

FATALLY FLAWED
EXPERIMENTS IN ASSISTED
SUICIDE AND EUTHANASIA

by Richard Egan

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Introduction

Beginning with the first, short-lived experiment with a law permitting euthanasia, which was conducted in the Northern Territory from July 1996 to March 1997, there are thirty jurisdictions which have (or had) a scheme permitting either euthanasia or assisted suicide or both.

For other jurisdictions considering whether to legalise assisted suicide or euthanasia these jurisdictions can usefully be seen as a series of experiments in attempting to create the much vaunted “safe” regime for assisted suicide or euthanasia.

The data from each of these laboratory experiments in ending human lives is patchy. Many of the regimes, despite claims of their “safety”, seem to have been deliberately designed to minimise the collection and publication of data to make it impossible ever to know how often things go wrong.

Nonetheless scrutiny of all the data that is available from these experiments leads to the conclusion that they are all – in various ways – fatally flawed.

None of the regimes that have so far been tried or designed excludes inevitable [wrongful deaths](#).¹

This publication is kept up to date and is readily available online for consultation or downloading at:

https://www.australiancarealliance.org.au/flawed_experiments

Richard Egan is a researcher who has studied euthanasia and assisted suicide since 1987.

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¹ https://www.australiancarealliance.org.au/wrongful_categories

Northern Territory (1996-1997)

The *Rights of the Terminally Ill Act 1995* (the ROTI Act) was in operation in the Northern Territory from 1 July 1996 until it was suppressed by the Commonwealth's *Euthanasia Laws Act 1997* on 27 March 1997.

During the nine month period in which the ROTI Act was in effect and under its provisions, four people were assisted to terminate their lives by Dr Philip Nitschke.

Case studies on these four deaths have been published.² The principal author of this paper is Professor David Kissane, who is a consultant psychiatrist and professor of palliative medicine. Philip Nitschke is a co-author of the paper.

The case studies examine how the conditions required by the ROTI Act were met. Cases numbered 3, 4, 5 and 6 in this paper refer to those cases which ended with the person's life being terminated with the assistance of Dr Philip Nitschke.

Clinical depression or demoralisation

Kissane noted that *"fatigue, frailty, depression and other symptoms"* – not pain – were the prominent concerns of those who received euthanasia. He observed that *"palliative care facilities were underdeveloped in the Northern Territory, and patients in our study needed palliative care... There is a need to respond creatively to social isolation, and to treat actively all symptoms with early and skilled palliative care."*

From the case histories, it is apparent that cases 3 and 4 each had depressive symptoms.

In case 3, the patient had received *"counselling and anti-depressant medication for several years"*. He spoke of feeling sometimes so suicidal that *"if he had a gun he would have used it"*. He had outbursts in which he would *"yell and scream, as intolerant as hell"* and he *"wept frequently"*.

Neither the patient's adult sons nor the members of the community palliative care team who were caring for him were told he was being assessed for euthanasia. *"A psychiatrist from another state certified that no treatable clinical depression was present."*

In case 4, *"the psychiatrist noted that the patient showed reduced reactivity to her surroundings, lowered mood, hopelessness, resignation about her future, and a desire to die. He judged her depression consistent with her medical condition, adding that side-effects of her antidepressant medication, dozepin, may limit further increase in dose."*

Kissane comments that *"case 4 was receiving treatment for depression, but no consideration was given to the efficacy of dose, change of medication, or psychotherapeutic management."* While Dr Nitschke *"judged this patient as unlikely to respond to further treatment"*, Kissane, comments that *"nonetheless, continued psychiatric care seemed warranted – a psychiatrist can have an active therapeutic role in ameliorating suffering rather than being used only as a gatekeeper to euthanasia"*.

² Kissane, D W, Street, A, Nitschke, P, ["Seven deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia"](#), *The Lancet*, Vol 352, 3 October 1998, p 1097-1102.

Further concerns are raised by the report on case 5. Dr Nitschke reported that “*on this occasion the psychiatrist phoned within 20 min, saying that this case was straightforward*”. This assessment took place on the day on which euthanasia was planned. This case involved an elderly, unmarried man who had migrated from England and had no relatives in Australia. Dr Nitschke recalled “*his sadness over the man’s loneliness and isolation as he administered euthanasia*”. Dr Nitschke has since revealed in testimony to a Senate committee, that he personally paid for this psychiatric consultation and that it in fact took less than 20 minutes.³

Dr David Kissane, comments on the issue of demoralisation:

Review of these patients’ stories highlighted for me the importance of demoralization as a significant mental state influencing the choices these patients made. They described the pointlessness of their lives, a loss of any worthwhile hope and meaning.

Their thoughts followed a typical pattern of thinking that appeared to be based on pessimism, sometimes exaggeration of their circumstances, all-or-nothing thinking in which only extremes could be thought about, negative self-labelling and they perceived themselves to be trapped in this predicament. Often socially isolated, their hopelessness led to a desire to die, sometimes as a harbinger of depression, but not always with development of a clinical depressive disorder. It is likely that the mental state of demoralization influenced their judgement, narrowing their perspective of available options and choices. Furthermore, demoralized patients may not make a truly informed decision in giving medical consent.

Demoralization syndrome ... is an important diagnosis to be made and actively treated during advanced cancer. It is recognised by the core phenomenology of hopelessness or meaninglessness about life. The prognostic language within oncology that designates ‘there is no cure’ is one potential cause of demoralization in these patients, a cause that can be avoided by more sensitive medical communication with the seriously ill. While truth telling is needed, hope must also be sustained so that life may be lived out as fully as possible. Patients with advanced cancer can be guided to focus on ‘being’ rather than ‘doing’, savouring the experiential moment of the present, so that purpose and meaning are preserved through inherent regard for the dignity of the person. Active treatment of a demoralized state by hospice services would involve counselling and a range of complementary therapies, use of community volunteers and family supports, all designed to counter isolation and restore meaning.⁴

³ Nitschke, P., *Hansard*, Senate Standing Committee on Legal and Constitutional Affairs, Reference: *Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008*, Monday, 14 April 2008, Darwin, p 42; https://www.aph.gov.au/~media/wopapub/senate/senate/commttee/S10740_pdf.ashx
<http://www.aph.gov.au/hansard/senate/commttee/S10740.pdf>

⁴ Kissane DW., “Deadly days in Darwin” in *The Case Against Assisted Suicide*, K. Foley & H. Hendin (ed), Johns Hopkins University Press, 2002, p.192-209 Available at: https://www.aph.gov.au/~media/wopapub/senate/committee/legcon_ctte/completed_inquiries/2008_10/terminally_ill/submissions/sub589_pdf.ashx
http://www.aph.gov.au/senate/committee/legcon_ctte/terminally_ill/submissions/sub589.pdf

Terminal illness?

The ROTI Act provided (Section 4) that: *“A patient who, in the course of a terminal illness, is experiencing pain, suffering and/or distress to an extent unacceptable to the patient, may request the patient’s medical practitioner to assist the patient to terminate the patient’s life.”*

The ROTI Act (Section 3) defined that: *“‘terminal illness’, in relation to a patient, means an illness which, in reasonable medical judgment will, in the normal course, without the application of extraordinary measures or of treatment unacceptable to the patient, result in the death of the patient.”*

The ROTI Act further provided that a *“medical practitioner who receives a request”* may, if certain conditions are met, *“assist the patient to terminate the patient’s life”*.

The conditions to be met included that:

- *“the medical practitioner is satisfied, on reasonable grounds, that – (i) the patient is suffering from an illness that will, in the normal course and without the application of extraordinary measures, result in the death of the patient; (ii) in reasonable medical judgment, there is no medical measure acceptable to the patient that can reasonably be undertaken in the hope of effecting a cure; and (iii) any medical treatment reasonably available to the patient is confined to the relief of pain, suffering and/or distress with the object of allowing the patient to die a comfortable death;”* (Section 7(1)(b));
- a second *“medical practitioner who holds prescribed qualifications, or has prescribed experience, in the treatment of the terminal illness from which the patient is suffering”* has examined the patient and has confirmed *“(A) the first medical practitioner’s opinion as to the existence and seriousness of the illness; (B) that the patient is likely to die as a result of the illness; and (C) the first medical practitioner’s prognosis”* (Section 7(1)(c)(i) and (iii));
- *“a qualified psychiatrist”* has *“confirmed that the patient is not suffering from a treatable clinical depression in respect of the illness”* (Section 7(1)(c)(ii) and (iv)); and
- the illness is causing the patient severe pain or suffering (Section 7(1)(d))

In case 4, there was no consensus that the person was terminally ill. The person was diagnosed with mycosis fungoides. *“One oncologist gave the patient’s prognosis as 9 months, but a dermatologist and a local oncologist judged that she was not terminally ill. Other practitioners declined to give an opinion. In the end an orthopaedic surgeon certified that the ROTI provisions for terminal illness had been complied with.”*⁵

In case 3 the patient may have benefited from radiotherapy or strontium but neither of these was available in the Northern Territory.⁶

In case 5, the patient had an obstruction and was clinically jaundiced.⁷ The ROTI Act required Dr Nitschke as a *“medical practitioner who receives a request”* to have *“informed the patient of the nature of the illness and its likely course, and the medical treatment, including palliative*

⁵ Kissane, D W, Street, A, Nitschke, P, [op. cit.](#), p 1101.

⁶ [Ibid.](#), p 1099.

⁷ [Ibid.](#), p 1100.

care, counselling and psychiatric support and extraordinary measures for keeping the patient alive, that might be available to the patient.”⁸ However, Kissane reports that “when questioned about options like stenting for obstructive jaundice or the management of bowel obstruction” Dr Nitschke “acknowledged limited experience, not having been involved in the care for the dying before becoming involved with the ROTI Act.”⁹

This raises doubts as to whether the patient in this case – who was reported by Dr Nitschke to exhibit “indecisiveness” over a two month period about whether or not to request euthanasia – would still have done so if he had been given better symptomatic relief for the jaundice and obstruction.¹⁰

Severe Pain Not the Issue

Section 4 of the ROTI Act provided that: “A patient who, in the course of a terminal illness, is experiencing pain, suffering and/or distress to an extent unacceptable to the patient, may request the patient’s medical practitioner to assist the patient to terminate the patient’s life.”

Section 7(1)(d) provided that “a medical practitioner may assist a patient to end his or her life” only if, among other conditions, “the illness is causing the patient severe pain or suffering”.

Section 8 of the ROTI Act provided that a “medical practitioner shall not assist a patient under this Act if, in his or her opinion, and after considering the advice of the medical practitioner” who has the “prescribed qualifications, or has prescribed experience, in the treatment of the terminal illness from which the patient is suffering” (cf Section 7(1)(c)(i)), “there are palliative care options reasonably available to the patient to alleviate the patient’s pain and suffering to levels acceptable to the patient.”

Kissane reports that pain “was not a prominent clinical issue in our study”¹¹. In case 3, “the patient took morphine for generalised bone pain.”¹² For case 4, “pain was well controlled”.¹³ In case 5 the patient “complained of mild background pain incompletely relieved by medication”.¹⁴ In case 6, “regular analgesia was needed for abdominal pain”.¹⁵

In none of these four cases is there any evidence of severe pain that was not being adequately controlled.

Other kinds of suffering or distress are reported. In case 3, these included “intermittent nausea, constipation, and diarrhoea” and “catheterisation”¹⁶. In case 4 the dominant problem was “pruritus”.¹⁷ In case 5 there were symptoms associated with the obstructive jaundice, which seems to have been inadequately treated. In case 6 a key factor seemed to be patient’s distress at “having witnessed” the death of her sister who also had breast cancer, “particularly the

⁸ [Rights of the Terminally Ill Act 1995](#), Section 7(1)(e).

⁹ Kissane, D W, Street, A, Nitschke, P, [op. cit.](#), p 1101

¹⁰ [Ibid.](#), p 1100.

¹¹ [Ibid.](#), p 1102.

¹² [Ibid.](#), p 1099.

¹³ [Ibid.](#), p 1099.

¹⁴ [Ibid.](#), p 1100.

¹⁵ [Ibid.](#)

¹⁶ [Ibid.](#), p. 1099.

¹⁷ [Ibid.](#)

indignity of double incontinence”¹⁸ She “feared she would die in a similar manner”. She “was also concerned about being a burden to her children, although her daughters were trained nurses”.

Kissane noted that *“fatigue, frailty, depression and other symptoms”* – not pain – were the prominent concerns of those who received euthanasia. He observed that *“palliative care facilities were underdeveloped in the Northern Territory, and patients in our study needed palliative care... There is a need to respond creatively to social isolation, and to treat actively all symptoms with early and skilled palliative care.”*

Conclusion

The failed experiment in the Northern Territory, thankfully brought to an end by the decisive action of the Commonwealth Parliament, shows that apparently strict safeguards fail to ensure careful practice.

¹⁸ [Ibid.](#) p 1100.

Oregon (1997-)

Oregon's *Dying With Dignity Act* allows for medical practitioners to prescribe drugs for self-administration by a person to allow the person to end his or her life. The Act came into force on 27 October 1997.

Oregon publishes annual reports on the operation of the *Dying With Dignity Act*. A careful analysis of this data reveals significant issues with the practice of physician assisted suicide in Oregon.

Increase in number of deaths

The number of deaths from ingesting lethal substances prescribed under Oregon's *Death With Dignity Act* reached 386 in 2023 (up 26.5% from 2022) continuing a steady rise at an average growth of 15% per annum, since 1998, the first year of the Act's operation when 16 people died under its provisions.¹⁹

These deaths in 2023 accounted for 0.91% of all deaths in Oregon that year (up 32.5% from 2022 and more than double the rate of 0.43% in 2017).

The 2024 annual report records 376 deaths. This is a preliminary number as each annual report usually increases the reported number of deaths by lethal ingestion for the previous reported year – for example, 26 additional deaths in 2022 were reported in the 2023 annual report. Also, deaths outside of Oregon are generally not reported unless the person is an Oregon resident at the time of death. Oregon ceased enforcing any residency requirement from 28 March 2022.

Physical suffering not a major issue but “being a burden” is

The Oregon annual reports indicate that physical suffering is not a major issue for those requesting physician assisted suicide.

Of the 3243 people who had died from ingesting a lethal dose of poison between 1998 and 2024 less than one in three (29.5%) mentioned “*inadequate pain control or concern about it*” as a consideration.²⁰

¹⁹ Oregon Public Health Division, *Oregon Death With Dignity Act: 2024 Data Summary, Table 1*, p. 12

<https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year27.pdf>

²⁰ Oregon Public Health Division, *Oregon Death With Dignity Act: 2024 Data Summary, Table 1*, p.16,

<https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year27.pdf>

Earlier annual reports noted that “Patients discussing concern about inadequate pain control with their physicians were not necessarily experiencing pain.”²¹

However, nearly 1 out of 2 (46.6%) of those who died after taking prescribed lethal medication cited concerns about being a “Burden on family, friends/caregivers” as a reason for the request.²²

Physician assisted suicide has much more to do with relieving other people of a “burden” than relieving unbearable pain.

To facilitate and fund assisted suicide of persons simply because they feel they are a burden on family, friends or caregivers sends a cruel message to the elderly, disabled or chronically ill who may need the care and support of others to function in daily life. It implies that only the strong and fully independent have the right to live.

Mental health: No adequate screening

Research by Linda Ganzini has established that one in six people who died under Oregon’s law had clinical depression.²³

Depression is supposed to be screened for under the Act. However, in 2024 only 3 out of 376 people (0.8%) who died under the Oregon law were referred by the prescribing doctor for a psychiatric evaluation before writing a script for a lethal substance.²⁴ This means it is likely that about 60 people with clinical depression were prescribed and took a lethal poison without being referred for a psychiatric evaluation.

Over the 27 years of legalised assistance to suicide it is likely that around 460 people with clinical depression were prescribed and took a lethal poison without being referred for a psychiatric evaluation.

²¹ Oregon Health Authority, *Sixth Annual report on Oregon’s Death With Dignity Act*, 2004, p. 24

<http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year6.pdf>

²² Oregon Public Health Division, *Oregon Death With Dignity Act: 2024 Data Summary*, Table 1, p.16,

<https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year27.pdf>

²³ Linda Ganzini et al., “Prevalence of depression and anxiety in patients requesting physicians’ aid in dying: cross sectional survey”, *BMJ* 2008;337:a1682,

<http://www.bmj.com/content/bmj/337/bmj.a1682.full.pdf>

²⁴ Oregon Public Health Division, *Oregon Death With Dignity Act: 2024 Data Summary*, Table 1, p.16,

<https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year27.pdf>

In 2011 Dr. Charles J. Bentz of the Division of General Medicine and Geriatrics at Oregon Health & Sciences University explained that Oregon's physician-assisted suicide law is not working well. He cited the example of a 76-year-old patient he referred to a cancer specialist for evaluation and therapy. The patient was a keen hiker and as he underwent therapy, he became depressed partly because he was less able to engage in hiking.

He expressed a wish for assisted suicide to the cancer specialist, who rather than making any effort to deal with the patient's depression, proceeded to act on this request by asking Dr Bentz to be the second concurring physician to the patient's request.

When Dr Bentz declined and proposed that instead the patient's depression should be addressed the cancer specialist simply found a more compliant doctor for a second opinion.

Two weeks later the patient was dead from a lethal overdose prescribed under the Act.

Dr Bentz concludes *"In most jurisdictions, suicidal ideation is interpreted as a cry for help. In Oregon, the only help my patient got was a lethal prescription intended to kill him."* He urges other jurisdictions *"Don't make Oregon's mistake."*²⁵

Financial considerations

Of those who died from ingesting a lethal dose of medication in 2024, nearly one in ten (9.3%) mentioned the *"financial implications of treatment"* as a consideration. It is appalling that since 1998, 193 Oregonians have died from a lethal prescription after expressing concerns about the financial implications of treatment.²⁶ The percentage of those referring to this as a consideration has increased by 82% over the past five years from 5.1% in 2018.

In two notorious cases, those of Barbara Wagner and Randy Stroup, the Oregon Health Plan informed a patient by letter that the cancer treatment recommended by their physicians was not covered by the Plan but that the cost of a lethal prescription to end their life would be covered.²⁷

²⁵ Charles Bentz, "Oregon's assisted suicide law isn't working", *The Province*, December 5 2011, <http://blogs.theprovince.com/2011/12/05/province-letters-icbc-egypt-assisted-suicide-oregon-christmas-pre-marital-sex/>

²⁶ Oregon Public Health Division, *Oregon Death With Dignity Act: 2024 Data Summary*, Table 1, p.16, <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year27.pdf>

²⁷ Susan Donaldson James, "Death drugs cause uproar in Oregon:", ABC News, August 6, 2008, <http://abcnews.go.com/Health/story?id=5517492#.Ty9-VsXy8sl> ; Dan Springer, "Oregon Offers Terminal Patients Doctor-Assisted Suicide Instead of Medical Care", July 28, 2008, <http://www.foxnews.com/story/0,2933,392962,00.html>

The misleading notion of a peaceful death

Euthanasia and assisted suicide proponents hold out the promise of a peaceful death by fast acting lethal substances.

Neither pentobarbital nor secobarbital are now available in the United States so physicians have been experimenting with various lethal cocktails.

In Oregon in 2024 all deaths by ingesting a prescribed lethal dose involved a cocktail including diazepam, digoxin, morphine sulfate, and amitriptyline, with phenobarbital included in 71.8% of cases.²⁸

These experimental lethal cocktails, like the barbiturates previously used, are not guaranteed to result in a swift and peaceful death.

In fact, there are reported complications each year with an overall complication rate of 7.5% (84 out of 1122 people for whom this data is available). This does not include prolonged time between ingestion and loss of consciousness or ingestion and death or where ingesting the substance did not cause death.

In 2024 there were 9 cases of complications out of 112 (8% or nearly one in twelve) of those for whom information about the circumstances of their deaths is available. This included 7 cases of difficulty ingesting or regurgitating the poison, one unspecified complication and one case of seizures. Five cases of people experiencing seizures have been reported since 2017.

The interval from ingestion of lethal drugs to unconsciousness has been as long as 8 hours and 8 minutes (in 2023). In 2022 one person took 5 hours to lose consciousness and in 2017 one person took 4 hours to lose consciousness.²⁹

The time from ingestion to death has been as long as 137 hours (5 days and 17 hours), for a person in 2023. Nearly one in fifteen (6.83%) people take more than 6 hours to die.

9 people have regained consciousness after taking the supposedly lethal dose, including one person in 2021.

²⁸ Oregon Public Health Division, *Oregon Death With Dignity Act: 2024 Data Summary*, Table 1, p.15,

<https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/27.pdf>

²⁹ Oregon Public Health Division, *Oregon Death With Dignity Act: 2024 Data Summary*, Table 1, p.17

<https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year27.pdf>

In 2005, “One patient became unconscious 25 minutes after ingestion, then regained consciousness 65 hours later. This person did not obtain a subsequent prescription and died 14 days later of the underlying illness (17 days after ingesting the medication).³⁰

This patient was lumberjack David Prueitt who, after ingesting the prescribed barbiturates spent three days in a deep coma, then suddenly woke up, asking his wife “*Honey, what the hell happened? Why am I not dead?*”

David survived for another 14 days before dying naturally from his cancer.³¹

Since 2005 eight other people have regained consciousness after ingesting the lethal medication.

“In 2010, two patients regained consciousness after ingesting medications. One patient regained consciousness 88 hours after ingesting the medication, subsequently dying from underlying illness three months later. The other patient regained consciousness within 24 hours, subsequently dying from underlying illness five days following ingestion.

In 2011, two patients regained consciousness after ingesting the medication. One of the patients very briefly regained consciousness after ingesting the prescribed medication and died from underlying illness about 30 hours later. The other patient regained consciousness approximately 14 hours after ingesting the medication and died from underlying illness about 38 hours later.”³²

In 2012 “*one patient ingested the medication but regained consciousness before dying of underlying illness ... The patient regained consciousness two days following ingestion, but remained minimally responsive and died six days following ingestion*” .³³

³⁰Department of Human Services, Office of Disease Prevention and Epidemiology, *Eighth Annual Report on Oregon’s Death with Dignity Act*, p. 13, <https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year8.pdf>

³¹ “Oregon man wakes up after assisted-suicide attempt”, *Seattle Times*, 4 March 2005, http://seattletimes.nwsourc.com/html/health/2002197134_webwake04.html

³² Oregon Health Authority, *Death With Dignity Act, Year 14 - Table 1, Characteristics and end-of-life care of 596 DWDA patients who died after ingesting a lethal dose of medication as of February 29, 2012, by year, Oregon, 1998-2011*, p. 6, footnote 12 <https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year14.pdf>

³³ *Oregon’s Death With Dignity Act -2012 Table 1, Characteristics and end-of-life care of 673 DWDA patients who died after ingesting a lethal dose of medication as of January 14, 2013, by year, Oregon, 1998-2012*, p. 2, <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year15.pdf>

In 2017 “one patient ingested the medication but regained consciousness before dying from the underlying illness”.³⁴

In 2018 one person regained consciousness after ingesting the prescribed substance and later died of the underlying illness.³⁵

In 2021 one person after ingesting the prescribed substance (DDMA) “regained consciousness before dying from the underlying illness”.³⁶

Three of the cases of regaining consciousness occurred after using DDMP2 or DDMA – two of the experimental lethal cocktails being used by pro-assisted suicide doctors.³⁷

Faulty prognosis

The *Death With Dignity Act* provides that before prescribing a lethal substance a doctor must first determine whether a person has a “terminal disease”. This is defined by section 127.800 (12) of the Oregon Revised Statute to mean “an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months”.

However, 4.5% of those who have died from ingesting the lethal substance had at the time they died already outlived their six-month prognosis – some by several years. In 2024, 6.1% of those who died from a lethal ingestion had outlived their supposed six-month prognosis.³⁸

³⁴ Oregon Public Health Division, *Oregon Death With Dignity Act: Data Summary 2017* p.5, <http://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year20.pdf>

³⁵ Oregon Public Health Division, *Oregon Death With Dignity Act: 2018 Data Summary, Table 1*, p.12
<https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year21.pdf>

³⁶ Oregon Public Health Division, *Oregon Death With Dignity Act: 2021 Data Summary*, , p.5, <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year24.pdf>

³⁷ Oregon Public Health Division, *Oregon Death With Dignity Act: 2021 Data Summary, Table 4*, p.17
<https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year24.pdf>

³⁸ Oregon Public Health Division, *Oregon Death With Dignity Act: 2024 Data Summary, Table 1*, p.15
<https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year27.pdf>

In 2023 one person ingested the lethal poison 1633 days (4 years 5 ½ months) after requesting it.³⁹ In 2022 one person ingested lethal medication 1859 days (5 years 1 month) after the initial request for the lethal prescription was made, setting a new record for the longest duration between initial request and ingestion which was previously 1503 days (4 years 4½ months).⁴⁰ In 2020 one person ingested the prescribed poison 1080 days (2 years 11 ½ months) after requesting it.⁴¹ In 2021 one person ingested the lethal poison 1095 days (3 years) after requesting it.⁴² Evidently in these, and other similar cases the prognosis was wildly inaccurate.

Of course, for those who ingested the lethal substance within six months of requesting it we can never know if also may have lived for months or years longer.

