR may be heard by a Chamber of seven judges and, after judgment, a party can request that the case be referred to a Grand Chamber of 17 judges for fresh consideration. 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.

123. Fati Mansour, "A Genève, le médecin d'Exit coupable d'avoir repoussé les limites du suicide assisté," *Le Temps* (Switzerland), 17 October 2019; and "La condamnation du vice-président d'Exit Suisse romande confirmée en appel," *Le Temps*, 30 April 2020.

124. Colombia, Constitutional Court, *Sentence # C-239/97*, 20 May 1997.

125. Michael Cook, "Euthanasia fails again in Colombian legislature," *Mercatornet*, 20 April 2021.

126. For further details about the case, see Sabine Michlowski, "Legalising active voluntary euthanasia through the courts: Some lessons from Colombia," *Medical Law Review*, Vol. 17, No. 2, 2009, pp. 183–218.

127. Colombia, Constitutional Court, *Muerte Digna-Caso de persona con enfermedad terminal que solicita a su EPS realizar la eutanasia*, Sentencia T-970/14 (2014 Constitutional Court decision).

128. Owen Dyer, Caroline White and Aser García Rada, "Assisted dying: law and practice around the world" (abstract), *The BMJ*, Vol. 351, 19 August 2015 [SUBSCRIPTION REQUIRED]; Javier Lafuente, "Why Colombia's first euthanasia was stopped with 15 minutes to go," *El País* (Spain), 3 July 2015; and Colombia, Ministry of Health and Social Protection, *Ministry of Health urges practi[s]ing early death process with a high humanitarian sense*, News release, 30 June 2015.

129. Stephanie Nolen, "Colombia takes medically assisted death into the morally murky world of terminally ill children," *The Globe and Mail*, 1 March 2019 [SUBSCRIPTION REQUIRED]; and "Eutanasia en Colombia: estas son las reglas que estableció minsalud y que generan polémica," *Noticias Caracol* (Colombia), 12 July 2021.

130. See, for example, Colombia, Senate, *Proyecto de ley de 2018 Senado por la cual se reglamentan las prácticas de la Eutanasia y la asistencia al suicidio en Colombia y se dictan otras disposiciones* (Senate bill tabled 30 July 2015).

131. Michael Cook, "Euthanasia fails again in Colombian legislature," *Mercatornet*, 20 April 2021.

132. 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," *LatinAmerican Post*, 13 March 2018. Also see links to primary sources in Australian Care Alliance, *Colombia*; and Stephanie Nolen, "Colombia takes medically assisted death into the morally murky world of terminally ill children," *The Globe and Mail*, 1 March 2019 [SUBSCRIPTION REQUIRED].

133. "Colombia's Health Ministry sets out guidelines for euthanasia, sparks controversies," *MercoPress*, 13 July 2021; and Colombia, Ministry of Health and Social Protection, *Resolución no. 971 de 2021*, 1 July 2021.

134. World Federation Right to Die Societies, *Colombian euthanasia activist Yolanda died*.

135. "Alcances del fallo que amplía la eutanasia a pacientes no terminales," *El Tiempo* (Colombia), 23 July 2021.

136. Australia, Victoria, Department of Health, "Overview," *Voluntary Assisted Dying*.

137. Australia, Victoria, *Voluntary Assisted Dying Act 2017*, No. 61 of 2017, s. 38, p. 35.

138. Ibid., s. 18, p. 20.

139. Ibid., s. 39, p. 36.

140. Australia, Victoria, Voluntary Assisted Dying Review Board, *Report of Operations: January – June 2020*, p. 3. Note that the numbers were revised from the original figures published in the *Report of Operations: June – December 2019*.

141. Australia, Victoria, Voluntary Assisted Dying Review Board, *Report of Operations: July – December 2020*, p. 5.

142. Ibid., p. 10.

143. Australia, Victoria, Voluntary Assisted Dying Review Board, *Report of Operations: January t– June 2020*, p. 15.

144. Australia, Victoria, Voluntary Assisted Dying Review Board, *Report of Operations: July – December 2020*, p. 14.

145. Australia, Western Australia, *Voluntary Assisted Dying Act 2019*, No. 27 of 2019; and Ben White et al., "WA's take on assisted dying has many similarities with the Victorian law – and some important differences," *The Conversation*, 8 August 2019.

146. Australia, Tasmania, Department of Health, *Voluntary Assisted Dying in Tasmania*.

147. Ibid.; and Matt Woodley, "New voluntary assisted dying Bill gives GPs and patients choice," *NewsGP*, 30 March 2021.

148. Australia, South Australia, SA Health, *Voluntary Assisted Dying in South Australia*.

149. Australia, South Australia, *Voluntary Assisted Dying Act 2021*.

150. Australia, Queensland, *Voluntary Assisted Dying Bill 2021*.

151. Germany, The Federal Constitutional Court, *Criminalisation of assisted suicide services unconstitutional*, News release, 26 February 2020.

152. Derek Scally, "Vote by Germany's doctors paves way for assisted suicide: Association of medics has removed a ban on the practice from its code of conduct," *The Irish Times*, 6 May 2021.