This also means that any assessment of competence made at the time of prescribing the lethal substance is well out of date - the person may well have become incompetent to make a decision to ingest the lethal substance for the purpose of causing their own death.

Dr Kenneth Stevens has written about his experience of how the prognosis of six months to live works in practice under Oregon's law:

Oregon's assisted-suicide law applies to patients predicted to have less than six months to live. In 2000, I had a cancer patient named Jeanette Hall. Another doctor had given her a terminal diagnosis of six months to a year to live. This was based on her not being treated for cancer.

³⁹ Oregon Public Health Division, *Oregon Death With Dignity Act: 2023 Data Summary, Table 1*, p.15

<https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year26.pdf>

⁴⁰ Oregon Public Health Division, *Oregon Death With Dignity Act: 2022 Data Summary, Table 1*, p.15,

<https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year25.pdf>

⁴¹ Oregon Public Health Division, *Oregon Death With Dignity Act: 2020 Data Summary, Table 1*, p.12

<https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year23.pdf>

⁴² Oregon Public Health Division, *Oregon Death With Dignity Act: 2021 Data Summary, Table 1*, p.14,

<https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year24.pdf>

At our first meeting, Jeanette told me that she did not want to be treated, and that she wanted to opt for what our law allowed – to kill herself with a lethal dose of barbiturates.

I did not and do not believe in assisted suicide. I informed her that her cancer was treatable and that her prospects were good. But she wanted “the pills.” She had made up her mind, but she continued to see me.

On the third or fourth visit, I asked her about her family and learned that she had a son. I asked her how he would feel if she went through with her plan. Shortly after that, she agreed to be treated, and her cancer was cured.

Five years later she saw me in a restaurant and said, “Dr. Stevens, you saved my life!”

For her, the mere presence of legal assisted suicide had steered her to suicide.⁴³

Not a terminal illness

Oregon’s Death With Dignity Act requires that a person be certified by two physicians as suffering from a terminal illness before a lethal dose of medication can be lawfully prescribed.

The 2016 Annual Report listed conditions that have been accepted as meeting this definition including besides malignant neoplasms (i.e. cancers) and amyotrophic lateral sclerosis, heart disease, chronic lower respiratory disease, HIV/AIDS, benign and uncertain neoplasms, other respiratory diseases, diseases of the nervous system (including multiple sclerosis, Parkinson’s disease and Huntington’s disease), musculoskeletal and connective tissue diseases, viral hepatitis, diabetes mellitus, cerebrovascular disease, and alcoholic liver disease.⁴⁴

Earlier annual reports⁴⁵ specifically mention some diseases that would not normally be classified as a terminal illness:

- myelodysplastic syndrome (not terminal unless it develops into acute myeloid leukemia which itself is not necessarily terminal) (2003 Annual Report, p. 19);

⁴³ Kenneth Stevens “Doctor helped patient with cancer choose life over assisted suicide”, *Missoulian*, 27 November 2012, http://missoulian.com/news/opinion/mailbag/doctor-helped-patient-with-cancer-choose-life-over-assisted-suicide/article_63e092dc-37e5-11e2-ae61-001a4bcf887a.html Janette Stevens is still alive today (April 2024).

⁴⁴ Oregon Public Health Division, *Oregon Death With Dignity Act: Data Summary 2016*, Table 1. *Characteristics and end-of-life care of 1,127 DWDA patients who have died from ingesting a lethal dose of medication as of January 23, 2016 [sic = 2017], by year, Oregon, 1998-2016*, p.9 and footnote 2 on p.11, <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year19.pdf>

⁴⁵ Oregon’s Death with Dignity Act Annual Reports Annual are available at: <https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx>

- Hepatitis C (2004 Annual Report, p. 21)
- digestive organ neoplasm of unknown behavior! (2004 Annual Report, p. 21)
- cardiomyopathy (may cause death but not necessarily terminal) (2006 Annual Report, p. 5)
- endocarditis (not usually considered a terminal illness, only 20% mortality rate during initial infection) (2006, Annual Report, p. 5).

The 2024 annual report reveals that there have been 50 people for whom the “underlying illness” was listed as “Endocrine/metabolic disease [e.g., diabetes]”. There were 10 people in this category in 2023 – representing 2.7% (more than one in forty) of all cases.⁴⁶

The 2021 annual report also cites arthritis, arteritis, stenosis and sclerosis (none of which is usually a terminal illness) as the underlying illness in at least one case each, as well as “complications from a fall” and “medical care complications”.⁴⁷

Anorexia is mentioned for the first time in 2021 as a condition for which a lethal poison was prescribed and subsequently ingested under Oregon’s law.

“Other illnesses” accounted for 14 out of 376 deaths in 2024 – 3.7% which is 231% the 1.6% of deaths for “other illnesses”, both in 2023 and overall from 1998-2023.

An email from the Oregon Health Authority stated these 14 deaths included 4 assisted suicides for chronic kidney disease, 2 assisted suicides for complications from a fall, 1 each for “sequelae of other accidents”, thrombocytopenia, common variable immunodeficiency, rheumatoid arthritis, osteomyelitis, an other specified bone disorder, inflammatory disorder of male genital organ and a “specified congenital malformation”.

Clearly the central requirement of Oregon’s law that an illness be terminal is not strictly applied and more illnesses that are not terminal are being accepted as if they were an eligible condition.

It has been confirmed by the Oregon Health Authority that if a person with a chronic illness, such as diabetes, foregoes treatment such as insulin injections, for any reason (including

⁴⁶ Oregon Public Health Division, *Oregon Death With Dignity Act: 2024 Data Summary*, Table 1, p.17, <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year27.pdf>

⁴⁷ Oregon Public Health Division, *Oregon Death With Dignity Act: 2021 Data Summary*, Table 1, p.12 and footnote 3 on p. 14, <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year24.pdf>

financial reasons or suicidal ideation) and thereby is likely to die within six months, the person becomes eligible for assisted suicide.⁴⁸

Dr Charles Blanke wrote a lethal prescription for a young woman with a more than 90% chance of surviving Hodgkin's lymphoma because "She did not believe in chemotherapy and feared its toxicity".⁴⁹

The Oregon Health Authority has also clarified that all information about a person's underlying illness is simply based on reports by the physician who prescribes the lethal medication and a second consulting physician. There is no independent checking of the veracity of those reports.⁵⁰

[A burden on the family: a recipe for elder abuse](#)

The data from Oregon shows that in 2019 nearly six out of ten (59%) people who died after taking prescribed lethal medication cited concerns about being a "Burden on family, friends/caregivers" as a reason for the request.⁵¹

Does the concern about being a burden originate from the person or is it generated by subtle or not so subtle messages from family, friends and caregivers - including physicians - who find the person to be a burden or a nuisance or just taking too long to die?

Elder law expert Margaret Dore comments:

In both Washington and Oregon, the official reporting forms include a check-the-box question with seven possible "concerns" that contributed to the lethal dose request. These concerns include the patient's feeling that he was a "burden."

The prescribing doctor is instructed: "Please check 'yes,' 'no,' or 'don't know' depending on whether or not you believe that a concern contributed to the request."

In other states, a person being described as a "burden" is a warning sign of abuse. For example, Sarah Scott of Idaho Adult Protection Services describes the following

⁴⁸ Fabian Stahle, *Oregon Health Authority Reveals Hidden Problems with the Oregon Assisted Suicide Model*, Jan 2018,

<https://drive.google.com/file/d/1xOZfLFrvuQcaZfFudEncpZp2b18NrUo/view>

⁴⁹ Tara Bannow "Rural Oregonians still face Death With Dignity barriers", *The Bulletin*, 14 Aug 2017, <https://www.bendbulletin.com/health/5512373-151/oregonians-can-choose-how-their-roads-end>

⁵⁰ Fabian Stahle, *Notarised Questions to Oregon health Authority*,

<https://drive.google.com/file/d/1XopTDjBA2SAVBGBxpDazNN899eTHixSe/view>

⁵¹ Oregon Public Health Division, *Oregon Death With Dignity Act: 2019 Data Summary, Table 1*, p.12,

<https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year22.pdf>

"warning sign": "Suspect behavior by the caregiver . . . [d]escribes the vulnerable adult as a burden or nuisance."

The recommendation is that when such "warning signs" exist, a report should be made to law enforcement and/or to the local adult protective services provider.

Washington and Oregon, by contrast, instruct its doctors to check a "burden" box. Washington and Oregon promote the idea that its citizens are burdens, which justifies the prescription of lethal drugs to kill them. Washington's and Oregon's Acts do not promote patient "control," but officially sanctioned abuse of vulnerable adults.⁵²

Short relationship with attending physicians

The Oregon statute specifies that lethal prescriptions only be written by a person's "attending physician" who is defined as "the physician who has primary responsibility for the care of the patient and treatment of the patient's terminal disease."⁵³

The data indicates that in some cases doctors have had a relationship with the patient of less than one week's duration and that in 2024 in 50% of cases the doctor-patient relationship was of 5 weeks duration or less.⁵⁴

In 2024 a total of 135 physicians wrote 607 prescriptions for the lethal substance. The number of prescriptions per physician ranged from 1 to 84 (one lethal prescription every 4.3 days) on average, with 69% of physicians writing only one or two prescriptions.⁵⁵

Taken together this data suggests that there are some doctors in Oregon very willing to write prescriptions for lethal substances for multiple patients they barely know.

Same day death on request

Prior to 1 Jan 2020, the Oregon law required a period of 15 days between a first request for a lethal prescription and the supply of the lethal dose.

⁵² Dore, Margaret K. (2010) "'Death With Dignity': A Recipe for Elder Abuse and Homicide (Albeit Not by Name)," *Marquette Elder's Advisor*: Vol. 11: Iss. 2, Article 8.
<http://scholarship.law.marquette.edu/elders/vol11/iss2/8>

⁵³ Oregon Revised Statute, Section 127.800 (2),
<http://www.oregon.gov/oha/ph/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ors.aspx>

⁵⁴ Oregon Public Health Division, *Oregon Death With Dignity Act: 2024 Data Summary, Table 1*, p.17
<https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year27.pdf>

⁵⁵ Oregon Public Health Division, *Oregon Death With Dignity Act: 2024 Data Summary*, p.10,
<https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year27.pdf>

Now an exemption from this requirement can be claimed if the attending physician (who may have just met the person and who is not required to have any expertise in the person's condition) states that the person is reasonably expected to live fewer than 15 days from the first request.

Doctors claimed this exemption for 179 people in 2024 – representing 47.6% of all deaths from assistance to suicide from lethal prescriptions written in 2024⁵⁶

The length of time from first request to death by ingestion of the lethal poison is reported to range from 0 days to 1633 days in 2023⁵⁷ – so some people asked for assistance to suicide and suicided with the lethal poison on the very same day.

This gives no time to explore other responses to a request for assisted suicide before a person is dead by a prescribed lethal poison.

Who administers the lethal medication?

In 2024 a physician or other healthcare provider was known to be present at the time the person died from ingesting the lethal substance in just 35% of cases. In the remaining 65% of cases there was no physician or other healthcare provider known to be present at the time of death, and there is no data available on complications for these cases.⁵⁸

In 2024 in 94 cases (out of 376) there was a “volunteer” present at the time of ingestion. These are apparently “Client Volunteers” provided by a non-government organisation - End of Life Choices Oregon. According to their job description they “*may be present at a planned death*” and “*prepare lethal medication for the client*”, including by “*opening drug capsules and/or mixing medication with fluid.*”⁵⁹

⁵⁶ Oregon Public Health Division, *Oregon Death With Dignity Act: 2024 Data Summary*, p. 10
<https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year27.pdf>

⁵⁷ Oregon Public Health Division, *Oregon Death With Dignity Act: 2023 Data Summary*, Table 1, p.15
<https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year26.pdf>

⁵⁸ Oregon Public Health Division, *Oregon Death With Dignity Act: 2024 Data Summary*, Table 1, p.16
<https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year27.pdf>

⁵⁹ <https://eolcoregon.org/wp-content/uploads/2020/02/EOLCOR-Client-Volunteer-Job-Description.pdf>

This still leaves 147 out of 376 cases (39%) cases where there is no evidence that the person took the lethal substance voluntarily. It may well have been administered to them by a family member or other person under duress, surreptitiously or violently. We can never know.

Increase in suicide rate

Proponents have claimed that legalising physician assisted suicide would actually prevent, or at least delay, suicides by giving those faced with a terminal illness an assurance that the means for obtaining peaceful death was legally available. However, a study of comparative rates of suicide in US states found that for the states, like Oregon and Washington, which had legalised physician assisted suicide there is an increase in the overall suicide rate of 6.3% compared to all other states and of the suicide rate of those aged 65 and over of 14.5%. There is no reduction in either the rate of non-assisted suicides or in the mean age of suicide.⁶⁰

Conclusion

Oregon's 27-year experiment with an assisted suicide law, far from providing a model that other jurisdictions should follow, serves as a warning that such a law cannot guarantee that all deaths from assisted suicide are either voluntary or peaceful, or limited to those who actually meet the eligibility criteria.

⁶⁰ David Albert Jones and David Paton, How does legalization of physician-assisted suicide affect rates of suicide?, *SMJ: Southern Medical Journal*, Vol. 108, Issue 10, p. 599-604, <http://sma.org/southern-medical-journal/article/how-does-legalization-of-physician-assisted-suicide-affect-rates-of-suicide/>

Appendix A: Concerns leading to requests for lethal medication under Oregon's assisted suicide law

What do attending physicians who prescribe lethal medication under Oregon's Death With Dignity Act know or believe are the concerns contributing to the decision of those who have subsequently died following ingestion of the lethal medication?

Data on this question is published annually by the Oregon Health Authority. The [2018](#) report initially reported this data differently than in previous reports by excluding "Don't know" answers in calculating the percentages.

The data is derived from Question 15 in Part B of the "[Oregon Death with Dignity Act Attending Physician Follow-up Form](#)"

On 5 March 2019 I queried by email to the Oregon Health Authority the percentages given in Table 1 of the 2018 Data Summary under End of Life Concerns as they did not seem to be correct.

For example for 2018, if N=168 then the correct percentage for "Losing autonomy (%)" "if N=168 and the number was 154 should have been 91.7% rather than 95.1% as given.

In an email reply dated 8 March 2019 Craig New, Research Analyst, Oregon Health Authority explained:

"The discrepancy is because we exclude unknown values from the denominator when calculating percentages. So, for example, 154 patients had "losing autonomy" as a reason for seeking DWDA in 2018, but six patients were reported as "unknown" on this reason. $154 / (168-6) = 95.1\%$ "

I applied this information to the data on "End of Life Concerns" for 2018 and for the total data 1998-2018) and produced the table below.

The 2018 report was reissued on 25 April 2019 with this data recalculated using the approach previously employed of including "don't know" responses with "No" responses.

What is immediately striking is the lack of knowledge attending physicians admit to having about some of the concerns that may have contributed to a person requesting a prescription for lethal medication.

A lack of knowledge by the attending physician of whether or not a particular concern contributed to a request for a prescription for lethal medication necessarily implies either that the attending physician NEVER explored that possible concern with the person or, if the attending physician did attempt to explore that possible concern he or she did not succeed in eliciting a sufficient response from the person to form a view as to whether or not the person had that possible concern.

[Steady loss of autonomy and decreasing ability to participate in activities that made life enjoyable](#)

These concerns clearly dominate the discussion between attending physicians and persons requesting a prescription for lethal medication. Only in around 1 in 20 cases does the attending physician admit to not knowing if these were concerns contributing to the request.

Loss of dignity

In about one out of six cases the attending physician reports not knowing if loss of dignity was a concern for the person.

Burden on family, friends or caregivers

In 2018 in 14.9% of cases (nearly one in seven cases) the attending physician reported not knowing if the person who requested lethal medication and subsequently died after ingesting had a concern about physical or emotional burden on family, friends or caregivers.

[ORS 127.815](#) sets out as the very first responsibility of an attending physician under the Death With Dignity Act a duty to *“Make the initial determination of whether a patient has a terminal disease, is capable, and has made the request voluntarily”*

How can a physician come to a firm conclusion that a person is voluntarily requesting lethal medication in order to end their lives without exploring whether or not the person is motivated by a concern about the physical or emotional burden on family, friends or caregivers?

Surely such a discussion is necessary to exclude any possibility that the person is making the request under duress, subject to coercion or undue influence from a family member or caregiver.

Additionally, in the absence of such a discussion there may be a missed opportunity to relieve the person’s concern about being a burden by arranging respite for family caregivers or additional care or support.

If the 14.9% of cases where the attending physician does not even bother exploring this issue with a person before writing a prescription for lethal medication are added to the 54.2% of cases in 2018 where the attending physician reports knowing that the person had a concern about the physical or emotional burden on family, friends or caregivers then in nearly seven out of ten cases (69.1%) concern about being a burden was or may have been a factor in a request for lethal medication.

Given what we know about [elder abuse](#) this is cause for alarm.

Inadequate pain control at the end of life

In 2018 in 17.9% of cases (nearly one in six) the attending physician reports that he or she does not know whether the person who has died after ingesting lethal medication which the physician prescribed had any concern about inadequate pain control at the end of life.

[ORS 127.815](#) sets out as another of the responsibilities of an attending physician under the Death With Dignity Act a duty *“To ensure that the patient is making an informed decision, inform the patient of the feasible alternatives, including, but not limited to, comfort care, hospice care and pain control”*.

Before lethal medication is prescribed a person must sign a request form affirming, among other things, *“I have been fully informed of my diagnosis, prognosis, the nature of medication to be prescribed and potential associated risks, the expected result, and the feasible alternatives, including comfort care, hospice care and pain control.”*

But if the attending physician has not asked the person about any concerns about inadequate pain control at the end of life how can the attending physician possibly have properly

informed the person about feasible alternatives to ingesting lethal medication such as “comfort care, hospice care and pain control”?

Loss of control of bodily functions, such as incontinence and vomiting

In over one in five cases (20.2%) in 2018 the attending physician reports not knowing whether the person had any concern about the loss of control of bodily functions, such as incontinence and vomiting.

In many cases these concerns can be alleviated. There are many methods for treating or managing incontinence or vomiting. Simply discussing the concern with a listening, compassionate physician may be sufficient to relieve it, at least to the point where it is not a reason to request lethal medication.

The financial cost of treating or prolonging his or her terminal condition

In more than one out of four cases (26.8%) in 2018 the attending physician simply did not bother to find out whether a concern about the cost of treatment or care was underlying the request for lethal medication.

How can an attending physician form a valid view that a request for lethal medication is being made “voluntarily” if a possible concern about the financial costs of treatment or care is never explored with the person?

In some cases treatments may be available that are effective and could either cure the person from the terminal condition or significantly extend their life with good quality. If the person is forgoing such treatments because of a concern about the cost which is not even discussed with the attending physician isn't that a tragedy and a failure of the care due from a physician to a patient?

The attending physician is obliged by [ORS 127.815](#) “*To ensure that the patient is making an informed decision, inform the patient of the feasible alternatives, including, but not limited to, comfort care, hospice care and pain control*”.

If the person has a concern about the cost of “comfort care, hospice care and pain control” that is not disclosed to the attending physician because he or she never bothers to ask then how can a decision by the person to request lethal medication instead of “comfort care, hospice care and pain control” possibly be fully informed and voluntary?

Conclusion

Thanks to the explanation from Mr New of the Oregon Health Authority we are now better placed to interpret the data from Oregon on the concerns people requesting lethal medication discuss with attending physicians and the concerns that may motivate such requests but are simply not explored by attending physicians or at least not explored sufficiently for the attending physician to form a view as to whether such a concern was contributing to the person's request for lethal medication.

In more than **one in four cases** there is no discussion of concerns about the **financial cost** of treating or prolonging his or her terminal condition. In more than **one in five cases** there is no discussion of concerns about the loss of control of bodily functions, such as **incontinence and vomiting**. In nearly **one in six cases** there is no discussion of concerns about **inadequate pain**

control at the end of life. In nearly **one in seven cases** there is no discussion of concerns about being a physical or emotional burden on family, friends or caregivers.

This suggest that in many cases discussions between attending physicians and persons requesting lethal medication are almost solely around autonomy and related matters and that there is no serious discussion about underlying issues such as family dynamics, feelings of being a burden, financial considerations, pain control or loss of bodily functions at the end of life.

In the absence of such discussions, it seems that an attending physician could not have properly fulfilled the obligation under the Death With Dignity Act to have fully informed the person of feasible alternatives. Nor could the physician come to a genuine conclusion that the person was making a fully informed and truly voluntary decision to request lethal medication.

Question 15 in Part B of the [“Oregon Death with Dignity Act Attending Physician Follow-up Form”](#) reads: *Several possible concerns contributing to the patient’s decision to request a prescription for lethal medication are shown below. Please check yes, no, or unknown to indicate whether you believe each concern contributed to the patient’s request.*

The results in the table below are derived from data as originally published in the 2018 annual report but subsequently revised.

Table 1: Concerns contributing to request for lethal medication in Oregon for 2018 and for 1998-2018

A CONCERN ABOUT ...	2018 YES	2018 NO	2018 UNKNOW N	TOTAL YES	TOTAL NO	TOTAL UNKNOWN
the financial cost of treating or prolonging his or her terminal condition?	5.4%	67.9 %	26.8%	3.9%	79.2%	16.9%
the physical or emotional burden on family, friends, or caregivers?	54.2 %	31.0 %	14.9%	44.8%	41.5%	13.6%
his or her terminal condition representing a steady loss of autonomy?	91.7 %	4.8%	3.6%	90.6%	4.2%	5.1%
the decreasing ability to participate in activities that made life enjoyable?	90.5 %	4.2%	5.4%	89.1%	5.1%	5.8%
the loss of control of bodily functions, such as incontinence and vomiting?	36.9 %	42.9 %	20.2%	44.3%	34.1%	21.5%
inadequate pain control at the end of life?	25.6 %	56.5 %	17.9%	25.7%	60.5%	13.8%
a loss of dignity?	66.7 %	17.3 %	16.1%	74.5%	10.7%	14.8%

Appendix B: Assisted suicides for “other illnesses” in Oregon in 2024:

Disease name	Disease section
Thrombocytopenia, unspecified	Blood disease / immune disorders
Common variable immunodeficiency	Blood disease / immune disorders
Rheumatoid arthritis	Musculoskeletal system diseases
Other specified disorders of bone density and structure	Musculoskeletal system diseases
Osteomyelitis, unspecified	Musculoskeletal system diseases
Chronic kidney disease	Genitourinary system diseases
Chronic kidney disease	Genitourinary system diseases
Chronic kidney disease	Genitourinary system diseases
Chronic kidney disease	Genitourinary system diseases
Inflammatory disorder of male genital organ	Genitourinary system diseases
Other specified congenital malformation	Congenital malformations
Fall (complications from)	External causes
Fall (complications from)	External causes
Sequelae of other accidents	External causes

Switzerland (1998-)

Euthanasia is illegal in Switzerland. However, the phrasing of the article in the Swiss Penal Code prohibiting assisting suicide has allowed organisations such as Dignitas, Eternal Spirit (lifecircle) and Exit to offer assisted suicide.

[Article 115](#) reads “Any person who for selfish motives incites or assists another to commit or attempt to commit suicide shall, if that other person thereafter commits or attempts to commit suicide, be liable to a custodial sentence not exceeding five years or to a monetary penalty”.⁶¹

Increasing number of deaths

[Assisted suicides of Swiss residents](#) have been rising dramatically from just 48 in 1998 to 254 in 2008, 965 in 2015, and 1,729 in 2023. In 2023, 2.4% of all deaths of Swiss residents were by assistance to suicide, more than double the rate in 2014 of 1.16% of all deaths.

The qualifier, “for selfish motives” effectively allows Dignitas to offer assisted suicide to all comers on a cost recovery” basis. Dignitas has assisted in 4,196 suicides from [1998-2024](#). It charges between [7500 and 11000 Swiss francs](#) plus VAT (roughly equivalent to between \$A13,000 and \$A19,000) for an assisted suicide.⁶²

The number of assisted suicides carried out by Dignitas in 2024 was 280, up 21.7% from 2023. Just 6.22% of assisted suicides carried out by Dignitas have been of Swiss residents. The remaining 93.78% involve assisted suicide tourism. In 2024 only 5 deaths carried out by Dignitas were of people from Germany, down from a high of 92 in 2013. The German Constitutional Court invalidated the law against assisted suicide in 2020.

Euthanasia tourists have included 45 Australians (five each in 2018 and 2019; one in 2021; two in 2022; three in 2023 and two in 2024).

[Eternal Spirit Foundation](#) and its associated organisation lifecircle was founded in 2011. It also offers assisted suicide to foreigners as well as Swiss residents. No statistics are available to date. Assisted suicide is offered to anyone who is either “incurably ill (main diagnosis) or have an unacceptably incapacitating disability or unbearable and uncontrollable pain.” or meet a lower (unspecified threshold) if over 85 years of age.⁶³ Western Australian, [David Goodall](#), was assisted to commit suicide at its Basel clinic in May 2018⁶⁴. Goodall was not terminally ill and had no major disease, so assisted suicide is apparently being offered also for those “tired of life”.

[Pegasos](#), established in August 2019 and previously associated with Phillip Nitschke’s Exit International, offers assistance to suicide to people from anywhere in the world, who are over 18 years of age. It is not necessary to be terminally ill or even sick, and mental illness is not necessarily an obstacle. “At Pegasos we believe that you can still have mental capacity even if you suffer from long

⁶¹ <http://www.admin.ch/ch/e/rs/3/311.0.en.pdf>

⁶² <http://www.dignitas.ch/images/stories/pdf/statistik-ftb-jahr-wohnsitz-1998-2021.pdf>

⁶³ <https://www.eternalspirit.ch/en/>

⁶⁴ <https://www.bbc.com/news/world-europe-44069885>

term depression.” No official data is available on the number of assisted suicides carried out by Pegasos.⁶⁵ However, one [report](#) suggest it may be carrying out close to 300 per year including around 45 on people from the United Kingdom.⁶⁶

[Athanasios](#), opened in 2025 offering assisted suicide to tourists for 9500 Swiss Francs and to Swiss residents for 4500 Swiss Francs.

Another Swiss organisation, Exit German Switzerland, limits its assistance in suicide to Swiss residents. In [2024](#) it was responsible for 1,235 assisted suicides. In [2023](#) it was responsible for 1,252 assisted suicides – up 11% from 2022. 338 (27%) of these cases involved “polymorbidity”, that is a collection of ailments of old age.

Its sister organisation Exit Romandie Switzerland provided 504 assisted suicides in [2023](#) – up 36.2% from the 370 assisted suicides it facilitated in 2020. In 2023 there were 184 cases of polymorbidity (36.5%) as well as 16 cases for mental illness. Between 2018 and 2023 there have been 62 couple suicides.

There is no age limit for assisted suicide and between 2010 and 2014 thirteen people under 35 years of age died by assisted suicide.

Limited screening for depression

[Swiss psychiatrist Thomas Schlaepfer](#), a specialist in depression, is disturbed by the way Dignitas operates. "If somebody flies into Zurich Airport, is brought into an interview for an hour and prescribed medication, that's totally wrong," he says. "That's ethically wrong. Legally, it might be OK in Swiss law, but ethically it's wrong."

Schlaepfer says it is "totally impossible" to find out in a brief visit or two whether someone is of sound mind. Dignitas chief Minelli, however, claims to have no doubts about what he is doing: "Ah, it is not knowing," he says. "It is feeling, and that is much better than knowing."

Dignitas has also helped people with mental illnesses such as schizophrenia to die. Minelli argues that mentally ill people have the same right to take their own lives as others: "You can't say and you shouldn't say that mentally ill people should not have human rights."

But Schlaepfer says suicidal tendencies are often a symptom of mental illness and can be treated. "In this office," he says, "many people said, 'I'm totally depressed; I want to end my life' and weeks later this opinion was changed."

Public prosecutor Andreas Brunner believes the law is dangerously unregulated, giving him little room to act. "These days, everyone - even you or me, we - can make assisted suicides," says Brunner, noting that nothing - not even a medical degree - is required to start an organization that helps people kill themselves."⁶⁷

⁶⁵ <https://pegasos-association.com/>

⁶⁶ [An in depth look at the Swiss end of life centre 'Pegasos' in Switzerland.](#)

⁶⁷ <https://www.cbsnews.com/news/switzerlands-suicide-tourists-12-02-2003/>

Non terminal illnesses, mental illness and disabilities

Dignitas has assisted the suicides of people with nonterminal diseases such as [Crohn's disease and rheumatoid arthritis as well as quadraplegics](#).⁶⁸ Research [published in the Journal of Medical Ethics](#) showed that 21.2% of all those of various nationalities ending their lives at Dignitas had a non-fatal illness.⁶⁹

Between [1998 and 2009 Exit assisted](#) 71 people to die on the grounds of depression and 24 people to die because they were blind.⁷⁰

In 22 cases (3%) of assisted suicide by Swiss residents in 2014 [depression](#) was stated as the only "concomitant disease".⁷¹

Assisted suicide for all

A [2014 study of assisted suicides in Switzerland](#) found that there was a "higher rate among people living alone and the divorced". Study leader, Professor Matthias Egger, commented that "Social isolation and loneliness are well known risk factors for non-assisted suicides and our results suggest that they may also play a role in assisted suicide." 16% of death certificates did not register an underlying cause. A previous study of suicides by two right-to-die organizations showed that 25% of those assisted had no fatal illness, instead citing "weariness of life" as a factor.⁷²

In [2014 the General Assembly of Exit](#) voted to extend the provision of assisted suicide to the elderly who had no terminal illness. The statutes now refer to "the right to the freely responsible death of a very old person wishing to die".⁷³

Another Swiss organisation [ERAS](#) is campaigning for every person, **including healthy young people**, to be able to easily access lethal barbiturates for the purpose of suicide.⁷⁴

In [2018](#) the Swiss Academy of Medical Sciences added to the scope of those for whom doctors may offer assisted suicide "Patients whose desire to die is not primarily attributable to a medical

⁶⁸ <http://www.guardian.co.uk/society/2009/jun/21/dignitas-suicide-clinic-britons>

⁶⁹ <http://jme.bmj.com/content/34/11/810>

⁷⁰ <http://www.telegraph.co.uk/news/worldnews/europe/switzerland/9170059/Almost-300-assisted-suicides-in-Switzerland-per-year.html>

⁷¹ <https://www.bfs.admin.ch/bfsstatic/dam/assets/3902308/master>

⁷² <https://medicalxpress.com/news/2014-02-people-wealthier-areas-women-die.html>

⁷³

http://www.swissinfo.ch/eng/swiss_news/Exit_members_vote_to_broaden_assisted_suicide_services.html?cid=38653642

⁷⁴ <https://www.verein-eras.ch/>

condition".⁷⁵ However, the Swiss Medical Association (FMH) has [rejected](#) incorporating this expansion of scope in its ethical code.⁷⁶

Prisoners

On 28 February 2023, the first reported assisted suicide of a prisoner took place. The prisoner was detained at the prison in Bostadel near Zurich.

Faulty diagnosis

It was only after the family of retired Italian magistrate Pietro D'Amico, aged 62, insisted on an autopsy that he was [found not to have a terminal illness at all](#), despite being given such a diagnosis by both Italian and Swiss doctors prior to undergoing assisted suicide at a clinic in Basel, Switzerland.

Effect on families

Like any suicide assisted suicide can profoundly affect surviving family members and friends. A [2011 study](#) found that witnessing death by assisted suicide impacts the mental health of family members and friends. About 20% of respondents had full or partial PTSD and 16% had symptoms of depression after about 19 months after the death. Witnessing the unnatural death of a significant has a strong impact on the bereaved, which **may lead to severe mental health problems** at 14 to 24 months post-loss.⁷⁷

Sarco

On 23 September 2024, a 64 year old woman died in the canton of Schaffhausen inside the so-called Sarco – a device promoted by Philip Nitschke which brings about death through nitrogen asphyxiation. Swiss authorities are still [investigating](#) the death as a possible crime of inducement and assistance in suicide.

Conclusion

Switzerland's experiment with exempting from the law on assisted suicide all actions not proven to be undertaken for "selfish motives" has unleashed a seemingly unstoppable expansion of the practice to cover all - both suicide tourists and locals - who request it.

Other jurisdictions should learn from this fatally flawed experiment and maintain or enact a comprehensive prohibition on any acts of assisting, encouraging or instructing in suicide and a social program of suicide prevention for all.

or all.

⁷⁵https://www.samw.ch/dam/jcr:25f44f69-a679-45a0-9b34-5926b848924c/guidelines_sams_dying_and_death.pdf

⁷⁶

https://www.fmh.ch/files/pdf21/Medienmitteilung_Aerztekammer_befuerwortet_eine_partnerschaftliche_Tarifrevision.pdf

⁷⁷ https://www.zora.uzh.ch/id/eprint/48670/1/Wagner_et_al_Death_by_request_in_Switzerland-V.pdf

Belgium (2002-)

Euthanasia became legal in Belgium on 3 September 2002.

Increase in number of deaths

In Belgium deaths by legal euthanasia increased nearly seventeenfold (1698%) from 235 in 2003 – the first full year of legalisation – to 3,991 in [2024](#). From 2020 to 2021 alone the increase was 10.4%, with further increases of 9.85% from 2021 to 2022, 15.4% from 2022 to 2023 and 16.6% from 2023 to 2024. Officially reported euthanasia now accounts for one in 33 (3.6%) of all deaths in Belgium in 2024.⁷⁸

Euthanasia rates are much higher, perhaps double, for Dutch speakers (est. 4.36% for 2024) compared to French speakers (est. 2.2% for 2024).

In Flanders in 2013 a total of 6.35% of deaths were physician assisted deaths: 4.6% by euthanasia on request; 0.05% by assisted suicide; and 1.7% by “hastening of death without an explicit request from the patient”.⁷⁹

In 2013 euthanasia by request accounted for 6.3% of all deaths in Flanders of persons aged 65-79.⁸⁰

Increased willingness of doctors to grant requests for euthanasia

A study of the granting of requests for euthanasia by doctors in Flanders comparing 2007 and 2013 data shows that by 2013 doctors were 1.4 more likely to grant requests for euthanasia overall (55.4 % in 2007; 76.7% in 2013); 1.7 times more likely to grant requests from women (45.7% to 76.4%); twice as likely to grant requests from persons over 80 (38.1% to 75.4%); twice as likely to grant requests from persons with no or only primary school education (35.1% to 69.5%); two and a half times more likely to grant request from patients with cardiovascular diseases (29.6% to 73.2%); 1.5 times more likely to grant requests from patients with respiratory diseases (47.1% to 72.7%); 1.4 times more likely to grant requests from patients with diseases of the nervous system (69.5% to 100%); 3.8 times more likely to grant requests for diseases other than cancer; cardiovascular, respiratory or nervous system disorders (18.8% to 70.7%) and three times more likely to grant requests from persons in nursing homes (22.9% to 68.2%).⁸¹

This data indicates that initial reservations about euthanasia requests from persons with particular characteristics or conditions are rapidly swept away with a clear trend towards euthanasia on demand.

Requirements routinely flouted

In 2013 in Flanders some 26.77% of all physician assisted deaths involved the explicitly intended hastening of death by administering drugs without an explicit request from the patient despite the

⁷⁸ [fccee-pressrelease_20250319-figures euthanasia2024 .pdf](#)

⁷⁹ K. Chambaere et al. “Recent trends in euthanasia and other end-of-life practices in Belgium”, *New England Journal of Medicine*, 17 March 2015, <http://www.nejm.org/doi/pdf/10.1056/NEJMc1414527>

⁸⁰ Sigrid Dierickx et al., “Comparison of the Expression and Granting of Requests for Euthanasia in Belgium in 2007 vs 2013”, *JAMA Internal Medicine*, Published online 10 Aug 2015, <http://archinte.jamanetwork.com/article.aspx?articleid=2426426>

⁸¹ Sigrid Dierickx et al., “Comparison of the Expression and Granting of Requests for Euthanasia in Belgium in 2007 vs 2013”, *JAMA Internal Medicine*, Published online 10 Aug 2015, Table 1: Euthanasia requests and granted requests in Flanders, Belgium, 2007 vs 2013, <http://archinte.jamanetwork.com/article.aspx?articleid=2426426>

legal requirement for an explicit request. *“This can include cases where a patient request was not judged as explicit by the physician, where the request came from the family or where the physician acted out of compassion.”*⁸²

Another study found that, contrary to the law which authorises only doctors to perform euthanasia, nurses administered the lethal drugs in 12% of cases involving an explicit request and in 45% of cases without an explicit request.⁸³

In its report for 2018 and 2019 the Commission fédérale de Contrôle et d’Évaluation de l’Euthanasie notes that it *“does not have the possibility to assess the proportion of the number of declared euthanasias compared to the number of euthanasia actually performed.”*

It is clear that in Belgium the legal requirements for euthanasia are routinely flouted.

Organ donation following euthanasia

Belgium allows organ donation after euthanasia.

The first four cases of organ donation (2005-2007) following euthanasia involved persons who were not in the terminal phase of a terminal illness but who had a *“debilitating neurologic disease, either after severe cerebrovascular accident or primary progressive multiple sclerosis”*.⁸⁴

In 2011 a report was published on a partially overlapping set of four cases lung transplants taken from persons who were euthanased between 2007 and 2009. The cases each involved *“an unbearable non-malignant disorder”*, including two cases of multiple sclerosis. One case involved a 52 year old woman with a mental disorder manifested with the symptom of automutilation – cutting to cause self-harm. Her consent to euthanasia and organ donation was accepted despite this particular mental illness.⁸⁵

In a paper delivered to the 21st European Conference on General Thoracic Surgery held in Birmingham in May 2013, Dirk Van Raemdonck and his colleagues reported on a total of six lung transplants following death by cardiac arrest brought on by the administration of euthanasia carried out in Belgium between January 2007 and December 2012. Of the six cases, three of them had neuromuscular disorders and three had neuropsychiatric disorders. The authors conclude *“More euthanasia donors are to be expected with more public awareness.”*⁸⁶

⁸² K. Chambaere et al. “Recent trends in euthanasia and other end-of-life practices in Belgium: Supplementary Appendix”, *New England Journal of Medicine*, 17 March 2015

http://www.nejm.org/doi/suppl/10.1056/NEJMc1414527/suppl_file/nejmc1414527_appendix.pdf

⁸³ Els, Ingehlbrecht et al., “The role of nurses in physician-assisted deaths in Belgium, *Canadian Medical Association Journal*, 2010, 182:905-910, <http://www.cmaj.ca/content/182/9/905.full.pdf> ,

⁸⁴ D Ysebaert et al. “Organ Procurement After Euthanasia: Belgian Experience”, *Transplantation Proceedings*, 2009, 41: 585–586, http://www.coma.ulg.ac.be/papers/death/organ_euthanasia09.pdf

⁸⁵ D Van Raemdonck et al., “Initial experience with transplantation of lungs recovered from donors after euthanasia”, *Applied Cardiopulmonary Pathophysiology* , 2011, 15: 38-48, http://www.applied-cardiopulmonary-pathophysiology.com/fileadmin/downloads/acp-2011-1_20110329/05_vanraemdonck.pdf

⁸⁶ D Van Raemdonck et al., “Lung transplantation with grafts recovered from euthanasia donors”, Abstracts, 21st European Conference on General Thoracic Surgery, Birmingham, 26-29 May, 2013, Abstract O-099, p, 137, <http://www.estsmeetings.org/2013/images/documents/ests-abstracts-2013.pdf>

There seems to be no awareness of the exploitation involved in accepting consent to euthanasia followed by organ donation from patients with mental illness.

The 2018-2019 report notes that 18 people who were euthanased donated their organs. These people suffered either from a disease of the nervous system or **from a mental and behavioral disorder**. The majority of them were Dutch speakers, in the age group 50 to 69, female and **death was not expected soon**.

There were 3 cases reported for 2020 and 2021 – all males, aged 33, 73 and 76.

There were 12 cases reported for 2022 and 2023 – mainly females and including some cases of euthanasia for psychiatric disorders.

There was a total of 76 cases of organ donation with euthanasia in Belgium between 2005 and 2023.

Dr Marc Cosyns has expressed support for beating heart donation following a decision to perform euthanasia.⁸⁷ In this case death would be caused by exsanguination following surgical incisions to remove a still beating heart for the purpose of organ transplantation.

No notification of family

In April 2012 Tom Mortier's mother was euthanased on the grounds of chronic depression. Tom writes:

I was not involved in the decision-making process and the doctor who gave her the injection never contacted me.

Since then, my life has changed considerably. Up until now, I am still trying to understand how it is possible for euthanasia to be performed on physically healthy people without even contacting their children. The spokesman of the university hospital told me that everything happened according to my mother's "free choice". After my mother's death, I talked to the doctor who gave her the injection and he told me that he was "absolutely certain" my mother didn't want to live anymore.

The death of my mother has triggered a lot of questions. How is it possible that people can be euthanased in Belgium without close family or friends being contacted? Why does my country give medical doctors the exclusive power to decide over life and death? How do we judge what "unbearable suffering" is? What are the criteria to decide what "unbearable suffering" is? Can we rely on such a judgment for a mentally ill person?

After all, can a mentally ill person make a "free choice"? Why didn't the doctors try to arrange a meeting between our mother and her children? How can a medical doctor be "absolutely certain" that his/her patient doesn't want to live anymore?⁸⁸

⁸⁷ Ibid.

⁸⁸ Tom Mortier, "How my mother died", *MercatorNet*, 4 February 2013, http://www.mercatornet.com/articles/view/how_my_mother_died

Euthanasia for non-terminal conditions

The Euthanasia Evaluation and Control Commission describes “polypathology” as including situations where mobility difficulties, increasing deafness or loss of vision have led to loneliness, social isolation or a decreased ability to engage in various activities as sufficient justification for euthanasia. Urinary or fecal incontinence, described as a loss of dignity, is also mentioned in this context.⁸⁹

Despite claiming that “*In the absence of a serious and incurable disease, a feeling of life completed, fatigue of life or old age are not valid reasons for requesting euthanasia*” the Commission describes issues with vision loss, whether or not accompanied by hearing loss, as

*at the origin of a total dependence, a marked loss of autonomy which caused the loss of patients in control of their lives and made them dependent on the decisions of others, and social isolation due to the inability to communicate with others. All this gave rise to a feeling of loneliness, the feeling of being a burden to others, and the feeling that continuing to exist no longer makes sense. It is frequently a question of an absent or deficient quality of life, accompanied by a weariness of living or **feeling like you're done with your life**.*⁹⁰

The Commission considers that general practitioners are “specialists” in polypathology so that where a specialist opinion is required from a second doctor for people not expected to die in the “months to come” another general practitioner can provide this opinion.

In [2022](#) there were 582 cases (19.6% of all cases) of euthanasia for polypathology, including 239 cases (8% of all cases) where death was not expected in the foreseeable future.⁹¹

Other cases of euthanasia where death was not expected in the foreseeable future included 41 for cognitive disorders; 24 for psychiatric disorders; and a range of physical non-terminal conditions, including arthritis (15), eye and ear disorders (2), chromosomal and congenital abnormalities (3) and injuries from external causes (7).

In total, there were 513 cases (17.3%) of euthanasia where the person was not expected to die in the foreseeable future.

In [2023](#) there were 793 cases (23.2% of all cases) of euthanasia for polypathology, including 372 cases (10.9% of all cases) where death was not expected in the foreseeable future.⁹²

Other cases of euthanasia where death was not expected in the foreseeable future included 35 for cognitive disorders; 48 for psychiatric disorders (double the number for 2022); and a range of physical non-terminal conditions, including arthritis (18), eye disorders (8), chromosomal and congenital abnormalities (3) and injuries from external causes (9).

⁸⁹ Ibid., p. 28

⁹⁰ Commission fédérale de Contrôle et d'Évaluation de l'Euthanasie Neuvième rapport aux Chambres législatives 2018 – 2019, https://organesdeconcertation.sante.belgique.be/sites/default/files/documents/9_rapport-euthanasie_2018-2019-fr_0.pdf

⁹¹ <https://organesdeconcertation.sante.belgique.be/sites/default/files/documents/cfcee-communiquepresse20230217-chiffreseuthanasie-2022.pdf>

⁹² <https://organesdeconcertation.sante.belgique.be/sites/default/files/documents/cfcee-communiquepresse20230217-chiffreseuthanasie-2022.pdf>

In [2024](#) there were 1070 cases (26.8% of all cases) of euthanasia for polypathology, including 519 cases (13% of all cases) where death was not expected in the foreseeable future.⁹³

Other cases of euthanasia where death was not expected in the foreseeable future included 54 for cognitive disorders; 53 for psychiatric disorders; and a range of physical non-terminal conditions, including arthritis (29), and injuries from external causes (10).

In [2024](#) there were 932 cases (23.35%) of euthanasia where the person was not expected to die in the foreseeable future – an increased share of all euthanasia deaths by 12.3% from 2023.

In 2016/2017 there were 27 cases where death was not expected but the mandatory one month waiting period between the written request for euthanasia and its execution was not complied with by the euthanasing doctor. The Euthanasia Evaluation and Control Commission took no action on these cases other than sending the offending doctor *“a didactic letter to remind the doctor of the procedure to be followed in case of unexpected death in the short term”*.⁹⁴

No physical suffering

In [2024](#) some 76 (1.9%) cases involved no physical suffering at all. This includes, for example cancer patients “whose physical suffering is relieved by painkillers” but who “suffer psychologically by loss of dignity or a loss of autonomy”.⁹⁵

Euthanasia for disability such as blindness

In December 2012 identical twin brothers were euthanased on the grounds of their psychological distress at learning they were both going blind. The brothers were reportedly distressed that they would not be able to see each other.⁹⁶

Commenting on this case, Dr. Marc Maurer, President of the [US] National Federation of the Blind, said: *“This disturbing news from Belgium is a stark example of the common, and in this case tragic, misunderstanding of disability and its consequences. Adjustment to any disability is difficult, and deaf-blind people face their own particular challenges, but from at least the time of Helen Keller it has been known that these challenges can be met, and the technology and services available today have vastly improved prospects for the deaf-blind and others with disabilities. That these men wanted to die is tragic; that the state sanctioned and aided their suicide is frightening.”*⁹⁷

⁹³ [fccee-pressrelease_20250319-figureseuthanasia2024 .pdf](#)

⁹⁴ Commission fédérale de Contrôle et d'Évaluation de l'Euthanasie Huitième rapport aux Chambres législatives années 2016 – 2017, p. 18
https://organesdeconcertation.sante.belgique.be/sites/default/files/documents/8_rapport-euthanasie_2016-2017-fr.pdf

⁹⁵ [fccee-pressrelease_20250319-figureseuthanasia2024 .pdf](#)

⁹⁶ Bruno Waterfield, “Belgian identical twins in unique mercy killing”, *The Telegraph*, 13 January 2013,
<http://www.telegraph.co.uk/news/worldnews/europe/belgium/9798778/Belgian-identical-twins-in-unique-mercy-killing.html>

⁹⁷ <https://nfb.org/national-federation-blind-comments-belgian-euthanasia-deaf-men-losing-sight>

In [2022](#) there were 2 cases of euthanasia for eye or ear diseases (non-terminal), 7 for injuries (non-terminal), and 3 cases (nonterminal) for a congenital malformation or chromosomal abnormality. Each of these may be a case of euthanasia for disability.⁹⁸

In relation to euthanasia for polyopathy, the Commission has stated that for 234 cases [in 2020 and 2021](#) *“Visual disturbances progressing to bilateral blindness due to macular degeneration, in association or not with a pronounced hearing impairment, were at the origin of a total dependence and a marked loss of autonomy, which made the patients lose control of their lives and made them dependent on the decision of others. This situation was partly at the origin of social isolation due to the inability to communicate with others. All this gave rise to a feeling of loneliness, the feeling of being a burden on others, and the feeling that continuing to exist no longer makes sense. It was often a question of an absent quality of life, accompanied by a weariness of to live or a feeling of having finished with his life.”*

Belgium is euthanasing the disabled as a “cure” for loneliness.

Euthanasia for victims of sexual abuse

In late 2012 a 44 year old woman known as Ann G was euthanased by her psychiatrist on the grounds of unbearable psychological suffering. She had been treated for anorexia since her teenage years by psychiatrist Walter Vandereycken. In 2008 she publicly accused Vandereycken of sexual abusing her under the guise of therapy. In October 2012 he admitted to years of sexual abuse of several of his patients. Following this admission Ann G spoke of some temporary relief from *“the cancer in her head”* but subsequently persisted in her request for euthanasia.⁹⁹

Ann G will not be available to testify against her abuser if charges are laid.

Euthanasia for gender dysphoria

On 30 September 2013 Nathan Verhelst was euthanased on the grounds of unhappiness following a sex change operation. Nathan (previously known as Nancy) had been rejected by a family who hated girls. Commenting on the euthanasia Nathan’s mother said:

“When I saw 'Nancy' for the first time, my dream was shattered. She was so ugly. I had a phantom birth. Her death does not bother me.”¹⁰⁰

The doctors who approved and carried out euthanasia on Nathan Verhelst effectively affirmed the rejection Nathan had experienced since childhood.

⁹⁸ <https://organesdeconcertation.sante.belgique.be/sites/default/files/documents/cfcee-communiquepresse20230217-chiffreseuthanasie-2022.pdf>

⁹⁹ “Patiënte van psychiater Vandereycken krijgt euthanasia” *De standard*, 28 January 2013, http://www.standaard.be/artikel/detail.aspx?artikelid=DMF20130127_00448215

¹⁰⁰ Bruno Waterfield, “Mother of sex change Belgian: 'I don't care about his euthanasia death'”, *The Telegraph*, 2 October 2013, <http://www.telegraph.co.uk/news/worldnews/europe/belgium/10349159/Mother-of-sex-change-Belgian-I-dont-care-about-his-euthanasia-death.html>

Euthanasia for same sex attraction

In June 2016 the BBC interviewed a 39 year old Belgian man, known as “Sebastien”, who was in the process of being assessed for euthanasia on the grounds of his sexual attraction to men which he said he had never accepted and found unbearable. The outcome of his assessment has not been reported. However, Gilles Genicot, a member of Belgium’s Federal Euthanasia Evaluation and Control Commission, commented *“It’s more likely he has psychological problems relating to his sexuality. I cannot find a trace of actual psychic illness here. But what you cannot do is purely rule out the option of euthanasia for such patients. They can fall within the scope of the law once every reasonable treatment has been tried unsuccessfully and three doctors come to the conclusion that no other option remains.”*¹⁰¹

Euthanasia for children

On 12 December 2013 the Belgian Senate voted 50-17 in favour of a bill to amend the euthanasia law to allow “emancipated minors” to request euthanasia on the same terms as adults; and to allow “unemancipated minors” with the capacity for discernment to request euthanasia for a hopeless medical situation resulting in death shortly and who have reported a constant and unbearable physical suffering that cannot be appeased and that results from a serious and incurable disease or an accident.¹⁰² For unemancipated minors at least one parent must consent to the act of euthanasia.