153. Italy, Constitutional Court, *Judgment 242 of 2019* (select 2019 in drop-down menu); The World Federation of Right to Die Societies, *Italian Constitutional Court now officially rules that aid in suicide is, under certain conditions, not punishable*, 7 December 2019; and Fabrizio Turoldo, "Aiding and Abetting Suicide: The Current Debate in Italy," *Cambridge Quarterly of Healthcare Ethics*, Vol. 30, No. 1, January 2021, pp. 123–135.

154. New Zealand Legislation, *End of Life Choice Act 2019*, Public Act 2019 No. 16, 16 November 2019.

155. New Zealand, Electoral Commission, *Official referendum results released*, 6 November 2020.

156. New Zealand, Ministry of Health, *End of Life Choice Act implementation*.

157. New Zealand, Ministry of Health, *About the End of Life Choice Act 2019*.

158. Peru, Office of the Ombudsman, *Defensoría del Pueblo destaca decisión de no apelar sentencia que reconoce derecho de Ana Estrada a una muerte en condiciones dignas*, News release, 3 March 2021; and Peru, Congress of the Republic, *Proyecto de ley que permite el uso de la eutanasia*, Bill No. 06976/2020-CR, 21 January 2021.

159. Spain, "Ley Orgánica 3/2021, de 24 de marzo, de regulación de la eutanasia," *Boletín Oficial del Estado*, No. 72, 25 March 2021, pp. 34037–34049; and United States, Library of Congress, *Spain: Bill on Euthanasia and Assisted Suicide Approved by Congress of Deputies, Moves to Senate for Consideration*, 9 February 2021.

160. Ibid.

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

Jurisdiction	Euthanasia (E)/ Assisted Suicide (AS) Allowed?	Terminal Illness Required?	Residency Required?	Advance Directives Permitted?	Permitted for Minors?	Permitted for Persons with Dementia/ Psychiatric Illness Not Capable of Making Decisions?	Psychological Suffering Sufficient?
Canada	E and AS allowed	No	Yes	No	No	No	No
United States (certain states only)	AS allowed	Yes	Yes	No	No	No	No
The Netherlands	E and AS allowed	No	Yes, although not explicitly in the law	Yes	Yes (12 years and older or newborn)	Yes, if there is a signed advance directive	Yes
Belgium	E and AS allowed	No	Yes, although not explicitly in the law	Yes (only for unconscious persons)	Yes (but not newborns or young children)	Yes, but the person must be competent at time of request	Yes
Luxembourg	E and AS allowed	No	Yes, although not explicitly in the law	Yes (only for unconscious persons)	No	Yes, but the person must be competent at time of request	Yes
Colombia	E allowed	No	Yes	Yes	Yes	Yes	Yes
Australia (certain states only)	E and AS (though E only in specific circumstances)	Yes	Yes	No	No	No	No
New Zealand	E and AS allowed	Yes	Yes	No	No	No	No
Spain	E and AS allowed	No	Yes	Yes	No	Yes	Yes

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. Switzerland, Germany, Italy and Peru are not included in the table because they do not have a detailed regulatory regime.

Sources: Table prepared by the Library of Parliament using information obtained from *Criminal Code*, R.S.C 1985, c. C-46; United States, Oregon, *The Oregon Death with Dignity Act*, O.R.S., 127.800 – 127.99; United States, Washington State Legislature, *The Washington Death With Dignity Act*, R.C.W, c. 70.245; United States, 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 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; United States, Colorado, *Colorado End-of-Life Options Act*, C.R.S., Title 25, art. 48; United States, District of Columbia, *Death with Dignity Act of 2016*, D.C. Law 21-182; United States, Hawaii, House of Representatives, *A Bill for an Act Relating to Health* (*Our Care, Our Choice Act*), H.B. 2739, H.D. 1, 29th Legislature, 5 April 2018; United States, New Jersey, *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; United States, Maine, *An Act to Enact the Maine Death with Dignity Act*, H.P. 948 – L.D. 1313, Public Law, c. 271, 129th Maine Legislature, 12 June 2019; United States, New Mexico Legislature, *Elizabeth Whitefield End-of-Life Options Act*, HB 47, 2021 Regular Session, 8 April 2021; The Netherlands, *Termination of Life on Request and Assisted Suicide (Review Procedures) Act* [UNOFFICIAL TRANSLATION]; Belgium, Belgian Federal Parliament, "28 Mai 2002. – Loi relative à l'euthanasie," *Moniteur belge*, 22 June 2002; Luxembourg, "Loi du 16 mars 2009 sur l'euthanasie et l'assistance au suicide," *Journal officiel du Grand-Duché de Luxembourg*, 16 March 2009; Colombia, Ministry of Health and Social Protection, *Resolución no. 971 de 2021*, 1 July 2021; Australia, Victoria, *Voluntary Assisted Dying Act 2017*, No. 61 of 2017; Australia, Western Australia, *Voluntary Assisted Dying Act 2019*, No. 27 of 2019; Australia, South Australia, *Voluntary Assisted Dying Act 2021*; Australia, Queensland, *Voluntary Assisted Dying Bill 2021*; New Zealand, *End of Life Choice Act 2019*, 16 November 2019; and Spain, "Ley Orgánica 3/2021, de 24 de marzo, de regulación de la eutanasia," *Boletín Oficial del Estado*, No. 72, 25 March 2021, pp. 34037–34049.