The proposed law was transmitted to the Chamber of Representatives on 13 December 2013¹⁰³ where it passed by 88 votes to 46 on 13 February 2014¹⁰⁴. It was signed into law by the King on 3 March 2014 and is now in effect.

Six children have so far been killed under the Belgian law: three in 2016 and 2017; one in 2019; one in 2023 and . These were a 17-year-old child who was suffering from muscular dystrophy; a nine-year-old child, who had a brain tumour, and an 11-year-old child, who was suffering from cystic fibrosis, and a child of unstated age and condition in 2019. No children were euthanased in 2020, 2021 or 2022. There are no details available yet for the children euthanased in 2023 and 2024.

Luc Proot a member of the Belgium’s Federal Euthanasia Evaluation and Control Commission, commented to Charles Lane of the *Washington Post* that he “saw mental and physical suffering so overwhelming that I thought we did a good thing”¹⁰⁵ As Lane points out he is referring to the Committee approving the cases after the fact based on reports from the doctors who carried out the killing. It is curious that Proot refers to “mental and physical suffering” when the Belgian law specifically refers only to “unbearable physical suffering” in relation to children in contrast to a

¹⁰¹ Jonathan Blake, “Man seeks euthanasia to end his sexuality struggle”, *BBC News*, 9 June 2016, <http://www.bbc.com/news/world-europe-36489090>

¹⁰² http://www.senate.be/www/?Mlval=/index_senate&MENUID=21320&LANG=fr

¹⁰³ <http://www.lachambre.be/FLWB/pdf/53/3245/53K3245001.pdf>

¹⁰⁴ <http://www.dekamer.be/doc/PCRI/html/53/ip186x.html>

¹⁰⁵ Charles Lane “Children are being euthanised in Belgium”, *Washington Post*, 6 August 2018, https://www.washingtonpost.com/opinions/children-are-being-euthanized-in-belgium/2018/08/06/9473bac2-9988-11e8-b60b-1c897f17e185_story.html?noredirect=on&utm_term=.388d76a167e4

reference to “unbearable physical or psychological suffering” for adults. This comment raises a doubt in relation to each of these three cases of child euthanasia as to whether there was “unbearable physical suffering” that could not be alleviated.

Good palliative care can relieve the various forms of physical suffering associated with end-stage brain tumours.¹⁰⁶

Relevant to these cases is a discrepancy between the French and Dutch language versions of Article 3 Section 1 of the Belgian euthanasia law in relation to children. The French language version reads “*qui entraîne le décès à brève échéance*”¹⁰⁷ which means “which will cause death in the short-term”. The Dutch language version reads “*binnen afzienbare termijn het overlijden tot gevolg heft*”¹⁰⁸ which means “will result in death in the foreseeable future”.

There is a clear difference between death being caused in the “short-term” or in the “foreseeable future”.

Life expectancy for people with cystic fibrosis is increasing significantly in response to developments in treatment regimes. In the United States the median predicted age of survival for people with CF has now increased to 47 years.¹⁰⁹ It is by no means clear that the 11 year old child euthanased in Belgium in 2016 or 2017 was facing imminent death. He or she may have had years to live. Depression is also a particular issue with CF.¹¹⁰ The “mental suffering” mentioned by Luc Proot may have been relievable through appropriate treatment.

The 17 year old child had Duchenne muscular dystrophy (DMD). “Until relatively recently, boys with DMD usually did not survive much beyond their teen years. Thanks to advances in cardiac and respiratory care, life expectancy is increasing and many young adults with DMD attend college, have

¹⁰⁶ See for example: M. Cohn et al., *Transitions in Care for Patients with Brain Tumors: Palliative and Hospice Care*, 2014 https://www.ucsfhealth.org/pdf/transition_of_care_handbook.pdf ;

Canadian Virtual hospice, *What can be expected as brain cancer progresses?*, http://www.virtualhospice.ca/en_US/Main+Site+Navigation/Home/Support/Support/Asked+and+Answered/What+to+Expect+with+Various+Illnesses/Cancer/What+can+be+expected+as+brain+cancer+progresses_.aspx

¹⁰⁷ http://www.ejustice.just.fgov.be/cgi_loi/change_lg.pl?language=fr&la=F&cn=2002052837&table_name=loi

¹⁰⁸

http://www.ejustice.just.fgov.be/cgi_loi/change_lg.pl?language=nl&la=N&cn=2002052837&table_name=wet

¹⁰⁹ Cystic Fibrosis Foundation, <https://www.cff.org/CF-Community-Blog/Posts/2017/Survival-Trending-Upward-but-What-Does-This-Really-Mean/>

¹¹⁰ Cystic Fibrosis Foundation, <https://www.cff.org/Life-With-CF/Daily-Life/Emotional-Wellness/Depression-and-CF/>

careers, get married and have children. Survival into the early 30s is becoming more common, and there are cases of men living into their 40s and 50s.”¹¹¹ On the available information it is not clear whether in this case the child was both imminently dying and experiencing unbearable physical suffering that could not be alleviated.

Euthanasia for prisoners and mental health detainees

On 15 September 2014 the Brussels Court of Appeal decided that Frank Van Den Bleeken, who has been detained since the 1980s as a mentally impaired man accused of rape and murder, could legally request euthanasia as an alternative to life in prison.¹¹²

His euthanasia was scheduled for 11 January 2015 but was halted after the doctors treating him decided not to go ahead with it.¹¹³

Geneviève Lhermitte was an infamous murderer. She killed her son and four daughters, aged between three and 14, in Nivelles, Belgium on 28 February 2007. On 28 February 2023, she was euthanised, after she successfully invoked her ‘right to die’.¹¹⁴

Euthanasia for suicidal ideation

Euthanasia has been approved for a 24 year old woman, known as Laura, on the sole grounds of her mental suffering based on suicidal ideation.¹¹⁵ Belgium now treats suicidal ideation by facilitating suicide.

Between 2014 and 2017 two patients who were in an irreversible coma after a suicide attempt were euthanased based on an advance directive 5 months and 35 months respectively before the suicide attempt.¹¹⁶

¹¹¹ Muscular Dystrophy Association, *Duchenne Muscular Dystrophy (DMD)*, <https://www.mda.org/disease/duchenne-muscular-dystrophy>

¹¹² “Belgian murderer Van Den Bleeken wins ‘right to die’”, BBC News Europe, 15 September 2014, <http://www.bbc.com/news/world-europe-29209459>

¹¹³ “Belgian rapist Van Den Bleeken refused ‘right to die’”, BBC News Europe, 6 January 2015, <http://www.bbc.com/news/world-europe-30699780>

¹¹⁴ <https://www.spiked-online.com/2023/03/08/how-assisted-suicide-has-revived-the-death-penalty/>

¹¹⁵ “Healthy Woman Will Die By Doctor-Assisted Euthanasia Over Suicidal Thoughts”, *Inquisitr*, 24 June 2015, <http://www.inquisitr.com/2196375/healthy-woman-die-doctor-assisted-euthanasia-suicidal-thoughts/>

¹¹⁶ Commission fédérale de Contrôle et d’Évaluation de l’Euthanasie Huitième rapport aux Chambres législatives années 2016 – 2017, p. 14, https://organesdeconcertation.sante.belgique.be/sites/default/files/documents/8_rapport-euthanasie_2016-2017-fr.pdf

Dr Marc van Hoey was investigated for his actions in 2015 when he assisted an elderly woman to suicide after the sudden death of her daughter.¹¹⁷ The prosecution dropped the charges.

Euthanasia for bipolar disorder

Dr Wim Distelmans, the chairman of the Belgian Euthanasia Control and Evaluation Commission, in March 2015, enthused about euthanasia as the solution for people with bipolar disorder:

*“Manic-depressive patients, in their manic moments, do the most improbable things: plunder their bank account, stay weeks in a five star hotel, buy numerous cars in one day. At that stage they are not mentally competent, that is obvious. But in moments of depression and exhaustion to the baseline, then they are indeed competent. Then they can say, for example: “I have lived for thirty years crazy highs and lows, I’ve tried everything to break that infernal cycle, including psychiatric hospitalization, but now I’m back on the baseline, and I know I have a few weeks left before I am back for a dip in the depth or a jump in height.” These are people who are eligible for euthanasia.”*¹¹⁸

Euthanasia for cognitive and psychiatric disorders, including Asperger’s

In [2024](#) there were 56 cases of euthanasia for cognitive disorders (including Alzheimer’s and other dementias) as well as 55 cases of euthanasia for psychiatric conditions¹¹⁹.

Of the 74 cases of euthanasia for psychiatric conditions in [2022 and 2023](#) combined, 13 were of people aged less than 40 years, including 4 aged less than 30 years. Conditions included depression (25), bipolar disorder (9), post-traumatic stress disorder (6), borderline personality disorder (5), personality disorder (5), autism spectrum (3), schizophrenia (3), and anxiety (1).¹²⁰

The Commission presents approvingly the euthanasia of a woman in her twenties “who suffered severe trauma in her childhood, including severe sexual abuse and repeated physical and verbal violence” as well as that of an 85 year old woman suffering pathological grief after the death of her husband.

Between 2018 and 2021 there were 97 cases of euthanasia for cognitive disorders (including Alzheimer’s and other dementias) as well as 102 cases of euthanasia for psychiatric conditions including depression/bipolar disorder (36), personality disorders (35), anxiety/stress disorders (10), schizophrenia (10), autism (6), and anorexia (2).

Extraordinarily, one person was euthanased in 2018 for “*Commonly occurring behavioral and emotional disturbances during childhood and adolescence (such as attachment disorder)*” and one person in 2020 for “*Mental and behavioral disorders related to the use of psychoactive substances*”.

The Commission reports that “*In young patients, the unbearable and persistent nature of the suffering was frequently associated with experiences from the past. In this regard, it was a question of sexual abuse, neglect as a child, rejection by parents, self-destructive behavior and suicide attempts. In*

¹¹⁷ <https://www.dailymail.co.uk/news/article-6450405/Belgiums-Dr-Death-proudly-admits-killed-140-patients-including-two-friends.html>

¹¹⁸“ Jaarlijks vijftig keer euthanasie om psychiatrische redenen”, *HLN*, 20 March 2015, <https://www.hln.be/nieuws/binnenland/-jaarlijks-vijftig-keer-euthanasie-om-psychiatrische-redenen~a832222b/>, Translated with the aid of Google Translate

¹¹⁹ [fccee-pressrelease_20250319-figureseuthanasia2024 .pdf](#)

¹²⁰ [11 rapport-euthanasie 2022-2023-fr.pdf](#)

addition, failed suicide attempts have made those affected aware that there is also another, more dignified way to end their life.”

A total of 201 people with psychiatric disorders were killed by euthanasia in **Belgium between 2014 and 2017** including for mood disorders such as depression, bipolar disorder (73 cases); organic mental disorders, including dementia and Alzheimer's (60 cases); personality and behavioural disorders (23 cases); neurotic disorders, and disorders related to stressors including posttraumatic stress disorder (16 cases); schizophrenia and psychotic disorders (11 cases); organic mental disorders, including autism (10 cases) and complex cases involving a combination of several categories (8 cases).¹²¹

Of these 201 cases there were 25 cases of people under 40 being killed by euthanasia. In relation to these troubled young people the Commission observes *“In the group of patients under 40, it is mainly personality and behavioral disorders. All these patients have been treated for many years, both outpatient and residential. There has always been talk of intractable suffering. For this type of disorder, serious psychological trauma at a very young age have been mentioned several times, such as domestic violence, psychological neglect or sexual abuse.”*¹²²

Belgium is treating the victims of child abuse by domestic violence, neglect and sexual abuse by killing them.

The breakdown for **2014-2015** is more detailed for the 124 people killed by euthanasia in Belgium for mental and behavioural disorders, including depression (41); dementia (36); borderline personality disorder (14); bipolar disorder (9); obsessive-compulsive disorder (5); personality disorder (3); post-traumatic stress disorder (1); psychosis (1); schizoaffective disorder (1) and anorexia (1).¹²³

A report on 100 cases where patients an outpatient psychiatric clinic in Dutch speaking Belgium who requested euthanasia between 2007 and 2011 found that of the 35 cases in which euthanasia had been carried out by December 2012 there were 9 men and 26 women, indicating women are more vulnerable to being killed for their poor mental health.

Of the 100 cases, 11 patients were under 30 years (average age was 47 years).

The conditions for which requests were considered included: depression, bipolar, schizophrenia, Asperger's syndrome (19 cases); post-traumatic stress disorder; complicated grief; eating disorders; obsessive-compulsive disorders; anxiety; and attention deficit hyperactivity disorder.

“In total, 48 of the 100 patients' euthanasia requests were accepted (48%), because LT [Lieve Thienpont] (psychiatrist), in discussion with the patients' other practitioners and families, considered

¹²¹ Commission fédérale de Contrôle et d'Évaluation de l'Euthanasie Huitième rapport aux Chambres législatives années 2016 – 2017, p. 46, https://organesdeconcertation.sante.belgique.be/sites/default/files/documents/8_rapport-euthanasie_2016-2017-fr.pdf

¹²² Ibid., p. 48

¹²³ Federale Controle- en Evaluatiecommissie Euthanasie, Zevende verslag aan de Wetgevende Kamers (2014 - 2015), 7 Oct 2016, p. 8; p. 38, <https://www.lachambre.be/flwb/pdf/54/2078/54K2078001.pdf>

the requests to be based on reasons that were sufficiently tangible and reasonable, and because all legal requirements had been fulfilled.”¹²⁴

This psychiatrist (Dr Lieve Thienpont) and two other doctors were prosecuted for the poisoning in April 2010 – under the guise of euthanasia - of a 38 year old woman, Tine Nys.

Dr Thienpont signed off on Tine’s request for euthanasia on the basis of a diagnosis of Aspergers Syndrome given just two months before she was killed by a lethal injection.

Tine’s family filed a criminal complaint in 2017 alleging that Tine did not have Aspergers Syndrome but was seeking to end her life after a failed relationship; that the doctors made no effort to treat her for any suffering allegedly arising from the supposed condition and that during the actual process of euthanasia the doctor asked Tine’s parents to hold the needle while he injected the lethal drugs, and even asked the family to check Tine’s heart with a stethoscope to confirm her death.

After the criminal complaint was initiated Dr Thienpont wrote to colleagues calling on them to “try to stop these people [the Nys family]. It is a seriously dysfunctional, wounded, traumatized family with very little empathy and respect for others.”

The three doctors were each acquitted in a jury trial in Ghent on 31 January 2020. The doctors’ lawyer Mr. Van Steenbrugge said the acquittal had sent a strong, reassuring message to doctors. “It was not manslaughter, it wasn’t a crime,” he said. “It was euthanasia.”¹²⁵ This reassuring message to doctors regarding the poisoning of persons with suicidal ideation and mental and behavioural disorders is far from reassuring for the wellbeing of these troubled people.

Euthanasia by advanced directive

19 people were killed by euthanasia while unconscious in [2023](#) pursuant to an advanced directive.¹²⁶

A nurse’s view

Claire-Marie Le Huu-Etchecopar is a French nurse who has worked in Belgium since 2008. She has written about her experience with euthanasia in Belgium. These are two of the disturbing cases she has recounted:

Monsieur R. never asked for euthanasia: he was released from life out of ‘compassion’

This was the view of an oncologist just after the euthanasia of Mr R. Some days before, the doctor informed his wife that her husband was in the terminal phase of lung cancer. The doctor added that the patient ‘will suffer enormously, even though he was showing no signs of pain or distress at the moment’. His wife asked the specialist not to say a word to her husband ‘so he

¹²⁴ Thienpont L, et al. “Euthanasia requests, procedures and outcomes for 100 Belgian patients suffering from psychiatric disorders: a retrospective, descriptive study. *BMJ Open*, July 2015, <http://bmjopen.bmj.com/content/5/7/e007454.full.pdf+html>

¹²⁵ Elian Peltier, “Belgium Acquits Three Doctors in Landmark Euthanasia Case”, *New York Times*, 31 January 2020, <https://www.nytimes.com/2020/01/31/world/europe/doctors-belgium-euthanasia.html>

¹²⁶ [CFCEE Press Release - Figures for the year 2023 | Public health \(belgique.be\)](#)

doesn't suffer further' and at the same moment seeks euthanasia to spare him the 'horror of the end of life'. Mr R died by euthanasia without ever knowing of his illness and without deciding or even once expressing the wish to have recourse to euthanasia.

A sixty year old woman with dementia: The worrying influence of her entourage.

The entourage, consisting of friends and some family due to conflict, seemed totally unprepared. They kept harassing caregivers demanding euthanasia for this lady. The Care team felt uncomfortable because they understood that despite the request of the patient there is another reality: that of feeling abandoned because of a lack of solidarity. Her companions were undoubtedly sincere, seeking [her] well-being. But their kindness was devoid of empathy, the perspective necessary for real solidarity. The whole time she was in hospital, she asked for a toothbrush. Instead of a toothbrush, they bring her what they believe to be good according to them: wine, cakes, but never meeting the lady's request.

Also, the majority of the care team feel frustrated because lots of measures have been put in place to improve her comfort and her desire to be more surrounded. Initially, she agreed to appropriate structures for her needs, and then under the influence of her environment, she rejected them. Those close to her are locked in the emotion of seeing their friend disabled. They cannot bear to see her different. Any other solution than euthanasia seems unimaginable to them. In a small notebook where they leave her messages while she's sleeping, the question of euthanasia is on every page. You can read words such as:

Do not forget your euthanasia, it is your right, you have to ask the doctors or they'll never do it for you...¹²⁷

A case of euthanasia without request

One case reported in 2016/2017 concerned an interruptive act of life without request from the patient.

In this complex case where the patient had not made an explicit request, some members of the Commission felt that the law on euthanasia had been violated and that the file should be sent to the public prosecutor. Indeed, demand is one of the essential legal conditions. However, other members considered that a referral to the prosecution was not appropriate. Two arguments have supported this position. On the one hand, the fact that the means used in such a situation of agony did not indicate not necessarily the practice of euthanasia. On the other hand, several members of the Commission pointed out that in this case the doctor was faced emergency characterized by an extremely painful agony suffered by the patient for 24 hours, while her life expectancy was at most 2-3 days. This patient was in danger of choking. In addition, the patient's behavior and non-verbal communication were interpreted by the physician, the nursing staff and the family members of the patient as a request for euthanasia. The two-thirds majority, legally required for referral to the King's

¹²⁷ Claire-Marie Le Huu-Etchecopar, *Lifting the veil on euthanasia: what really happens in Belgium's healthcare system - a nurse's story*, 28 May 2014, <http://alexschadenberg.blogspot.com.au/2014/05/lifting-veil-on-euthanasia-what-really.html>; Originally published in French under the title "Euthanasie: le model Belgique a la derive", <http://plusdignelavie.com/?p=2773>

Attorney (see Article 8 of the law) was not reached (9 for referral to the King's public prosecutor, 7 against).¹²⁸

This high threshold of two-thirds majority of the Commission for referral to the public prosecutor helps explain why only one case has ever been referred (in 2015).

Euthanasia tourism

There were 61 cases of euthanasia tourism in [2022](#), including one person from Australia. Of these 13 (21.4%) were cases where death was not expected in the foreseeable future.

There were 110 cases of euthanasia tourism in [2023](#). Of these 44 (40%) were cases where death was not expected in the foreseeable future.

There were 120 cases of euthanasia tourism in [2024](#). Of these 44 (36.7%) were cases where death was not expected in the foreseeable future.

Conclusion

The 23-year experiment with euthanasia in Belgium is fatally flawed. It has resulted in the abandonment of the frail aged, the disabled, the mentally ill, the suicidal and the victims of child abuse to hopelessness and State sanctioned death by lethal injection.

¹²⁸ Commission fédérale de Contrôle et d'Évaluation de l'Euthanasie Huitième rapport aux Chambres législatives années 2016 – 2017, p. 30, https://organesdeconcertation.sante.belgique.be/sites/default/files/documents/8_rapport-euthanasie_2016-2017-fr.pdf /

Netherlands (2002-)

Euthanasia was formally legalised in the Netherlands on 1 April 2002 after several years in which it was practised openly after court decisions allowing it in certain circumstances.

Increasing number of deaths

The number of reported deaths from euthanasia rose nearly five and a half fold (548%) from 1,815 in 2003, the first year under the new law, to 9,958 deaths reported in [2024](#).¹²⁹

In 2003 some 1.28% of all deaths were brought about by reported acts of euthanasia. In 2024 this had risen more than four and a half fold (451%) to 5.78% of all deaths.

In 2023 deaths by reported euthanasia accounted for 8.18% (one in 12) of all deaths of persons aged between 50 and 70 years and for 10.77% (more than one in 10) of deaths reported as due to cancer.

The data above relates only to officially reported cases of euthanasia and assisted suicide. A more comprehensive picture is provided by the five or six yearly surveys by Statistics Netherlands on all deaths by “medical end-of-life decision”. The latest data reports on all deaths in the Netherlands in [2021](#).¹³⁰

For 2021 there is a significant discrepancy (1,617) between the number of cases of euthanasia (9,038) or assisted suicide (245) with request reported by Statistics Netherlands and the number of such cases reported (as required by law) to the Euthanasia Review Committees – 7,477 cases of euthanasia and 189 of assisted suicide¹³¹.

Additionally, the 2021 Statistics Netherlands report records 517 cases of “ending life without an explicit request”.

In total for 2021, there were 9,799 people whose deaths were caused intentionally by lethal medication representing nearly 1 in 20 (5.73%) of all deaths in the Netherlands – with 2,133 of those deaths (more than one in five or 21.77%) without an explicit request under the law, including 517 (5.28%) with no explicit request at all from the person.

In 2021 more than 1 in 10 (10.63%) of all deaths, other than sudden and expected deaths, of 17–79 year-olds in the Netherlands were caused intentionally by euthanasia or assisted suicide. Nearly 1 out of 3 of these deaths, or nearly 1 in 30 (3.24%) of all deaths, other than sudden and expected deaths, of 17–79 year-olds in the Netherlands were caused intentionally by euthanasia or assisted suicide outside the provisions of the law.

¹²⁹ Regionale Toetsingscommissies Euthanasie Jaarverslag 2024.

<https://www.euthanasiecommissie.nl/binaries/euthanasiecommissie/documenten/jaarverslagen/2024/03/24/index/RTE-jaarverslag2024-DEF+17-3-25.pdf>

¹³⁰ [StatLine - Deaths by medical end-of-life decision; age, cause of death \(cbs.nl\)](#)

¹³¹ Regional Euthanasia Review Committees, Annual Report 2021,

https://www.euthanasiecommissie.nl/binaries/euthanasiecommissie/documenten/jaarverslagen/2021/maart/31/jaarverslag-2021/RTE_JV2021_ENGELS_def.pdf

Nearly 1 out of 150 (0.65%) deaths of people aged between 17 and 64 years was caused by the administration of lethal drugs with no explicit request at all from the person.

Complications

Technical problems, complications and problems with completion in the administration of lethal drugs for euthanasia have been reported from the Netherlands.

Technical problems occurred in 5% of cases. The most common technical problems were difficulty finding a vein in which to inject the drug and difficulty administering an oral medication.

Complications occurred in 3% of cases of euthanasia, including spasm or myoclonus (muscular twitching), cyanosis (blue colouring of the skin), nausea or vomiting, tachycardia (rapid heartbeat), excessive production of mucus, hiccups, perspiration, and extreme gasping. In one case the patient's eyes remained open, and in another case, the patient sat up.

In 10% of cases the person took longer than expected to die (median 3 hours) with one person taking up to 7 days.¹³²

From 2016 to July 2018 the Board of Procurators General reported on 11 cases of euthanasia with serious breach of protocols by the doctor, including a failed assisted suicide because the doctor ordered the wrong drug; seven cases of the muscle relaxant being administered when the person was not in a full coma and therefore potentially causing pain; and three cases where a first attempt at euthanasia failed and the doctor had to leave the person to get a second batch of lethal drugs.¹³³

In 2021, one case involved the doctor leaving the person to get a third set of euthanasia drugs.

For assisted suicide in the Netherlands the doctor is required to be present until death occurs. Attempts at assisted suicide regularly fail to bring about death in the desired timeframe. In these cases, under the Netherlands protocols, the doctor then administers euthanasia drugs. This occurred in between 7% and 15% of cases of assisted suicide in the years 2014 to 2024.¹³⁴

In [2024](#), 18 out of 187 (9.6%) cases of attempted assisted suicide were completed by an act of euthanasia. In three cases the doctor was found not to have followed the protocol with the possibility in each case that the person was not in a full coma and may experienced pain from the muscle relaxant.¹³⁵

¹³² Groenewoud J, et al. (2000) "Clinical Problems with the Performance of Euthanasia and Physician-Assisted Suicide in the Netherlands", *New England Journal of Medicine*, Vol 342, p. 551-556, <http://content.nejm.org/cgi/reprint/342/8/551.pdf>

¹³³ <https://www.om.nl/onderwerpen/euthanasie/beslissingen-college/>

¹³⁴ Regionale Toetsingscommissies Euthanasie, Jaaverslag 2018, p. 13, https://www.euthanasiecommissie.nl/binaries/euthanasiecommissie/documenten/jaarverslagen/2018/april/1/jaarverslag-2018/RTEjv2018_DEF.pdf

¹³⁵ Regionale Toetsingscommissies Euthanasie Jaarverslag 2024, pages 69-72 <https://www.euthanasiecommissie.nl/binaries/euthanasiecommissie/documenten/jaarverslagen/2024/03/24/index/RTE-jaarverslag2024-DEF+17-3-25.pdf>

Grounds for euthanasia: psychiatric disorder and dementia

As is usually the case when legalised euthanasia is first proposed supporters in the Netherlands initially focussed solely on unbearable and unrelievable physical suffering associated with a terminal illness.

However, even before formal legalisation the grounds for euthanasia were expanded by the courts well beyond physical suffering to allow psychiatric conditions such as depression, anorexia, and anxiety associated with asymptomatic HIV to be considered as sufficient grounds to justify a physician granting a request by a person for the administration of lethal drugs.¹³⁶

One of the requirements of careful practice, under which physicians performing euthanasia and assisting with suicide were assured freedom from prosecution, required that the patient be suffering. Doctors with patients who were suffering physically were not subject to prosecution, but it was not yet clear whether they would be treated the same in cases involving patients with non-somatic suffering. The psychiatrist and general practitioner of a woman suffering from depression decided to assist the woman with suicide. Although they were acquitted, the Rotterdam District Court noted that in cases of non-somatic suffering the consultation of another independent physician is preferable.

In another case, the Almelo District Court held that although the suffering of a 25 year-old anorexia nervosa patient was not primarily physical, it was unbearable and therefore sufficient to dismiss the indictment against the pediatrician who had assisted in the patient's suicide.

The Supreme Court addressed the issue of non-somatic suffering in the landmark 1994 case of Chabot.

Dr. Boudewijn Chabot was a psychiatrist who supplied lethal drugs to a patient who had recently experienced a series of traumatic events that had left her with no desire to live. Although offered treatment for her condition, the patient refused. The Court began by affirming its earlier holdings that euthanasia and assisted suicide can be justified if:

the defendant acted in a situation of necessity, that is to say ... that confronted with a choice between mutually conflicting duties, he chose to perform the one of greater weight. In particular, a doctor may be in a situation of necessity if he has to choose between the duty to preserve life and the duty as a doctor to do everything possible to relieve the unbearable and hopeless suffering of a patient committed to his care.

The prosecution argued that the defense of justification should not be available to doctors who assist with suicides in cases where the suffering is non-somatic and the patient is not in the "terminal phase."

The Supreme Court rejected this contention, and held that in such cases the justification can be rooted in the autonomy of the patient herself. The Court noted that, "the wish to die of a person whose suffering is psychic can be based on an autonomous judgment."¹³⁷

¹³⁶ "Choosing Death," *The Healthcare Quarterly*, WGBH-Boston, aired March 23, 1993.

¹³⁷ Smies. Jonathan T. "The legalization of euthanasia in the Netherlands", *Gonzaga Journal of International Law*, (2003-4) 7, p. 19-20, <http://www.gonzagajil.org/pdf/volume7/Smies/Smies.pdf>

Euthanasia is now legally permitted in the Netherlands for dementia patients and for persons with depression or other mental health issues in the complete absence of any physical illness or suffering.¹³⁸

There were 427 notifications involving dementia in 2024 (up 27% from 2023 and nearly double the 215 notifications involving dementia in 2021). All these cases were in the absence of any other condition justifying euthanasia.

More than four out of ten (123 cases – 42.7%) of the 288 cases of euthanasia for dementia in 2022 were carried out by doctors from the Expertisecentrum Euthanasie (Euthanasia Expertise Centre).¹³⁹

In 8 of the dementia cases in 2023 and 6 in 2024 euthanasia was performed on the basis of an advanced directive rather than a contemporary request by the person who was euthanased.

In 2024 there were 219 notifications of euthanasia or assisted suicide involving patients with psychiatric disorders (up 58.7% from 2023 and nearly double the 115 cases in 2022). Of the 44 cases of euthanasia in 2024 for people aged between 18 and 30, 30 cases (68%) were for psychiatric disorders.

Additionally in 2024, there were 90 cases where one or more psychiatric disorders was cited as an underlying condition for which euthanasia was performed, along with one or more physical disorders. In total 309 people were euthanased at least in part because they suffered from a psychiatric disorder. This represents 3.1% of all euthanasia cases.

Of the 115 psychiatric cases reported in 2022, 24 cases involved a person aged between 18 and 40 years of age.¹⁴⁰ For example, Case 2022-085 involved the euthanasia of a young woman aged between 20 and 30 years of age who had obsessive-compulsive disorder, autism spectrum disorder (ASD), post-traumatic stress disorder related to being bullied when younger, and recurrent depressive episodes. The patient was also known to have anorexia nervosa and a mild intellectual disability.¹⁴¹

In five of these 115 cases (4.35%) the medical practitioner performing the euthanasia did so without complying with the requirement to consider fully the view of an independent psychiatrist who has examined the person in relation to the request for euthanasia.

In Case [2023-002](#), the medical practitioner who performed euthanasia on woman for her somatic symptom disorder (tinnitus) arrogantly defended his failure to consult an independent psychiatrist. The Review Committees ruled that breach of the due care criteria had occurred.¹⁴²

¹³⁹ Ibid.

¹⁴⁰ Regionale Toetsingscommissies Euthanasie Jaarverslag 2022, p. 13
https://www.euthanasiecommissie.nl/binaries/euthanasiecommissie/documenten/jaarverslagen/2022/april/6/jaarverslag-2022/RTE_JV2022_def_2april.pdf

¹⁴¹ <https://www.euthanasiecommissie.nl/uitspraken-en-uitleg/p-2022/documenten/publicaties/oordelen/2022/2022-81-tm-2022-100/oordeel-2022-085>

¹⁴² <https://www.euthanasiecommissie.nl/uitspraken-en-uitleg/p-2023/documenten/publicaties/oordelen/2023/2023-001-tm-2023-020/oordeel-2023-002>

In [Case 2024-015](#) the medical practitioner who performed euthanasia on a woman with an obsessive compulsive disorder who could no longer clean due to a spinal fracture failed to consult a psychiatrist. The Review Committees ruled that breach of the due care criteria had occurred 143

It is not clear what further action, if any, the Review Committees are now taking in such cases.

Well over half (126 cases – 57.53%) of the 219 cases of euthanasia for psychiatric disorders in 2024 were carried out by doctors from the Expertisecentrum Euthanasie (Euthanasia Expertise Centre).

In 2021 psychiatric conditions for which euthanasia was performed included borderline personality disorder, post-traumatic stress disorder and somatically unexplained physical complaints.

Euthanasia: autism and intellectual disability

A 2018 paper examines nine case reports on euthanasia in the Netherlands between 2012 and 2016 of people with an intellectual disability or an autism spectrum disorder.¹⁴⁴

The case reports make for chilling reading, illustrating how once euthanasia becomes normalised in a society it becomes the go-to, accepted, “final solution” for “difficult” patients.

A man in his 60s with Asperger’s, described as “an utterly lonely man whose life had been a failure”, was euthanased because he was “horrified at moving into sheltered accommodation”. Although he had been diagnosed with “severe and probably chronic depression with a persistent death wish” another psychiatrist, after seeing him just once, certified that he was free of depression in order to facilitate his euthanasia.

Another man in his 30s, also with Asperger’s, was euthanased based on his distress at “his continuous yearning for meaningful relationships and his repeated frustrations in this area, because of his inability to deal adequately with closeness and social contacts”.

A third case was of an intellectually disabled woman in her 60s who was euthanased for tinnitus despite a finding that “the patient had indeed gone through many treatments in the past, but also, that often the wrong treatments had been instigated. It had also become clear to the physician that the patient often wanted to abandon the treatments, and that the treating practitioners had not encouraged her to try and persevere with these treatment(s) a bit longer”.

Another [study](#) of 39 cases of euthanasia of people with autism spectrum disorders (ASD) or intellectual disability, carried out between 2012 and 2021 in the Netherlands, found that:

Factors directly associated with intellectual disability and/or ASD were the sole cause of suffering described in 21% of cases and a major contributing factor in a further 42% of cases. Reasons for the [euthanasia] request included social isolation and loneliness (77%), lack of resilience or coping strategies (56%), lack of flexibility (rigid thinking or difficulty adapting to

¹⁴³ [Oordeel 2024-015, onzorgvuldig, huisarts, psychische stoornis, geen onafhankelijk psychiater geraadpleegd, niet gehandeld overeenkomstig de zorgvuldigheidseisen inzake een vrijwillig en weloverwogen verzoek, het uitzichtloos lijden en het ontbreken van een redelijke andere oplossing. | Publicatie | Regionale Toetsingscommissies Euthanasie](#)

¹⁴⁴ Irene Tuffery-Wijne et al., “Euthanasia and assisted suicide for people with an intellectual disability and/or autism spectrum disorder: an examination of nine relevant euthanasia cases in the Netherlands (2012–2016)”, *BMC Medical Ethics*, 5 Mar 2018, <https://bmcomedethics.biomedcentral.com/articles/10.1186/s12910-018-0257-6>

change) (44%) and oversensitivity to stimuli (26%). In one-third of cases, physicians noted there was 'no prospect of improvement' as ASD and intellectual disability are not treatable.

Euthanasia for multiple geriatric syndromes

In its June 2011 publication *The role of the physician in the voluntary termination of life* the Royal Dutch Medical Association (KNMG) states that as the elderly experience "various other ailments and complications such as disorders affecting vision, hearing and mobility, falls, confinement to bed, fatigue, exhaustion and loss of fitness take hold ... The patient perceives the suffering as interminable, his existence as meaningless and – though not directly in danger of dying from these complaints neither wishes to experience them nor, insofar as his history and own values permit, to derive meaning from them." The KNMG considers that "such cases are sufficiently linked to the medical domain to permit a physician to act within the confines of the Euthanasia Law."¹⁴⁵

In its first year of operation (1 March 2012 to 1 March 2013) the Levenseindekliniek (End of Life Clinic) granted euthanasia to 11 out of 34 cases of persons who requested on the sole grounds of being "tired of living" without any other medical (physical or psychological) condition.¹⁴⁶

In 2024 there were 397 cases of euthanasia involving "multiple aging disorders" – up 29.3% from 2021.

In 2022 more than four out of ten (157 cases – 41.4%) of these 379 cases were carried out by doctors from the Expertisecentrum Euthanasie (Euthanasia Expertise Centre).¹⁴⁷

The [Euthanasia Code 2022](#) published by the Regional Euthanasia Review Committees provides for euthanasia on the basis of "multiple geriatric disorders":

*Multiple geriatric syndromes – such as sight impairment, hearing impairment, osteoporosis, osteoarthritis, balance problems or cognitive deterioration – may cause unbearable suffering without prospect of improvement. These syndromes, which are often degenerative in nature, generally occur in elderly patients, and a combination of these syndromes and the related symptoms can cause suffering. For these patients, too, the suffering and its unbearable nature are connected to matters such as life history, personality and stamina.*¹⁴⁸

¹⁴⁵ KNMG [Royal Dutch Medical Association], *The role of the physician in the voluntary termination of life*, June 2011, p. 23, Available at: <http://knmg.artsennet.nl/Publicaties/KNMGpublicatie/Position-paper-The-role-of-the-physician-in-the-voluntary-termination-of-life-2011.htm>

¹⁴⁶ 6 cases where the person died before a decision was made or withdrew the request are excluded. Marianne C. Snijdewind et al., "A Study of the First Year of the End-of-Life Clinic for Physician-Assisted Dying in the Netherland", *JAMA Internal Medicine*, Published online 10 Aug 2015, Table 2: Outcomes of Requests to the End-of-Life Clinic for Euthanasia or Physician-Assisted Suicide, According to Medical Conditions, <http://archinte.jamanetwork.com/article.aspx?articleID=2426428>

¹⁴⁷ Regionale Toetsingscommissies Euthanasie Jaarverslag 2022, p.15 https://www.euthanasiecommissie.nl/binaries/euthanasiecommissie/documenten/jaarverslagen/2022/april/6/jaarverslag-2022/RTE_JV2022_def_2april.pdf

¹⁴⁸ Regionale Toetsingscommissies Euthanasie, *Euthanasia Code 2022*, p.22 https://www.euthanasiecommissie.nl/binaries/euthanasiecommissie/documenten/publicaties/ec-2022/ec-2022/7/5/RTE_EuthaCode2022_English.pdf

Of the 392 cases of euthanasia for “multiple ageing disorders” reported for 2024, 244 cases (62.24%_ involved persons under 90 years of age. This represents 25% of the 975 cases of euthanasia for people aged over 90 years.

Euthanasia for loss of vision or hearing

In Case 2016-44 the Review Committees approved the action of a doctor who euthanased a man aged between 80 and 90 years of age on the sole ground of having progressive loss of vision due to macular degeneration with his lack of capacity to read being accepted as unbearable and hopeless suffering.¹⁴⁹

The *Euthanasia Code 2022* includes sight impairment and hearing impairment in its definition of “multiple geriatric syndromes”.¹⁵⁰

The 2023 and 2024 annual reports refer without further comment to “blindness” as one of the “other conditions” for which euthanasia was performed.

Euthanasia for a broken hip

In Case [2023-120](#) the Review Committees approved the action of a doctor who euthanased a man in his nineties within two weeks after the man had a fall and broke his hip. The loss of independence and need for care was held to be suffering that could only be relieved by ending the man’s life through euthanasia.

Euthanasia for alopecia

In Case 2021-28 the Review Committees approved the action of a doctor who euthanased a woman in her 90s on the ground that she was concerned that as she needed more personal care with ageing, she would not be able to hide her alopecia (whole body baldness). The social geriatrician consulted did not support the opinion of the doctor from the Euthanasia Expertise Centre that the woman’s suffering from this concern could only be relieved by euthanasia.¹⁵¹

Euthanasia on wheels

In March 2012 the Dutch Right to Die organisation launched the Levensindekliniek (End of Life Clinic) with six mobile teams of doctors to “*end their lives free of charge in their own homes*”.¹⁵² By the end of 2014 there were 29 mobile teams and the clinic dealt with 1035 requests for euthanasia in 2014.¹⁵³

¹⁴⁹ Regionale Toetsingscommissies Euthanasie, *Jaarverslag 2016*, p. 46

https://www.euthanasiecommissie.nl/binaries/euthanasiecommissie/documenten/jaarverslagen/2016/april/12/jaarverslag-2016/RTE_jaarverslag2016.pdf

¹⁵⁰ Regionale Toetsingscommissies Euthanasie, *Euthanasia Code 2022*, p.22

https://www.euthanasiecommissie.nl/binaries/euthanasiecommissie/documenten/publicaties/ec-2022/ec-2022/7/5/RTE_EuthaCode2022_English.pdf

¹⁵¹ <https://www.euthanasiecommissie.nl/uitspraken/publicaties/oordelen/2021/2021-21-tm-2021-40/oordeel-2021-28>

¹⁵² Tony Paterson “Euthanasia squads offer death by delivery”, *The Independent*, 5 March 2012,

<http://www.independent.ie/health/health-news/euthanasia-squads-offer-death-by-delivery-3039420.html>

¹⁵³ Marianne C. Snijdewind et al., “A Study of the First Year of the End-of-Life Clinic for Physician-Assisted Dying in the Netherland”, *JAMA Internal Medicine*, Published online 10 Aug 2015,

<http://archinte.jamanetwork.com/article.aspx?articleID=2426428>

This approach bypasses any need for the person's regular physician to be involved in the decision making about euthanasia.

Loneliness

In nearly half the cases where the Levenseindekliniek (End of Life Clinic) granted a request for euthanasia in its first year of operation (1 Mar 2012 to 1 Mar 2013) loneliness was listed as a type of unbearable suffering in nearly half (49.1%) the cases.¹⁵⁴

Couple euthanasia

In 2018 nine couples were euthanased together.¹⁵⁵ Case reports are available for one of these couples. The husband had oesophageal cancer. The wife had multiple sclerosis. Her reason for requesting euthanasia at the same time as her husband was "*the prospect of having to be cared for entirely by strangers and unable to continue living independently*". While the case reports note that "*In the event that partners make a request for euthanasia at the same time, it must be established that the request of one partner has not been influenced or has been prompted by that of the other partner*" there is no discussion in the case report on the wife of any efforts being made to explore her fears of being cared for by others.¹⁵⁶

In 2022, the number of couples euthanased together was 29 (up 81.25% from 2021).¹⁵⁷

In one of these cases, contrary to the *Euthanasia Code 2022*, the same consultant was used for both spouses.

In 2024, 54 couples (some of whom were 'close family members' but not partners) were euthanased together. This was up 64% from 33 couples in 2023 and represents 1.08% of all euthanasia cases. In [one of the 2024 cases](#) the doctor consulted the same consultant for both of the couple. Although the Review Committees found this to be a breach of the requirements no disciplinary action seems to have been taken.¹⁵⁸

¹⁵⁴ Marianne C. Snijdewind et al., "A Study of the First Year of the End-of-Life Clinic for Physician-Assisted Dying in the Netherland", *JAMA Internal Medicine*, Published online 10 Aug 2015, Table 3: Outcome of Requests for Euthanasia or Physician-Assisted Suicide According to Patient Characteristics and Other Circumstances <http://archinte.jamanetwork.com/article.aspx?articleID=2426428>

¹⁵⁵ Regionale Toetsingscommissies Euthanasie, Jaaverslag 2018, p. 17, https://www.euthanasiacommissie.nl/binaries/euthanasiacommissie/documenten/jaarverslagen/2018/april/1/jaarverslag-2018/RTEjv2018_DEF.pdf

¹⁵⁶ Regionale Toetsingscommissies Euthanasie, Jaaverslag 2018, p. 45, https://www.euthanasiacommissie.nl/binaries/euthanasiacommissie/documenten/jaarverslagen/2018/april/1/jaarverslag-2018/RTEjv2018_DEF.pdf

¹⁵⁷ Regionale Toetsingscommissies Euthanasie Jaarverslag 2022, p. 17, https://www.euthanasiacommissie.nl/binaries/euthanasiacommissie/documenten/jaarverslagen/2022/april/6/jaarverslag-2022/RTE_JV2022_def_2april.pdf

¹⁵⁸ [Judgment 2024-006, careless, general practitioner, duo euthanasia, combination of disorders, consult independent doctor. | Publication | Regional Euthanasia Review Committees](#)

Euthanasia “experts” trump physicians giving care

On 22 April 2015 a woman with dementia, Cobi Luck, was euthanased by a doctor at the Levenseindekliniek (End of Life Clinic), after a court ruled that doctors from the clinic had an expertise in euthanasia leading him to prefer their testimony to that of the doctors and staff from the nursing home who were providing her with daily care.

They testified that Ms Luck only spoke about euthanasia after her family had paid a visit. She still appeared to enjoy life and made comments which were not consistent with a desire for euthanasia. The nursing home staff knew her well and believed that she was not competent to make such a momentous decision. They stressed that people like Ms Luck were very vulnerable.¹⁵⁹

Review is too late for the dead patient

The review committees in the Netherlands are required to consider whether all the conditions of the euthanasia law have been met in each case. In case 15 of the 2011 annual report the Regional Euthanasia Review Committees concluded that the attending physician failed to achieve an accurate diagnosis of the woman’s back pain and only prescribed limited pain relief medication. Consequently, it could not be said that the woman’s pain was definitively unrelievable. Of course, the woman can get no relief from this finding of error on the part of the doctor who failed her and then euthanased her as she is already dead by euthanasia.¹⁶⁰

The same lack of remedy applies to the two cases of people with dementia who were euthanased in 2012 in relation to which the Review Committees found “*not to have been handled with due care*”.¹⁶¹

In 2015 there were four cases where the Review Committee found a lack of due care before euthanasia was carried out. These included:

- Case 2015-01 where euthanasia was carried out on a woman with a history of stomach pains from an undiagnosed cause, who was reluctant to be examined by a geriatrician;¹⁶²
- Cases 2015-28 and 2015-29 where the doctor failed to give an adequate dose of propofol to induce coma before administering rocuronium, a neuromuscular blocker that causes paralysis of all muscles except the heart and brings on respiratory arrest. Consequently these people may have experienced the distress of suffocation;¹⁶³
- Case 2015-81 where, after the person was still breathing with a full pulse 25 minutes after being given thiopental to induce coma and rocuronium to cause respiratory failure, the doctor

¹⁵⁹ “Vrouw (80) krijgt euthanasie tegen wil van haar behandelaars [80 year old woman receives euthanasia against the will of her carers”, *nrc.nl*, 3 April 2015, <http://www.nrc.nl/nieuws/2015/04/23/vrouw-80-krijgt-euthanasie-tegen-wil-van-haar-behandelaars/>

¹⁶⁰ Regional Euthanasia Review Committees, *Annual report 2011*, p. 17, http://www.euthanasiecommissie.nl/Images/RTE.JV2011.ENGELS.DEF_tcm52-33587.PDF

¹⁶¹ Regional Euthanasia Review Committees, *Annual report 2012*, p. 13 http://www.euthanasiecommissie.nl/Images/JV.RTE2012.engelsDEF2_tcm52-39100.pdf

¹⁶² Regionale Toetsingscommissies Euthanasie, *Jaarverslag 2015*, p. 28-31 https://www.nvve.nl/files/8414/6166/0719/RTE_jaarverslag2015DEF.pdf

¹⁶³ Regionale Toetsingscommissies Euthanasie, *Jaarverslag 2015*, p. 44-46 https://www.nvve.nl/files/8414/6166/0719/RTE_jaarverslag2015DEF.pdf

administered a second dose of rocuronium without adequately ensuring the person was in a full coma.¹⁶⁴

Even where the Review Committees identify failures and report the cases to the Public Prosecution Service action is seldom taken apart from “counselling” the offending doctor. In Case 2014-02 a doctor performed euthanasia on a woman with aphasia after a stroke solely based on a twenty-year-old living will in which she expressed a desire for euthanasia if she ever had to live in a nursing home. The doctor subjectively concluded that she would be experiencing unbearable suffering simply from being in the nursing home despite the woman being unable to communicate. There were no signs of distress. Both the Review Committee and the Board of Procurators General recommended no prosecution.¹⁶⁵

Since 2016 the Board has finalised 23 other cases¹⁶⁶ referred to it by the Euthanasia Review Committees including 8 cases of botched execution of assisted suicide or euthanasia where the wrong drugs were used, where the person was not fully sedated before being given possibly painful lethal drugs, or where no back up euthanasia drugs were brought and the person had to wait for some time after a failed attempt at assisted suicide. Five of these cases were dismissed unconditionally. In 3 cases the doctor was placed on one year probation.

Another 3 cases where the doctor failed to bring a backup second euthanasia kit and the person had to wait after a failed first attempt at euthanasia were all dismissed unconditionally.

Another case involved a doctor leaving the patient’s residence to return to his office after the patient ingested assisted suicide drugs. The patient died within 20 minutes. The doctor was placed on one year’s probation.

Four further cases involved questions about the independence of the consultant - all dismissed unconditionally.

Two cases involved a psychiatrist from the End of Life Clinic who went ahead with the euthanasia of patients with psychiatric disorders (one an autistic man who had attempted suicide four times after his mother’s death; the other a man with chronic paranoid schizophrenia) despite a finding by consultants that euthanasia was not justified. Both cases were dismissed unconditionally.

Four cases centred on whether or not the person met the eligibility criteria. Two of these were dismissed unconditionally. One of these involved a woman with poor lung function. The Board found that “living on the ground floor was not a reasonable alternative”. In the other two cases the doctor was given one year’s probation. In one of these cases a doctor from the End of Life Clinic went ahead with euthanasia despite the views of the patient’s neurologist and psychiatrist that further treatment

¹⁶⁴ Regionale Toetsingscommissies Euthanasie, *Jaarverslag 2015*, p. 47-48
https://www.nvve.nl/files/8414/6166/0719/RTE_jaarverslag2015DEF.pdf

¹⁶⁵ Regionale Toetsingscommissies Euthanasie, *Jaarverslag 2015*, p. 68-69
https://www.nvve.nl/files/8414/6166/0719/RTE_jaarverslag2015DEF.pdf

¹⁶⁶ <https://www.om.nl/onderwerpen/euthanasie/beslissingen-college/>

options were available for his mild Parkinson's disease, treatable anxiety and mood disorder. The man is still dead. He has no remedy for this lack of proper medical care.¹⁶⁷

The take home message is that even where the law on euthanasia is clearly breached the most sloppy, negligent or arrogant doctors face for unlawfully killing a person seems to be one year probation - that is essentially a good behaviour bond.

Euthanasia request by gestures

The Board of Procurators General of the Netherlands announced on 26 October 2018 that it has decided not to prosecute a doctor who performed euthanasia on a 72-year-old woman in April 2017 and to dismiss the case unconditionally. In this case it was determined contrary to the finding of the regional euthanasia Review committees - that hand squeezes, nods, eye blinking and crying (!) were all sufficient signs of a request for euthanasia from a woman who was drifting in and out of a comatose state for the doctor to go ahead with administering lethal injection.¹⁶⁸

In Case 2022-006 a woman is reported as requesting euthanasia for post-stroke issues, including a loss of speech and of autonomy, by responding "to closed questions with head movements".¹⁶⁹

Euthanasia despite resistance

The district court in the Hague has [ruled](#) that a person with dementia may be euthanased even if the person is actively resisting the process provided that an advanced directive requesting euthanasia was completed when the person was considered competent.¹⁷⁰

The case involved a 74-year-old woman whose coffee was drugged and who was forcibly restrained by family members while a doctor administered a lethal injection. She had said just a few days before that she didn't want to die.

However, the Court ruled that as she was now demented neither her contemporary expressions of a desire to live nor her active resistance were of any legal value. They were trumped by her previous written declaration.

The legal question posed by the case was stated by the Court:

¹⁶⁷ Regionale Toetsingscommissies Euthanasie, *Jaarverslag 2016*, p. 46

https://www.euthanasiecommissie.nl/binaries/euthanasiecommissie/documenten/jaarverslagen/2016/april/12/jaarverslag-2016/RTE_jaarverslag2016.pdf ;

¹⁶⁸ <https://www.dutchnews.nl/news/2018/10/doctor-will-not-be-prosecuted-for-euthanasia-of-woman-disabled-by-coma/> ; <https://www.om.nl/publish/pages/58699/2018-03.pdf>

¹⁶⁹ Regionale Toetsingscommissies Euthanasie Jaarverslag 2022, p. 33,

https://www.euthanasiecommissie.nl/binaries/euthanasiecommissie/documenten/jaarverslagen/2022/april/6/jaarverslag-2022/RTE_JV2022_def_2april.pdf

¹⁷⁰ Rechtbank Den Haag, Zoekresultaat - inzien document

ECLI:NL:RBDHA:2019:9506,

<https://uitspraken.rechtspraak.nl/inziendocument?id=ECLI:NL:RBDHA:2019:9506>

Does the physician have a duty to verify the current desire for life or death of an incapacitated, deeply demented patient in order to speak of a voluntary, well-considered request for euthanasia?

The Court's answer was a clear **no**.

The court is of the opinion that the doctor did not have to verify the current wish to die. The patient was deeply demented and completely incapacitated. The use of pre-medication [that is drugging her coffee] was discussed with the family and doctors and was not negligent in this case.

The written advanced declaration signed by the woman included the following paragraph:

*This euthanasia request remains in full force regardless of the time that may have elapsed since it was signed. **It is completely clear to me that I can withdraw this euthanasia request.** By signing this euthanasia request I therefore **consciously accept the possibility that a doctor will respond to the request, about which I might have started to think differently in the case of current awareness.***

There is an apparent contradiction in this paragraph. On the one hand the request can be withdrawn; on the other hand the doctor can act on the request even if the person has "started to think differently".

The Court essentially decided that as soon as a person with dementia becomes incapable of the level of decision making required to make a valid request for euthanasia, the person then can no longer validly revoke a previously made advanced directive for euthanasia.

In the opinion of the court, it would be contrary to the purport of the [euthanasia law] that a person who once became incapable of doing something would be able to revoke a legally valid euthanasia request previously made by him or her.

The Court considered evidence from the woman's GP who had met with her on 28 January 2016, three months before she was euthanased on 22 April 2016. The GP testified:

*I wanted to know what she was like and what she thought about this [euthanasia]. I asked how it went and she said "it goes well". I then asked about admission and euthanasia. She didn't know what that was, the euthanasia. I explained it to her and at that moment she said, "no, I don't want that." I explained to her that she would be admitted and that she had to stay there and that she had previously indicated that she did not want that and then **I started talking about euthanasia. She said: "yes, maybe I want it, but not now."** You ask what my impression of her was, if she still understood. No. (...) For me it was the moment that she did not know exactly what euthanasia meant. You ask if I had the impression that she understood me after I explained what euthanasia meant. Yes, because I explained it to her. Because of her reaction to this, I felt that she understood what I meant. (..)*

*Counsel asks me whether (patient) was competent on euthanasia on this day, 28 January 2016. Not as far as I can judge. You, Commissioner-in-Law, ask me to explain why not. Before my explanation of euthanasia, she did not know what it meant. I had to go so far that **I told her she would get an injection and not wake up. Only then did she say "no, no"**.*

The geriatrician who euthanased the woman testified about an exchange with her on 10 March 2016, just seven weeks before she was euthanased:

*(...) March 10, 2016 (...) Then I ask if she hates dementia. She does not recognize that word. I ask further whether she is troubled by the fact that she has less good memory and whether she finds it bad. She replies that she had that, but that this is already better, luckily. Then I ask her if she would rather be dead: yes, if I get sick, I will, **but not yet***

The Court dismissed medical guidelines requiring a doctor to check whether a person has a current desire before euthanasing him or her.

The court is aware that in the medical world guidelines have been drawn up about medical treatment in euthanasia in which the position is taken that the treating physician must also try to verify the patient's position on his current euthanasia desire even in the case of incapacitated persons. However, as is clear from the legal history cited above, that position is stricter than the law. From the point of view of medical care it may be advisable to speak with the person. However, the court was unable to see the need for this, let alone that there is a legal obligation to do so.

Any resistance can just be dismissed as "reflexive reactions that did not penetrate the consciousness of the patient."

In April 2020 the Review Committee amended the Euthanasia Code to reflect the Court findings as endorsed by the Supreme Court. The Euthanasia Code 2022 in a section headed "ADVANCE DIRECTIVE: POINTS TO CONSIDER " sets out the following points:

- Is the patient no longer capable expressing their wishes with regard to euthanasia?
- Was the patient decisionally competent with regard to euthanasia when they set out that request in their advance directive?
- Have the due care criteria been met to the greatest extent possible in the given situation? The physician must apply the due care criteria in a way that does justice to the exceptional nature of the case.
- Does the patient's current situation correspond to the situation described by the patient in their advance directive? The physician can interpret the advance directive with a view to determining the patient's intentions.
- Are there any contraindications that preclude the performance of euthanasia?
- Is the patient suffering unbearably?

- In addition to the independent physician, has the physician consulted an expert on the patient's conditions?
- Is premedication required? If no meaningful communication is possible with the patient, it is not necessary for the physician to consult with the patient about what method will be used (including the administration of premedication).

In Case [2022-043](#) a woman who had made an advanced declaration requesting euthanasia for dementia was given a sedative in her apple sauce and 45 minutes later killed by euthanasia.¹⁷¹

There were 9 cases of euthanasia based on an advanced directive in 2023. 8 cases involved a person with dementia and 1 involved a person with a cerebral haemorrhage.

In Case [2023-065](#) a man who had made an advanced directive requesting euthanasia for Alzheimer's Disease was administered drugs to "soothe the man before the execution" of euthanasia, the man was given 30 mg of midazolam by a regular trusted nurse. This was justified, according to the Review Committees, "due to the man's troubled behaviour and the possible manifestations of anger, frustration and physical aggression". "This caused the man to fall asleep. The doctor then performed the euthanasia in the presence of the wife and children in accordance with the Guideline."

There were 6 cases of euthanasia for dementia based on an advanced directive in [2024](#). In one of these cases the euthanasia proceeded one month after the man expressly stated that he would not "take an injection" that would cause his death. This was interpreted by a multidisciplinary "reflection meeting" as "an incidental statement, not a consistent and clear statement".¹⁷² In euthanasia by advanced directive for dementia "No" apparently does not mean "No".

Pressure from family members

Professor Theo Boer, who served on a regional euthanasia committee for 9 years says that 'In some instances there is pressure from the family.' From the 4,000 case files that have crossed his desk, Boer estimates that "the family is a factor with one in five patients. The doctor doesn't want to put it in the dossier; you need to read between the lines. Sometimes it's the family who go to the doctor. Other times it's the patient saying they don't want their family to suffer. And you hear anecdotally of families saying: "Mum, there's always euthanasia".'

Dr Ruben Van Coevorden, an Amsterdam physician who has performed euthanasia, believes Boer's figure of one in five is realistic: 'There was one case where a woman was dying and had terrible stomach pains, her doctor was tearing his hair out, and when I turned up at the house the family practically pinned me to the wall and said: "You need to give mum the jab now, she's in agony!" 'I discovered that her treatment wasn't working, she was on the wrong type of laxatives and was terribly constipated. I organised a palliative regime that made her more comfortable, and afterwards the

¹⁷¹ Regionale Toetsingscommissies Euthanasie Jaarverslag 2022, p. 53, https://www.euthanasiecommissie.nl/binaries/euthanasiecommissie/documenten/jaarverslagen/2022/april/6/jaarverslag-2022/RTE_JV2022_def_2april.pdf

¹⁷² Regionale Toetsingscommissies Euthanasie Jaarverslag 2024. P.58-59 <https://www.euthanasiecommissie.nl/binaries/euthanasiecommissie/documenten/jaarverslagen/2024/03/24/index/RTE-jaarverslag2024-DEF+17-3-25.pdf>

family were extremely grateful. She was close to dying anyway, but it allowed them to say goodbye in a better way.¹⁷³

Organ removal after euthanasia

28 cases of organ/tissue retrieval after euthanasia were reported in 2024 – up from 6 cases reported in 2022.

Child euthanasia (12-17 years of age)

Children as young as 12 years of age may be given euthanasia under the Netherlands euthanasia law.

For 12- to 15-year-old children the parents must agree with the child's request for euthanasia before it can put into effect. For 16- and 17-year-olds the parents must be involved but the decision is for the child alone.

A total of 21 children have been given euthanasia, including a **12 year old child** in 2005, a 16 year old child in 2015, five 17 year old children between 2002 and 2015, two children (aged 16 or 17 years) in 2016, three children in 2017 (one aged 16 or 17 years, other two cases no case report), three children (aged 16 or 17 years) in 2018, one boy (aged between 12 and 16 years) in 2020, one boy, aged 16-17 years in 2021, one child aged 12-15 years in 2022 and two children aged 16-17 years in 2023 and one child in 2024.

14 cases with detailed case reports involved end stage cancer.

The 2 cases in 2023 involved psychiatric disorders, including one case of a 16–17-year-old boy with autism who suffered from anxiety and suicidal ideation. Details (in Dutch) given in [Case 2024-037](#).¹⁷⁴

It is not known what the underlying condition was for the other five cases.

Child euthanasia (0-12 years of age)

The intentional termination of life without request remains unlawful in the Netherlands, but always subject to the possible defence available under Section 40 of the Netherlands Criminal Code:

Any person who commits an offence under the compulsion of an irresistible force shall not be criminally liable.¹⁷⁵

Since 2007 a regulation has been in force providing for the assessment by an expert committee of acts by a doctor to intentionally terminate the life of a newborn (a child under 1 year of age). Doctors who

¹⁷³ "Rise in euthanasia requests sparks concern as criteria for help widen", *DutchNews.nl*, 3 July 2015, <http://www.dutchnews.nl/features/2015/07/rise-in-euthanasia-requests-sparks-concern-as-criteria-for-help-widen> .

¹⁷⁴ [Oordeel 2024-037, zorgvuldig, psychiater, minderjarige patiënt, psychische stoornis, vrijwillig en weloverwogen verzoek, uitzichtloos en ondraaglijk lijden, geen redelijke andere oplossing. | Publicatie | Regionale Toetsingscommissies Euthanasie](#)

¹⁷⁵ https://www.legislationline.org/download/id/6415/file/Netherlands_CC_am2012_en.pdf

perform such life-ending acts are supposed to report the details to this committee, which then sends its assessment to the Public Prosecution Service for a decision on whether or not to prosecute.

Article 7 of the current regulation (which has been in force since 1 February 2016) states:

In the case of termination of life in a newborn, the doctor has acted carefully if:

a. in the opinion of the doctor, the newborn is suffering hopelessly and unbearably, which means, among other things, that cessation of medical treatment is justified, that is, according to prevailing medical opinion it is established that intervention is futile and that according to prevailing medical knowledge, there is no reasonable doubt about the diagnosis and the prognosis;

b. the doctor has fully informed the parents of the diagnosis and the prognosis and the doctor and the parents have come to the conclusion that, for the situation in which the newborn is, there is no other reasonable solution;

c. the parents have consented to the termination of life;

d. the doctor has consulted at least one other, independent doctor, who has expressed his opinion in writing about the aforementioned due care requirements, or, if an independent physician could not reasonably be consulted, has consulted the treatment team, which in writing has given its opinion on the aforementioned due care criteria;

e. the termination of life has been carried out with medical care.¹⁷⁶

Only three such cases have been considered by the committee since 2007.

In 2009, the committee approved as having acted carefully a doctor who ended the life of a 10-week 6 day old boy with Junctional Epidermolysis Bullosa (JEB) - generalised severe type by an injection of rocuronium.¹⁷⁷

A 2015 case was found not to involve the intentional termination of life without request.¹⁷⁸

In 2017 the ending of the life of an infant with a serious neurological disorder and life expectancy of less than 10 years performed by a doctor injecting 15 mg of rocuronium was assessed by the committee as the doctor having acted carefully.¹⁷⁹

In [2021](#), six children aged less than 1 year with congenital anomalies were killed by intentional by the administration of lethal drugs.

¹⁷⁶ Regulation for the Assessment Committee for Late Pregnancy Termination and Termination of life In Newborns, <https://www.lzalp.nl/documenten/regelingen/2016/januari/26/regeling-beoordelingscommissie-late-zwangerschapsafbreking-en-levensbeeindiging-bij-pasgeborenen>

¹⁷⁷ <https://www.lzalp.nl/publicaties/oordelen/lp/2009/lp-2009-001>

¹⁷⁸ <https://www.lzalp.nl/publicaties/oordelen/lp/2015/lp-2015-001>

¹⁷⁹ <https://www.lzalp.nl/publicaties/oordelen/lp/2017/lp-2017-001>

In January 2022 the Netherlands Minister for Justice and Security to extend the regulation to cover children aged between 1 and 12 years of age. The Public Prosecution Service replied to the Minister with an analysis rejecting this proposed extension.¹⁸⁰

However, on 14 April 2023 the Minister for Health, Welfare and Sport [announced](#) that the existing regulation would be broadened before the end of 2023 to apply to children aged up to 12 years and streamlined to allow for more ready approvals to euthanase children.

Assisted suicide for “completed life”

On 12 October 2016 the Netherlands Government formally reported to the Parliament its response to the February 2016 report of a commission on assisted suicide for “completed life”.¹⁸¹ The report considered the possibility of expanding the law to specifically provide for legalised assisted suicide for people who felt their life was complete but who did not qualify under the existing law because there was no medical basis for the feeling that life was an unbearable burden. The report suggested that in most cases such people could be accommodated under the existing law by the increasingly broad interpretation being given to its requirements.

However, the government’s response, cosigned by Edith Schippers, Minister of Health, Welfare and Sport and Ard van der Steur, Minister of Security and Justice, proposed a new law – to be drafted in 2017 – to specifically legalise assisted suicide for those who feel that their life is complete and who wish to die in cases where there is no underlying medical basis for this feeling.

The government proposes the creation of a new category of community worker – *stervenshulpverlener* – a death worker, whose role would be to assess whether the person’s request for assisted suicide was voluntary and persistent and that there were no reasonably available medical or social measures to relieve the feeling that life was a burden.

The government response points out that the existing law on euthanasia is premised on a doctor being confronted with a patient who has unbearable suffering that cannot be relived other than by deliberately ending the patient’s life. Euthanasia is portrayed as an act of mercy.

The government response suggests that for persons who feel that they have completed their life and that to continue living it is a burden the State also can facilitate an act of mercy – namely after approval by a death worker and confirmation by a second death expert, facilitating assisted suicide.

There is a suggestion that as this feeling of completed life is most common in elderly people it would be in order to impose a minimum age limit but no indication is given as to what this might be.

¹⁸⁰ <https://www.om.nl/documenten/wetgevingsadviezen/2022/4/11/ontwerpregeling-levensbeeindiging-kinderen-1-tot-12-jaar>

¹⁸¹ Kamerbrief over Kabinetsreactie en visie Voltooid Leven, 12 Oct 2016, <https://www.rijksoverheid.nl/binaries/rijksoverheid/documenten/kamerstukken/2016/10/12/kamerbrief-over-kabinetsreactie-en-visie-voltooid-leven/kamerbrief-over-kabinetsreactie-en-visie-voltooid-leven.pdf> ; Rapport Adviescommissie Voltooid leven, 4 February 2016, <https://www.rijksoverheid.nl/binaries/rijksoverheid/documenten/rapporten/2016/02/04/rapport-adviescommissie-voltooid-leven/01-adviescommissie-voltooid-leven-voltooid-leven-over-hulp-bij-zelfdoding-aan-mensen-die-hun-leven-voltooid-achten.pdf>

Conclusion

The failed euthanasia experiment in the Netherlands has demonstrated that legalised euthanasia rapidly expands from a few hard cases to become the normal way to die - including for people struggling with mental illness or trying to adjust to the usual frailties of old age. It also emboldens some doctors to readily kill their patients without any request from the patient and even in the face of active resistance from the person.

Luxembourg (2009-)

Euthanasia and assisted suicide have been legal in Luxembourg since 2009. The person requesting euthanasia or assisted suicide must have a serious, incurable and irreversible affliction which leads to unbearable physical or mental suffering.

The [eight biennial report](#) by the National Commission for Control and Evaluation covering 2023-2024 was published in October 2025.

There were 22 cases of euthanasia in 2023 and 34 cases in 2024 – slightly fewer over the two years than the 58 in 2021-22. This brings the total number of cases from 2009-2024 to 226.

In 2024 euthanasia accounted for 0.69% of all deaths in Luxembourg.

Most cases involved euthanasia by lethal injection, except for seven cases in total of assisted suicide by oral ingestion of a barbiturate.

The euthanasia law allows for euthanasia of an unconscious person following a written advanced directive registered with the Commission. 6,107 people have completed such a directive. There was one case in 2011 of euthanasia giving effect to an advanced directive, five cases in 2021, four in 2022 and one in 2023. In these circumstances, there is no requirement for suffering but only for a serious and incurable condition.

In 2020 the Commission approved (after the fact) the euthanasia of a 96-year-old man based on “fatigue of life” combined with poly pathology, citing the Belgian practice.

The law requires that the person have unbearable suffering that cannot be relieved. This is [assessed largely on a subjective basis](#):

“In most cases, many types of suffering, both physical and mental were present simultaneously. Sufferings have all been described as constant, unbearable and without prospect of improvement.

While certain objective factors can contribute to the estimation of the constant character, unbearable nature and lack of any prospect of improvement of suffering, it is largely subjective and depends on the personality of the patient, and his or her own conceptions and values.”¹⁸²

The Commission would like to see training in euthanasia for all health professionals in Luxembourg as well as the establishment of a specialist euthanasia service as exists in Belgium and the Netherlands. It wants all pharmacies to have euthanasia kits in stock.

Although there is a right for individual doctors to refuse to participate in euthanasia the Luxembourg government and the Commission [agree](#) that:

“Freedom of conscience is an individual and not an institutional freedom. Thus, no hospital establishment can validly invoke this freedom to refuse to allow a doctor to practice within that institution euthanasia or assisted suicide, when the conditions laid down in the law are fulfilled.

At the level of integrated centers for the elderly (aged care homes), it should be noted that the rights of people with serious and incurable conditions are themed as part of the annual accreditation visits. In case of refusal on the part of an institution of the practice of assisted suicide, it is obliged to inform

¹⁸² <http://sante.public.lu/fr/publications/r/rapport-loi-euthanasie-2015-2016/index.html>

any user before signing the hosting contract. If such is not the case, the center cannot refuse a request for assistance to the suicide from a user ".¹⁸³

The Commission supports euthanasia for psychiatric conditions and asserts that the law permits this although there has not yet been a case.

The Commission also states that discussion on extending the law to allow the euthanasia of minors should not be taboo.

¹⁸³ Ibid.

Washington State (2009-)

Washington State's *Death With Dignity Act*, based on Oregon's, came into operation on 9 March 2009. It was significantly amended effective from 23 July 2023.

The amended Act allows for one of the two "qualified medical providers" who "medically confirm" that the applicant has a terminal illness which "will, within reasonable medical judgement, produce death within six months" to be a "physician assistant" or "advanced registered nurse practitioner".

The two assessing medical providers must not have "a direct supervisory relationship with each other".

Physician assistants in Washington operate under the provisions of Chapter 18.71A of the Revised Washington Code. It provides for physician assistants "to practice medicine according to a practice agreement with one or more participating physicians, with at least one of the physicians working in a supervisory capacity." There is nothing in the Act to prevent a physician assistant signing off as the second medical provider on an assisted suicide assessment made by one of the participating physicians at the same practice who is not the direct supervisor of the physician assistant.

The provision treating an assessment by a "physician assistant" that a person will die within six months as a making that prognosis "medically confirmed" necessarily increases the risk of wrongful deaths from errors in [diagnosis](#) and [prognosis](#). The evidence set out below indicates that even where the two assessing medical providers were physicians, between 5% and 17% of applicants for assisted suicide assessed as dying within six months outlived this erroneous prognosis.

The amendments also reduced the required waiting period between an initial request and a final written request from 15 days to 7 days, and also abolished the further 48 hours previously required between a final written request and the writing of the prescription for the lethal substance.

Increase in numbers

Deaths from lethal substances prescribed under the Act increased more than eightfold from 51 in 2010 to 427 in 2023, accounting for 0.64% of all deaths in Washington that year¹⁸⁴

Lethal substances unaccounted for in the community

Not all of those who are prescribed lethal drugs end up taking them. Some die of natural causes.

There is no tracking of lethal drugs that are not used by those for whom they are prescribed so these lethal drugs are available in the community and could be used accidentally or intentionally to cause death.

Pain control not the issue but being a burden is

59% of those for whom a prescription for lethal substances was provided in 2023 did not cite any concern about pain control as a reason for asking for the prescription.

However, 51% cited concerns about being a burden on family, friends or caregivers and 10% cited concerns about the financial implications of treatment.¹⁸⁵

¹⁸⁴ <http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct/DeathwithDignityData>

¹⁸⁵ <https://doh.wa.gov/sites/default/files/2025-01/422-109-DeathWithDignityAct2023.pdf>

Poor screening for mental health and short term doctor patient relationships

In 2018 just 4% of those given a lethal prescription were referred to a psychiatrist or psychological for evaluation. For 2023 the numbers referred were so low that the data had to be suppressed under the “Department Small Numbers Guidelines”!

The amendments to the Act which came into effect in July 2023 now allow for the referral for a mental health screening to made to a social worker, a mental health counsellor or a psychiatric nurse practitioner. This can only increase the risk of [wrongful deaths](#) of those with mental illness.

In 2018 in some cases the prescribing doctor knew the patient for less than a week before writing the prescription, and in half the cases (50%) the doctor knew the patient for less than 25 weeks.¹⁸⁶

This information is not provided in the annual reports from 2019 onwards.

Faulty prognosis

Although the Act specifies that only persons who have a disease that will “produce death within six months” may request lethal doses of medication from a physician, the data shows that in each year between 5% and 17% of those who die after requesting a lethal dose do so more than 25 weeks later with one person in 2012 dying nearly 3 years (150 weeks) later, one person in 2015 dying nearly two years later (95 weeks); one person in 2016 dying more than two years (112 weeks) later and one person in 2018 dying more than two years (115 weeks) later.¹⁸⁷

From 2019 this information is not available. The 2023 annual report only states that 6% of those who died after being prescribed a lethal dose died more than 120 days (four months) after first request.¹⁸⁸

Not a peaceful death

In 2018 one person took one full day and six hours (30 hours) to die after ingesting the lethal dose. In 2017 one person took 6 hours to lose consciousness after ingesting the lethal dose and one person took 35 hours to die after ingesting the lethal dose. In 2016 one person took 11 hours to lose consciousness after ingesting the lethal dose. In 2015 one person took 72 hours (3 days) to die after ingesting the dose. In 2013 one person took 3 hours to lose consciousness after ingesting the lethal dose and one person took 41 hours (1 day and 17 hours) to die after ingesting the dose. In 2009 two people awakened after initially losing consciousness. In 2014 one person suffered seizures after ingesting the lethal medication. At least 18 patients have regurgitated the lethal medication. Seven of these cases occurred in 2016 alone. In 2018 some 8 people (4.25% of those for whom information is available) experienced “Regurgitation, Seizures, Awakening or Other” complications. The report does not specify how many people experienced each of these.¹⁸⁹

This may be related to the use of new experimental cocktails of lethal drugs being used since the price of the previously used drugs, secobarbital and pentobarbital (Nembutal), escalated.

¹⁸⁶ Ibid., Table 3 on p.12

¹⁸⁷ Washington State Department of Health, *Death with Dignity Act Reports, 2009-2018* available at: <http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct/DeathwithDignityData>

¹⁸⁸ <https://doh.wa.gov/sites/default/files/2025-01/422-109-DeathWithDignityAct2023.pdf>

¹⁸⁹ Washington State Department of Health *2018 Death with Dignity Act Report*, Table 4 on p. 13, <https://www.doh.wa.gov/Portals/1/Documents/Pubs/422-109-DeathWithDignityAct2018.pdf>

The first of the new cocktails is a mix of phenobarbital, chloral hydrate and morphine sulfate. It was prescribed in 88 cases in 2015 and 106 cases in 2016 but no longer prescribed in 2017 no doubt due to the fact that it was found to be very caustic and to cause a profound burning in the throat.¹⁹⁰

The second experimental cocktail includes morphine sulfate, propranolol, diazepam, digoxin and a buffer suspension. It was prescribed used in 4 cases in 2015, 53 cases in 2016, 130 cases (66%) in 2017 and 195 (78%) in 2018.¹⁹¹

The annual reports from 2019 onwards do not report on complications, on which lethal drugs were used or on the full range of times between ingestion and loss of consciousness or ingestion and death. In 2023, 23 people (6.5%) took between 10 and 20 minutes to lose consciousness, and perhaps 5 more took more than 20 minutes (but how much longer is not reported). 17.75% of people took more than two hours to die, but how much longer than 2 hours is not reported.¹⁹²

If they struggled who would know?

There is no requirement under the Act for a physician or any other person to be present when the lethal dose is ingested. Between 2009 and 2018 there were 240 cases where no health-care provider was present when the lethal dose was ingested and a further 178 cases where it is not known if a health-care provider was present.¹⁹³ In other words in some 418 cases people have died ingesting a dose of lethal medication, legally prescribed under Washington law, and nobody knows whether the person freely ingested the lethal dose or they were cajoled, coerced or forced to do so by another person.

Failure to enforce compliance

As of 26 May 2022, for 46 out of 400 applicants who were prescribed a lethal substance in 2021 the most basic document – the Written Request for Medication to End Life Form – had not been received although it is a legal requirement that the attending physician do so within 30 days of writing the prescription. No disciplinary action seems to ever have been taken to address this significant rate (11.5%) of non-compliance with the law.

Conclusion

Washington continues its experiment with prescribing various cocktails of lethal drugs to be taken, often with no witness present, leaving people at risk of distressing complications and at risk of being killed by a family member or someone else interested in their early death.

It has reduced the information contained in its annual reports since 2019, continues to fail to enforce compliance despite a significant rate of basic non-compliance by attending physicians, and from July

¹⁹⁰ JoNel Aleccia, "In Colorado, a low-price drug will tamp down cost of death", *USA Today*, 15 Dec 2016, <https://www.usatoday.com/story/news/2016/12/15/kaiser-colorado-low-price-drug-cocktail-tamp-down-cost-death-dignity/95490168/>

¹⁹¹ Washington State Department of Health *2016 Death with Dignity Act Report*, p. 9, <https://www.doh.wa.gov/Portals/1/Documents/Pubs/422-109-DeathWithDignityAct2016.PDF>

¹⁹² Washington State Department of Health *2021 Death with Dignity Act Report*, Table 3 on p.8-9, <https://doh.wa.gov/sites/default/files/2022-11/422-109-DeathWithDignityAct2021.pdf>

¹⁹³ Washington State Department of Health, *Death with Dignity Act Reports, 2009-2018* available at: <http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct/DeathwithDignityData>

2023 amended the law in a manner likely to increase wrongful deaths from errors in diagnosis and prognosis as well as of those with mental illness.

In 2025 it was [announced](#) that due to funding cuts the annual report for 2024 would be the final report.

Vermont (2013-)

On 20 May 2013 the Governor of Vermont signed into law the *Patient Choice and Control at End of Life Act*. The Act permits Vermont physicians to prescribe lethal medication to terminally ill patients.

Suicide normalised

On 20 May 2014 a community organisation, True Dignity Vermont, [reported that since the law was enacted two clinical psychologists had cases of patients believing suicide was now a more acceptable option](#). Additionally, an 85-year-old Korean war veteran from New Jersey suffering depression was seeking information on getting a lethal prescription in Vermont.¹⁹⁴

These reports confirm the obvious: assisted suicide laws tend to **normalise suicide for everyone** not just those who formally qualify under the law.

Pressure to request assisted suicide

[Beth Neill reports that her elderly mother](#), who was in a care facility for four months for rehabilitation after a fall, was continually reminded by staff of her right to request assisted suicide, even though legally she would not qualify.

Clinicians at the Berlin Health and Rehab Center informed her mother at regular intervals during her 4-month stay there that she had a “right” to request assisted suicide, and that, “*She didn’t even have to discuss it with her family.*” This act of repeatedly bringing up this possibility as a health care “option” that caused her mother to feel pressure. Neill said that her mother had made it clear she wanted nothing to do with assisted suicide and was disturbed that staff re-introduced the topic repeatedly.

Neill notes that her mother was, and is, in otherwise surprisingly good health for her age, and would not have qualified for Act 39, as the extended stay in Berlin Health and Rehab was strictly for help recovering from her fall.¹⁹⁵

Minimalist reporting

Compared even to Oregon and Washington, the official statistical reports on assisted suicide in Vermont are extremely minimalist.

Four reports have been issued to date. The [first](#) covered 31 May 2013 to 30 June 2017, the [second](#) covered 1 July 2017 to 30 June 2019, the [third](#) covers 1 July 2019 to 30 June 2021, and the [fourth](#) covers 1 July 2021 to 30 June 2023.¹⁹⁶

All we can learn from these reports is that over this ten-year period 203 prescriptions were issued under the Act for 153 cancer cases; 26 cases of neurodegenerative disease; 6 for end stage lung

¹⁹⁴ <http://www.truedignityvt.org/assisted-suicide-law-one-year-later/>

¹⁹⁵ <http://www.truedignityvt.org/from-the-netherlands-to-vermont-patients-under-pressure-to-die/>

¹⁹⁶ <https://legislature.vermont.gov/assets/Legislative-Reports/2018-Patient-Choice-Legislative-Report-12-14-17.pdf> ; <https://legislature.vermont.gov/assets/Legislative-Reports/2020-Patient-Choice-Legislative-Report-2.0.pdf> ; <https://legislature.vermont.gov/assets/Legislative-Reports/2022-Patient-Choice-Legislative-Report-Final.pdf> ; <https://legislature.vermont.gov/assets/Legislative-Reports/Patient-Choice-Legislative-Report-Final.pdf>

disease; and 5 for end stage heart disease. A further 12 cases were for one or more unspecified conditions.

In Oregon lethal prescriptions have been written for conditions not usually considered terminal such as diabetes and anorexia. It is not clear whether this is the case in Vermont given the limited reporting.

Of these 203 cases for which prescriptions for a lethal substance were written in 146 cases the “mechanism of death” is reported as having “died by Patient Choice” (Vermont newspeak for having ingested the lethal substance).

The phrase “mechanism of death” is a neologism to avoid referring accurately to the manner of death. The reports all state that “100% of the death certificates listed the appropriate cause (the underlying disease) and manner of death (natural), per Act 39 requirements.”

This is curious as Act 39, as passed, does not include the provision in the bill as introduced requiring the “manner of death” following ingestion of a lethal substance to be falsely recorded as “natural”.

Even more curious is how in those cases where the mechanism of death is reported as unknown or as from “other causes” the death certificate can still specify the manner of death as “natural”.

The data is not broken down further by age, sex or by year of death although this data is collected.

No information is collected in Vermont on the reasons for requesting assisted suicide (apart from the underlying condition); on complications; on the substance prescribed; on the length of time from prescription to ingestion, from ingestion to unconsciousness, or from ingestion to death; or on the duration of the patient-doctor relationship.

Death tourism

In May 2023, Act 10 (2023) was enacted, removing the requirement that only Vermont residents have access to the prescription of a lethal substance under the Patient Choice Act.

Conclusion

Vermont’s experiment with assisted suicide has yielded no useful official data but anecdotal evidence points to suicide contagion and the fostering of a cavalier attitude among some clinicians towards the elderly, actively encouraging access to assisted suicide instead of promoting a culture of care.

California (2016-)

California's [End of Life Option Act](#), which legalised assisted suicide, came into effect on 9 June 2016.¹⁹⁷ It was amended by [SB380](#) with effect from 1 January 2022.

The Act requires an annual report with very minimal data. The latest annual report covers [2024](#)¹⁹⁸.

Number of deaths

The 2024 annual report so far reports the deaths of 1032 people under the Act. This represents 0.36% of all deaths in California (up 28.6% from 2022)

However, the number of people reported each year to have died from ingesting lethal substances prescribed under the Act gets revised in each subsequent report, so this is likely to be significantly less than the real number of deaths by assisted suicide for 2024.

For example, the number initially reported for 2019 (405) was revised upwards each year and is now (2024) reported as 504.

Reported deaths by assisted suicide in 2022 accounted for 0.451% of all deaths of white Californians – 30 times the rate for blacks (0.015%) and 14 times the rate for Hispanics (0.033%).¹⁹⁹

Mental health

Although there is a requirement in the [Act](#) that “If there are indications of a mental disorder, the physician shall refer the individual for a mental health specialist assessment” and, if such a referral is made for the physician to report this to the California Department of Public Health, the annual reports do not contain any information about whether any such referrals occurred.

Complications

There is a [follow up form](#) which must be completed and returned to the California Department of Public Health by the “attending physician”, that is the physician who writes the prescription for the lethal substance, within 30 days of the death of the person whether from ingesting the lethal substance, from the underlying illness or other causes.²⁰⁰

In the case of those people who die from ingesting the lethal substance and for whom a licensed health care provider was present at the time of death this form also seeks information on the length of time between ingestion and unconsciousness and between ingestion and death, as well as any complications that occurred.

¹⁹⁷ https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520162AB15

¹⁹⁸ https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/CDPH_End_of_Life_Option_Act_Report_2024.pdf

¹⁹⁹ Deaths by sex and ethnicity from: [Statewide Death Profiles - 2014-2022 Final Deaths by Year Statewide - California Health and Human Services Open Data Portal](#)

²⁰⁰ [https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/EOL%20Attending%20Physician%20follow-up%20form%20\(fillable\).pdf](https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/EOL%20Attending%20Physician%20follow-up%20form%20(fillable).pdf)

However, no information on complications, or length of time between ingestion and unconsciousness and between ingestion and death has so far been included in the annual reports or otherwise published.

In 3,075 (56.7%) of the 5,423 deaths by ingestion of a lethal poison reported to 2024, there was no health care provider known to be present. In these cases, we will never know if there were any complications. Nor will we know if the person ingested the lethal poison voluntarily or was forced, cajoled, pressured or tricked into doing so.

Reasons for request

In all cases the form also seeks information on the concerns that may have contributed to the patient's decision to request a prescription for a lethal substance including a concern about: His or her terminal condition representing a steady loss of autonomy; The decreasing ability to participate in activities that made life enjoyable; The loss of control of bodily functions; Persistent and uncontrollable pain and suffering; A loss of Dignity.

None of this information has been reported in the published annual reports although the Act does not preclude the publication of this data.

Final attestation

The Act initially provided that “Within 48 hours prior to the individual self-administering the aid-in-dying drug, the individual shall complete the final attestation form. If aid-in-dying medication is not returned or relinquished upon the patient’s death as required in Section 443.20, the completed form shall be delivered by the individual’s health care provider, family member, or other representative to the attending physician to be included in the patient’s medical record.”

There was no penalty for failure to comply with this provision. The annual reports did not give any information as to whether final attestation forms were received for all 2,422 people who were reported as dying from lethal substances prescribed under the Act up until 2021.

The requirement for a final attestation was abolished from 1 January 2022.

Automatic repeal

One feature of the initial Act was that it “shall remain in effect only until 1 January 2026, and as of that date is repealed”. This repeal date has now been extended to 1 January 2031.

Aiding, advising or encouraging suicide now lawful

California used to have an absolute prohibition against aiding, advising or encouraging suicide.

Until 5 September 2018 section 401 of its Penal Code provided that:

Every person who deliberately aids, or advises, or encourages another to commit suicide is guilty of a felony.

Since 5 September 2018 **this absolute prohibition has been eroded by an exception.**

Section 401 now reads:

(a) Any person who deliberately aids, advises, or encourages another to commit suicide is guilty of a felony.

(b) A person whose actions are compliant with the provisions of the End of Life Option Act (Part 1.85 (commencing with Section 443) of Division 1 of the Health and Safety Code) shall not be prosecuted under this section.

California's *End of Life Option Act* facilitates the request and ingestion of lethal substances in order to commit suicide. It is available for anyone who is said to have "an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, result in death within six months".

Section 443.17 of the *End of Life Option Act* does provides that:

Knowingly coercing or exerting undue influence on an individual to request or ingest an aid-in-dying drug for the purpose of ending his or her life or to destroy a withdrawal or rescission of a request, or to administer an aid-in-dying drug to an individual without his or her knowledge or consent, is punishable as a felony.

There is a **significant gap** between "knowingly coercing or exerting undue influence" and *deliberately advising, or encouraging* a person to commit suicide.

This change to California's Penal Code makes it lawful for a person to deliberately advise and encourage a person to request and/or subsequently to ingest a lethal substance in order to kill herself, provided only that the intensity or manner of the advising and encouragement falls just short of "knowingly coercing or exerting undue influence".

An impatient heir – or anyone else who wanted a person dead - could almost certainly get away with repeatedly and persuasively suggesting that the person make a request for a lethal substance or later, having been supplied with the lethal substance, to take it.

Financial issues

[Stephanie Packer](#), a wife and mother of four who was diagnosed with a terminal form of scleroderma, said her insurance company initially indicated it would pay for her to switch to a different chemotherapy drug at the recommendation of her doctors.

But shortly after California's *End of Life Option Act* went into effect, Ms. Packer's insurance company had a change of heart.

"And when the law was passed, it was a week later I received a letter in the mail saying they were going to deny coverage for the chemotherapy that we were asking for," Ms. Packer said.

She said she called her insurance company to find out why her coverage had been denied. On the call, she also asked whether suicide pills were covered under her plan.

"And she says, 'Yes, we do provide that to our patients, and you would only have to pay \$1.20 for the medication,'" Ms. Packer said.

Ms. Packer said her doctors have appealed the insurance company's decision twice, to no avail. She said **the assisted-suicide law creates an incentive for insurance companies to deny terminally ill patients coverage.**²⁰¹

[Dr Brian Callister](#), associate professor of internal medicine at the University of Nevada, said he tried to transfer two patients to California and Oregon for procedures not performed at his hospital. Representatives from two different insurance companies denied those transfer requests by phone, he said.

The patients were not terminal, but “would have become terminal without the procedures.”

And in both cases, the insurance medical director said to me, "Brian, we're not going to cover that procedure or the transfer, but would you consider assisted suicide?" "

The phone calls took place last year within the span of a month, Dr. Callister said. He said he did nothing to prompt the suggestion in either case.²⁰²

Cooling off period

As from 1 January 2022, the final request for the prescription and supply of a lethal substance to end life can now be made 48 hours after the initial request – compared to the 15 days initially required. In 2024, 79.8% of applicants waited less than 15 days between the initial and final requests.

Shortening the gap between an initial request and the act of suicide with a prescribed lethal substance necessarily increases the risk of wrongful deaths, particularly of those who are experiencing depression or other mental health issues as result of a terminal diagnosis or some other change in their circumstances. With more time to adjust the wish to die by ingesting a lethal poison may fade.

For those for whom death is truly imminent – within a few days – surely the better approach is to make them comfortable through palliative care rather than hazarding a suicide by ingesting an experimental lethal substance that cannot, in any case, be guaranteed to bring about a rapid, peaceful, painless death.

Conclusion

California's experiment with assisted suicide includes allowing others (including impatient heirs) to deliberately advise and encourage a person to request and/or subsequently to ingest a lethal substance in order to kill herself.

Not even all of the minimal data required to be reported by physicians is being made public.

Californians are being denied health insurance coverage for treatment but being offered payment for assisted suicide instead.

²⁰¹ <https://www.washingtontimes.com/news/2016/oct/20/assisted-suicide-law-prompts-insurance-company-den/>

²⁰² <https://m.washingtontimes.com/news/2017/may/31/insurance-companies-denied-treatment-to-patients-o/>

Canada (2015-)

History of legalisation

On 21 April 2010 the Canadian House of Commons [defeated](#) *Bill C-384 An Act to amend the Criminal Code (right to die with dignity)* by 228-59.²⁰³

The Quebec National Assembly passed an [“An Act respecting end-of-life care”](#) by a vote of 94-22. It came into effect on 10 December 2015. This Act permits euthanasia on the request of an adult who is *“at the end of life; with a serious and incurable illness; and in an advanced state of irreversible decline in capability”*.²⁰⁴

On 6 February 2015 the Supreme Court of Canada in [Carter v Canada \(Attorney General\)](#) declared that provisions in the Canadian Criminal Code making it an offence to aid or abet suicide “unjustifiably infringe” section 7 [*“Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.”*] of the Charter of Rights and Freedoms *“and are of no force or effect to the extent that they prohibit physician-assisted death for a competent adult person who (1) clearly consents to the termination of life and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition.”* The declaration was suspended for a year, giving the opportunity for the Parliament to amend the offending laws by providing a scheme for physician assisted suicide.

The core paragraph in the judgement reads that *“The right to life is engaged where the law or state action imposes death or an increased risk of death on a person, either directly or indirectly. Here, the prohibition deprives some individuals of life, as it has the effect of forcing some individuals to take their own lives prematurely, for fear that they would be incapable of doing so when they reached the point where suffering was intolerable. The rights to liberty and security of the person, which deal with concerns about autonomy and quality of life, are also engaged. An individual’s response to a grievous and irremediable medical condition is a matter critical to their dignity and autonomy. The prohibition denies people in this situation the right to make decisions concerning their bodily integrity and medical care and thus trenches on their liberty. And by leaving them to endure intolerable suffering, it impinges on their security of the person.”*²⁰⁵

The argument based on the right to life is specious as it takes no account of the inevitability that a law permitting euthanasia will result in [wrongful deaths](#) based on medical errors, coercion, discrimination against or differential treatment of the disabled and mentally ill and suicide contagion.²⁰⁶

²⁰³ <http://openparliament.ca/bills/votes/912/>

²⁰⁴ <http://legisquebec.gouv.qc.ca/en/pdf/cs/S-32.0001.pdf>

²⁰⁵ <https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/14637/index.do>

²⁰⁶ https://www.australiancarealliance.org.au/wrongful_categories

The argument from liberty, if pressed to its logical conclusion, would require a law permitting assisted suicide or euthanasia on request by any person, including a minor, with capacity.

The argument from security is based on [a false claim](#) that pain and other physical symptoms cannot be relieved by best practice palliative care.²⁰⁷

In response to the Supreme Court judgment, the Canadian parliament passed [Bill C-14](#) which came into effect on 17 June 2016 and legalised euthanasia and assisted suicide on request for any adult who has “*a serious and incurable illness, disease or disability*”; is in “*an advanced state of irreversible decline in capability*”; and whose “*natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining*”.²⁰⁸

“Death be reasonably foreseeable”

The Canadian law required that “death be reasonably foreseeable”. The decision of the Ontario Superior Court of Justice in [AB v Attorney General of Canada](#) delivered on 19 June 2017, in paragraph 81, interpreted this requirement as **not requiring any connection whatsoever** between the underlying conditions for which euthanasia is sought and the reasonable foreseeability of death – which can be based simply on advanced age. The woman in this case was 79 years old.²⁰⁹

On 11 September 2019, the Quebec Superior Court, in the case of *Truchon c. Procureur général du Canada*, [invalidated](#) the relevant provisions in the Canadian law which limiting euthanasia to cases where “natural death has become reasonably foreseeable” and the Quebec law which required that the person be “at the end of life”. The effect of this decision was suspended for six months.

The Canadian Government introduced [Bill C-7](#) into the House of Commons in February 2020 to give statutory effect to the decision. The Bill passed with some amendments and became law on 21 March 2021.

From that date there is no longer a requirement that death be reasonably foreseeable.

732 cases of euthanasia where “death was not reasonably foreseeable” were reported for 2024 – an increase of 38.4% from 2023. Notably 56.7% of these cases involved women, so women, whose death is not reasonably foreseeable, are being euthanased at numbers 31% higher than men.

The official report is relaxed about this higher rate of killing women who are not dying claiming it is “consistent with overall population health trends where women experience long-term chronic illness, which can cause enduring suffering but would not typically make a person’s death reasonably foreseeable”.

²⁰⁷ https://www.australiancarealliance.org.au/access_to_palliative_care

²⁰⁸ https://laws-lois.justice.gc.ca/PDF/2016_3.pdf

²⁰⁹ <https://www.canlii.org/en/on/onsc/doc/2017/2017onsc3759/2017onsc3759.pdf>

Increase in numbers

In December 2025 the [Sixth Annual Report on Medical Assistance in Dying in Canada](#) was published. It stated that there had been 16,499 reported cases of euthanasia and assisted suicide in 2024, bringing the total of such deaths since legalisation to 76,800.

The number of cases each year has increased more than five and a half fold (581%) in the 8 years from 2,838 in 2017, the first full year of legalisation, to 16,499 in 2024 with annual increases of 57.8% (2018); 26.4% (2019) 34.2% (2020); 32.4% (2021); 31.2% (2022); 15.8% (2023) and 7.5% (2024).

“Fewer than seven” cases of assisted suicide have occurred each year since 2019 with “fewer than five” in 2023 and not a single case in 2024. Canadian practice overwhelming uses euthanasia. The [2019 report](#) states that “providers are less comfortable with self-administration [assisted suicide] due to concerns around the ability of the patient to effectively self-administer the series of medications, and the complications that may ensue”.

In 2024 euthanasia and assisted suicide accounted for 5% of all deaths in Canada. Provincial rates of euthanasia are highest in Quebec (7.6%) and British Columbia (6.76%).

The [latest report](#) on euthanasia in Quebec covers 1 April 2024-31 Mar 2025. It states that there were 6,268 people euthanased in that 12-month period, representing 7.9% of all deaths in Quebec. Rates vary across the 18 Region sociosanitaire of Quebec – with 13.4% in Lanaidiere (including the city of Joliette); 10.6% on Bas-Saint-Laurent and 10.4% in Nationale-Capitale (Quebec city).

Unreported cases

There was a discrepancy of 289 cases (7.3%) of euthanasia between the number of official reports received (3,663) and the number of cases reported by institutions (3,629) and the College of Physicians (323) in Quebec for April 2021 to March 2022, suggesting a failure by physicians to report all cases to the Commission as required by law. The report suggests that a partial explanation may be double reporting through an institution and to the College of physicians and says it will investigate. However, the report does not refer to any results of investigation from a similar discrepancy in previous years reports.

The discrepancy in the April 2023 to March 2024 report was 157 (2.7%). If the 5874 reported by institutions and the College is the correct figure then the rate of euthanasia in Quebec would be 7.5% of all deaths (not 7.3%).

Failure to comply with the legal processes

According to the [report](#) for Quebec for April 2023-March 2024, 20 cases failed to comply with the law, including:

- Thirteen cases where the person did not have a grave and incurable condition;
- Three cases where the person was unable to give consent at the time euthanasia was administered;
- Two cases where there was no confirmation of eligibility from a second practitioner;
- One case where the signature on a form was provided by unqualified persons; and
- One case where the person was not insured as required under the law.

Of course, there is no remedy for the 20 people who were illegally killed.

Underlying conditions

Very limited data is provided on the “main condition” for which euthanasia is performed.

In 2022, for 8.3% of cases the “main condition” is reported as “multiple comorbidities” and a further 14.9% as “other conditions” - that is other than cancer, cardiovascular, respiratory, neurological or organ failure – together accounting for 23.2% of all cases. For these two categories combined, 25% of cases involved “frailty” and 11.9% involved diabetes. Other conditions cited included vision or hearing loss, tendency to falls; and difficulty swallowing.

In 2023, there was no reporting on multiple comorbidities, which were presumably now included under “other conditions”, which accounted for 4,255 cases of euthanasia - 27.77% of all cases.

There were 92 cases where frailty was the sole condition; 23 cases where chronic pain was the sole condition and 106 cases where dementia was the sole condition, including 25 under Track 2 (death not reasonably foreseeable).

In 2024, for women the “other conditions” category now accounts for nearly one out of three (31%) deaths by euthanasia where death from the condition is considered to be reasonably foreseeable and 57.8% of cases where death is not reasonably foreseeable.

The 2024 report states “The conditions provided for the “other” conditions category include: diabetes, frailty, autoimmune conditions, chronic pain and mental disorders, but practitioners sometimes listed other conditions such as joint, bone and muscle issues, hearing and visual issues and various internal diseases in the write-in fields.”

There was no further breakdown in the 2024 annual report on “other” conditions. However, there were 368 reported cases of euthanasia where dementia was the underlying condition.

In [Ontario](#) in 2023 there were 198 cases were diabetes and 422 cases were frailty were given as the “serious and incurable disease” for which death was “reasonably foreseeable” and euthanasia was administered.

In [Quebec](#) in April 2024-March 2025, 9% of cases were for “polypathology” – a combination of disorders.

In 2023, there were 9,461 cases of euthanasia for cancer, accounting for 10.9% of the 86,647 deaths attributed to cancer in Canada.

In only 177 cases in 2023 did the clinician administering euthanasia give their specialty as oncology. The majority (64%) of those administering euthanasia were primarily engaged in family medicine.

The 2019 report also notes that among those administering euthanasia were “a small number of practitioners identifying themselves as “MAID Providers.” While this specialty is not officially recognized by medical certifying bodies in Canada, it may be considered a functional specialty by some providers when MAID is the primary focus of their practice.”, that is doctors whose primary practice is euthanasia.

The 2022 report notes that the second opinion on eligibility was given by a nurse practitioner in 7.3% of cases.

[Short time between initial request and euthanasia being performed](#)

Until it was repealed from 21 March 2021, Section 241.2 (3) (g) of the Canadian Criminal Code required a physician to “ensure that there are at least 10 clear days between the day on which the request was signed by or on behalf of the person and the day on which the medical assistance in dying is provided or — if they and the other medical practitioner or nurse practitioner referred to in paragraph (e) are both of the opinion that the person’s death, or the loss of their capacity to provide informed consent,

is imminent — any shorter period that the first medical practitioner or nurse practitioner considers appropriate in the circumstance”.

Nonetheless according to [a study](#) of euthanasia at three institutions in Quebec the median number of days between the request for euthanasia and the patient’s death was just 6 days.²¹⁰

This study also found that in 32% of cases a palliative care consultation only took place less than 7 days before euthanasia was requested and in a further 25% of cases it took place on the same day or AFTER euthanasia was requested. This suggests that euthanasia is being routinely provided to people before they have had a chance to experience the full effect of palliative care to relieve their suffering and concerns.

Of the 7,384 people killed by euthanasia in Canada in 2020 for whom data is available on the length of time between first request and when euthanasia was administered some 34.3% or 2,532 people were euthanased in less than 10 days of first requesting it. For 905 of these people the only justification given for the haste with which euthanasia was performed was that loss of capacity to consent was imminent.

This raises real questions about the validity of the original request. If a person is on the verge of losing capacity what degree of certainty can there be that the person currently has full capacity?

In the period April 2023 to March 2024 in [Quebec](#), 46% of people were euthanased less than 10 days after making a request. Only 15% of people had a prognosis of less than 2 weeks to live.

Under the revised law from 21 March 2021 there is no longer any required waiting period for any person whose death is said to be “reasonably foreseeable”. Same day request and lethal injection is acceptable.

With this change the annual reports from 2021 no longer include information about the length of time between a request for euthanasia and its implementation.

In cases where death is reasonably foreseeable, a 90-day waiting period is specified but if the two assessing practitioners think that loss of decision-making capacity is imminent this can be waived entirely. No information is given in the 2022 annual report as to in how many of these 463 cases was this 90-day waiting period waived. However, in 2023 it was waived for 28 (4.5%) people.

Advanced directive

Euthanasia can now (since 21 March 2021) be provided on the basis of an advanced directive to persons who have lost decision making capacity, and are on Track 1 (death reasonably foreseeable). This is not supposed to be done if the person resists or refuses by “*words, sounds or gestures*”. However, this requirement is undermined by a provision that “*involuntary words, sounds or gestures made in response to contact do not constitute a demonstration of refusal or resistance*”.

In Canada in 2023, 594 (4% of Track 1 cases) cases of euthanasia involved euthanasia of a person who at the time they were killed was incapable of giving consent. This increased in 2024 to 785 people (5% of Track 1 cases).

²¹⁰ <https://jme.bmj.com/content/early/2018/11/22/medethics-2018-104982>

In [Ontario](#) in 2023, 190 (4.2%) cases of euthanasia where death was “reasonably foreseeable” involved euthanasia of a person who at the time they were killed was incapable of giving consent. Of these 5 cases involved euthanasia on the same day as a first request for it was made. How confident can we be that a person was competent when they requested euthanasia but had become incompetent that same day at the time euthanasia was performed? A further 59 cases involved euthanasia of an incompetent person based on a “waiver of final consent” and request for euthanasia made between 2 and 7 days earlier.

In Ontario in 2024, 254 (5.12%) of all cases of euthanasia involved euthanasia of a person who at the time they were killed was incapable of giving consent.

Reasons for requesting euthanasia

A [study from an Ontario hospital](#) reported that those who received euthanasia tended to be white and relatively affluent and 95% of them indicated that loss of autonomy was the primary reason for their request. Other common reasons included the wish to avoid burdening others or losing dignity and the intolerability of not being able to enjoy one’s life. Few patients cited inadequate control of pain or other symptoms.²¹¹

The 2024 annual report lists reasons for requesting euthanasia with separate percentages for Track 1 and Track 2. The most cited reasons are “loss of ability to engage in meaningful life activities” (95.1%, 97.5%) followed closely by “loss of ability to perform activities of daily living” (85.4%, 85.1%). were the most common reasons for a euthanasia request.

Inadequate control of pain, or concern about it, is reported for 59.8% of those in Track 2. In 2023 there were 166 people in Track 2 for whom chronic pain was an underlying condition, including 52 people under 65 years of age. The 2023 report notes that “Individuals with chronic pain often encounter challenges related to the availability and accessibility of treatment such as long wait times, limited access to services in rural and remote areas and financial barriers to accessing certain services, such as psychological support and physiotherapy.” Canada is killing people, including young people, with chronic pain rather than improving access to treatment.

Disturbingly, in 2024, 48.4% of Track 1 and 50.3% of Track 2 reported as a reason for their euthanasia request “Perceived burden on family, friends or caregivers” and 21.9% of Track 1 and 44.7% of Track 2 reported “Isolation or loneliness”. (In [Quebec](#) for April 2024-March 2025, 50% of people cited a perceived burden on families, friends or caregivers and 24% cited isolation or loneliness).

So, in 2024, 3780 people were euthanased in Canada at least partly because they were experiencing loneliness and isolation, including 327 people whose death was not reasonably foreseen.

A voluntary request?

The 2023 annual report states that practitioners reported that they had consulted directly with the patient to determine the voluntariness of the request for euthanasia in 15,248 cases. This means that in 95 cases the practitioner who administered euthanasia did NOT consult directly with the person he or she euthanased to “determine the voluntariness of the request”!

No Disability Support

In 2023 there were 432 cases where disability support services were needed but NOT received including 5 cases where the needed services were “not accessible” and 369 cases which were reported

²¹¹ <https://www.worldrtd.net/sites/default/files/newsfiles/MAID%20protocol%20Canada%20hospital.pdf>

as “Required disability support services but such services were not provided and it is not known if such services were accessible to the person”. Apparently the euthanasia practitioner did not bother to find out if needed disability support services were accessible or not before agreeing to kill the person with a disability who needed such services!

The 2020 report stated that “Disability support services could include but are not limited to assistive technologies, adaptive equipment, rehabilitation services, personal care services and disability based income supplements.” The 2021 report admits that, even for those who were reported as having received disability support services, the data “does not provide insight into the adequacy of the services offered”.

Disability – the story of Candice Lewis

Candice Lewis was a 25 year old Canadian woman who happened to have cerebral palsy.

In [September 2016 Candice](#) went to the emergency room at Charles S. Curtis Memorial Hospital in St. Anthony after having seizures.²¹²

Dr. Aaron Heroux told her she was very sick and likely to die soon. He offered her assisted suicide. The doctor also proposed assisted suicide for Candice to her mother Sheila Elson.

This offer was repeated despite both Candice and her mother making it clear that this was not an option Candice would consider. Dr Heroux told Sheila she was being selfish by not encouraging her daughter to choose assisted suicide.

Candice has described how bad it made her feel that a doctor was offering her assisted suicide.

More than [twelve months later Candice had recovered well](#) and her health was much improved. Candice wasn’t having any seizures, was now able to feed herself, walk with assistance, use her iPad. She was more alert, energetic and communicative. She was able to walk down the aisle as a bridesmaid at her sister’s wedding in August 2017. She was doing what she loved most, painting and being with her family.²¹³

Candice and her mother Sheila have been interviewed by Kevin Dunn, who is producing a film on euthanasia and assisted suicide called Fatal Flaws. The film of the interview can be viewed [here](#).²¹⁴

There are several take home lessons from Candice’s experience:

- Doctors can [get the prognosis wrong](#).²¹⁵ Candice was told she was dying but is flourishing twelve months later. A wrong prognosis can lead to assisted suicide or euthanasia. A life can be thrown away needlessly;

²¹² <http://www.northernpen.ca/news/local/st-anthony-mother-claims-physician-assisted-death-was-wrongly-offered-for-her-daughter-25491/>

²¹³ <http://www.northernpen.ca/community/candice-lewis-seeing-her-condition-improved-83812/>

²¹⁴ <https://youtu.be/hB6zt43iCs8>

²¹⁵ https://www.australiancarealliance.org.au/a_wrong_prognosis_part_1

- People with a disability already suffer discrimination in health care. When assisted suicide and euthanasia are legal, [people with a disability are more at risk](#) of being offered death as a solution because doctors and others consider that they would be better off dead²¹⁶;
- Once doctors are authorised by the law to provide assisted suicide and euthanasia some of them will feel empowered to offer it to anyone they think would be better off dead. This undermines patients' trust in doctors and can cause great distress.

Sadly, Candice has since passed away from natural causes.

Financial issues: Denied assisted living but offered assisted suicide

[Roger Foley](#), who has a crippling brain disease, has been seeking support to live at home. He is currently in an Ontario hospital that is threatening to start charging him \$1,800 a day. The hospital has told Roger that his other option is euthanasia or assisted suicide under Canada's medical assistance in dying law.²¹⁷

Prisoners

As of August 2020, 11 prisoners who were federally incarcerated in a Canadian prison had requested euthanasia and three of these prisoners were euthanised.²¹⁸

In one case a terminally ill prisoner, who was a non-violent recidivist serving a two year sentence, was denied compassionate leave or parole. His request for euthanasia was assessed by a prison doctor and then by another doctor, while the prisoner was shackled and guards were present.

Canada's [federal prison ombudsman](#) has commented critically on each of the three cases and called for a complete moratorium on any further euthanasia of federal prisoners, because incarceration compromises individuals' ability to consent to euthanasia.²¹⁹

Practitioners frequently killing patients

Of the 2112 physicians and 154 nurse practitioners who euthanased people in 2024, 102 of them did 37.5% (6190 people including 199 whose death was not reasonably foreseeable) of the killing between

²¹⁶ https://www.australiancarealliance.org.au/better_off_dead

²¹⁷ https://www.australiancarealliance.org.au/canada_assisted_suicide_not_assisted_living

²¹⁸ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8742296/>

²¹⁹ <https://www.oci-bec.gc.ca/cnt/rpt/annrpt/annrpt20192020-eng.aspx#s3>

them, averaging 60 people each practitioner. Five practitioners killed between 11 and 20 people each for whom death was not reasonably foreseeable.

Conclusion

Canada's court ordered experiment with euthanasia is out of control with numbers spiralling upwards and the lonely, disabled and women with chronic conditions increasingly at risk of being euthanased instead of helped.

Colombia (2015-)

It should be noted that at no time has the Congress passed a law permitting euthanasia. It is only carried out in Colombia pursuant to judgements of the Constitutional Court and subsequent Resolutions of the Department of Health and Social Protection.

Numbers killed

Between April 2015 and 31 December 2024, 1,044 people were killed by euthanasia in Colombia – with [numbers](#) increasing from 4 in 2015 to 43 in 2019; 181 in 2022; 271 in 2023; and 352 in 2024 (up 29.9% from 2023).²²⁰

This represents 0.13% of all deaths in 2024.

Court ordered euthanasia

On 20 May 1997 the Constitutional Court of Colombia [ruled](#) that, subject to certain conditions, if a physician responded to a voluntary request from a terminally ill patient for an act of mercy killing in order to end great suffering that cannot otherwise be relieved, then constitutionally this cannot be a criminal act.²²¹

The Court called on the Congress to pass a law “in the shortest possible time” to provide detailed regulations for euthanasia.

The Congress has repeatedly declined to do so.

However, on 15 December 2014 the Constitutional Court in another case [ordered](#) the Ministry of Health to issue a regulation on euthanasia.²²²

On 8 April 2021, the Chamber of Representatives again voted against progressing a bill to regulate euthanasia.

On 22 July 2021 a further decision of the Constitutional Court, decided by 6-3, removed the requirement for a terminal illness in allowing a physician to respond to a request for an act of euthanasia. The Court made its sixth call for the legislature to pass a law regulating access to euthanasia.

On 16 November 2021, a Bill to regulate euthanasia was [again rejected](#) by the Chamber of Representatives by a vote of 78-65.²²³

²²⁰ <https://www.desclab.com/post/eutanasiacifras#>

²²¹ <https://euthanasia.procon.org/sourcefiles/colombia-court-decision-05-20-1997.pdf>

²²² <https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/INEC/IGUB/Sentencia-T-970-14.pdf>

²²³ <https://www.camara.gov.co/se-hunde-reglamentacion-de-derecho-a-morir-dignamente>

On 11 May 2022 the Constitutional Court, in a 6-3 decision, also legalised physician assisted suicide for any person diagnosed with a serious or incurable disease or bodily injury who claims to suffer from intense physical or psychological pain that is incompatible with the person's idea of a dignified life.²²⁴

Euthanasia by executive resolution

The Department of Health and Social Protection issued [Resolution 1216 of 2015](#) on 20 April 2015²²⁵ providing [detailed rules for euthanasia](#).²²⁶

These rules were updated by [Resolution 971 of 2021](#).²²⁷

The Resolution allows the conscientious objection of the health professional, but does not allow an objection of institutional conscience. "If a doctor does not want to do the procedure because of his personal convictions, that is classified as an objection of conscience and that is respected by the norm. In that case, the institution must find another doctor who performs the procedure".

The Resolution also gives effect to the ruling of the Court permitting requests for euthanasia to be made by advanced directive, even those made before a person has a terminal illness, as well as to be made by a "substituted judgement"

"In relation to the consent it was specified that, according to the moment in which it is expressed, it may be prior or subsequent. The **prior** consent is issued before suffering the terminal illness and the **later** when the will to exercise the right to a dignified death is manifested after the pathological event has occurred. Likewise, the **substitute consent** was foreseen, which proceeds in the events in which the patient suffering from the terminal illness is in fact unable to express his will. In these events, **the family may substitute the consent** and the same procedure will be carried out, but the interdisciplinary committee must be stricter in complying with the requirements."

Euthanasia of children

On 25 August 2017 another [ruling](#) from the Constitutional Court instructed the Department of Health and Social Protection to issue regulations for the euthanasia of children.²²⁸

On 9 March 2018 the Department issued [Resolution 825 of 2018](#) which allows the euthanasia of children as young as 7 years old who have an incurable disease with a prognosis of less than 6 months to live and with pain that cannot be otherwise relieved. The case must be considered by a committee

²²⁴ <https://colombiareports.com/colombia-legalizes-assisted-suicide-in-historic-ruling/>

²²⁵ https://www.minsalud.gov.co/Normatividad_Nuevo/Resoluci%C3%B3n%201216%20de%202015.pdf

²²⁶ <https://www.minsalud.gov.co/Paginas/MinSalud-cumple-mandato-de-la-Corte-sobre-muerte-digna-en-Colombia.aspx>

²²⁷ https://www.minsalud.gov.co/Normatividad_Nuevo/Resoluci%C3%B3n%20971%20de%202021.pdf

²²⁸ <https://colombiareports.com/colombia-legalizes-assisted-suicide-in-historic-ruling/>

of a doctor, a lawyer and a psychiatrist. Up to 12 years of age the consent of both parents, as well as the child, is required. From 12 to 14 years the consent of only one parent and of the child is required and from 14 years onwards only the consent of the child is required.

One case of euthanasia of a child took place in 2023 and one case in 2024.

It is disturbing to note that the case that led to this expansion of euthanasia to include children, involved a 13-year-old intellectually disabled boy with cerebral palsy whose suffering from scoliosis and from repeated instances of respiratory difficulty stemmed from significant failures of the health service to deliver needed treatments including oxygen supplies as well as orthopaedic treatments and a suitable wheelchair.

By the time the ruling was issued the boy had died following a severe incident. He received palliative care at this time to relieve his distress.

The Court ruling proposes that substituted consent to euthanasia of a child lacking the required cognitive development can be supplied by the “parents, persons or entities that are legally in charge” of the child.

The voice of reason

In the [2017 case](#) there was a significant dissent by Judge Cristina Pardo Schlesinger.²²⁹

She pointed out that at the argument for euthanasia assumes that “there are conditions in which life stops being worthy to live”. To the contrary Judge Schlesinger asserted that “In fact, life is not a simple operation among many, but consists in the very being of the living person. Losing life, for a living being is losing his own being. Consequently, from the affirmation that there is an unworthy life there necessarily follows the affirmation that the person who suffers from certain conditions *is unworthy*. The idea that life can be “unworthy” in a proper sense and not metaphorically, is inevitably linked to the idea of the inferiority in legal status of the most vulnerable members of society, a thesis that is, obviously, contrary to the spirit of the Constitution.

“The terminally ill person is “authorized” to die, not because their autonomy is respected (as sometimes they try to present) but because in some way, their life is considered “less”. “

“The reason why it is not possible to understand that euthanasia is licit by virtue of being directed at the mitigation of suffering consists fundamentally in the fact that such action is naturally directed to the termination of life. Contrary to actions such as sedating or anesthetizing, whose first and most direct effect is the alteration of the sensation, or the change in the functioning of an organ, euthanasia is distinguished by being directly directed to suppress life. This direct orientation to end life is not distinguishable from the orientation to eliminate the person who lives. Now, whenever the person and dignity are inseparable, any action that eliminates the subject of law is an action that attempts to suppress a worthy subject, that is, an attack on dignity. And, inevitably, an attempt against a worthy being is an attempt against dignity.”

The assertion of a right to dispose of one’s life “seems to ignore one of the founding statements of the liberal tradition of human rights, that is, the existence of inalienable rights. The liberal tradition, in fact, has always maintained the existence of a fundamental difference between those who are the

²²⁹ <http://www.corteconstitucional.gov.co/relatoria/2017/t-544-17.htm>

subjects of rights and the objects of law. The latter form the orbit of goods and on them the acts of disposition and trade are exercised. On the other hand, the subject of law cannot dispose of his own subjectivity without reifying himself. For this reason, all the authors representative of the liberal tradition that gave rise to the modern rule of law denied the possibility of a legal business whose purpose is the transfer of one's own legal subjectivity, as it would be, the sale of one's being to be a slave. This premise remains incontestable. Nobody doubts the current illegitimacy of the slavery pact. Not even full availability regarding labor rights is allowed. Nor would the legitimacy of a document accepting torture in a judicial interrogation be accepted. But when it comes to the life of the subject in terminal conditions we strangely accept a much more extreme act in all aspects." Judge Schlesinger goes on to address the reality that depression in the terminally ill is very likely going to affect decision making casting doubts of the competence of the person to make such a profound and final decision:

"It turns out, however, that consent to euthanasia is usually given in circumstances that, by definition, hinder the freedom of consent. It should not be forgotten that in many of these cases the decision is made in conditions of psychic alteration, in the midst of depressive states concomitant with the illness, of feelings of uselessness or self-perception of being burdensome, as well as of physical pain, family embarrassment and, in some cases, economic concern. If practically all consent to euthanasia occurs in these special circumstances that reduce the freedom of the act, it is concluded that, paradoxically, **a weak and questionable consent is enough for the most extreme and irreversible of possible decisions.** Circumstances that in other contexts would suffice to invalidate a will, contract or marriage are inexplicably irrelevant in deciding on one's own death.

"Special consideration is required regarding the interference of depressed mood in the request for assisted suicide. Indeed, it is common knowledge that certain diseases trigger depressive processes and that those who suffer from these disorders present within their clinical picture inclinations and suicidal desires. Precisely for this reason, the "consent" associated with such a request must be considered, by definition, spurious."

Judge Schlesinger goes on to object to the idea that the law on such a serious matter can be made without the action of Congress and that consequently the orders of the Court are "are issued without regard to the constitutional powers of the other branches of public power, without sufficient democratic legitimacy and in total disrespect for the principle of separation of powers".

She also objected strongly to the arrogant claim of the Court that institutions – including those founded on a religious ethos that prohibits euthanasia – must provide it.

Finally, commenting on the case of the 13-year-old boy she concluded that all the considerations outlined above applied even more so "since he is a 13-year-old boy who suffered from severe cerebral palsy whose parents requested euthanasia due to *"the delay in providing the services and supplies necessary to treat the diseases that it suffers"*. That is, the request for euthanasia was based on a situation of despair on the part of the parents, who because of the negligence of the Health Service were seeing the suffering of their son, decided that the best goal was his death. Therefore, I believe that in this context, it cannot be affirmed that the decision to request euthanasia was carried out in a totally free manner, much less in observance of the dignity of the child."

Conclusion

This dissent by Judge Schlesinger is an eloquent condemnation of the arrogance of the court ordered experiment with euthanasia in Colombia.

Colorado (2016-)

Assisted suicide has been legal in Colorado since 16 December 2016 following the passing of a ballot initiative.

Minimal data

Eight annual reports have been [published](#)²³⁰ with the latest covering [2024](#)²³¹.

Even compared to the limited data reported annually in Oregon the annual reports are sparse and uninformative.

In 2024 prescriptions for a lethal substance were written for 510 people – a 31% increase from 2023 – with 313 prescriptions known to have been dispensed.

A range of experimental lethal cocktails have been dispensed, but in 2024 the majority (79.6%) were prescribed DDMA^{Ph} – a combination of diazepam, digoxin, morphine sulfate, amitriptyline and phenobarbital with a further 17.3% being prescribed DDMA.

It is not known whether the prescription was not dispensed in the other 197 cases or if the mandatory paperwork was simply not lodged.

Death certificates for 429 people for whom a lethal prescription had been written were received. However, as the death certificates, by law, only record the underlying illness and make no mention of whether death was caused by ingesting a lethal substance, it remains unknown how many of these people actually died from the lethal substance or even collected it.

The median time between the lethal prescription being written and death (from any cause) was 15 days (0 days- 42 months range). This means one person survived the six months "prognosis" by 3 full years.

The youngest person who has been prescribed a lethal substance was reported as aged "in the 20s".

There is no requirement (or even any process) for reporting complications for people from taking the lethal substance despite the mandated written declaration under the law requiring a person to acknowledge "*although most deaths occur within three hours, my death may take longer*". The record length of time from ingestion to death reported [from Oregon](#) is 104 hours (4 days 8 hours).²³²

Although [the law](#) requires a referral to a psychiatrist or psychologist "if the attending physician believes that the individual may not be mentally capable of making an informed decision" only 10 out of 1,985 (0.5%) of those people for whom a lethal prescription was written (2017-2024) were first referred for an assessment.

²³⁰ <https://cdphe.colorado.gov/center-for-health-and-environmental-data/registries-and-vital-statistics/medical-aid-in-dying#Annual>

²³¹ <https://drive.google.com/file/d/1IBp-r-KSjE19IYdHix5bLA9dTBB81GIM/view>

²³²

<http://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year20.pdf>

Waiting period

The original legislation provided for a waiting period of 15 days. From 7 August 2024 this will be reduced to 7 days.

This waiting period can be ignored if the person is assessed as “unlikely to survive 48 hours”.

“Other”, unspecified conditions

The 2024 report includes 28 cases of a lethal prescription written for “other illnesses/conditions” with no indication of what these were. This is more than five times the 5 reported in 2021.

A Colorado medical practitioner, Dr Jennifer Gaudiani, has [reported](#) acting as a consultant in two out-of-state cases of the prescription of a lethal substance for two 36 year old women with anorexia.²³³

With no details given in the Colorado reports on “other illnesses/conditions” we may never know when cases of prescribing a lethal substance for anorexia or other non-terminal illnesses, including mental illnesses, occur.

Significant non-compliance by physicians

What is most concerning is the level of non-compliance by physicians who prescribe lethal substances with even the very minimal reporting requirements.

From 2017-2024, of the 1995 cases in which people were provide a written prescription for a lethal drug, in 402 cases (20.15%) the physician failed to lodge a copy – as required by law - of the person’s written request; and in 432 cases (21.65%) the physician failed to lodge the mandatory written report from the consulting physician.

But the Colorado Board of Health is relaxed about this massive rate of non-compliance:

While reporting of the required documentation (including prescribing forms, patients’ written requests, consulting physicians’ written confirmations, and mental health provider confirmation) may be incomplete, all attending/prescribing forms received contained physicians’ signed attestations that all requirements of the Colorado End-of-Life Options Act have been met, and that required documentation is complete and contained in patients’ records. Efforts continue to educate physicians and other health care providers about reporting requirements.

These efforts are failing with violations of the reporting requirements increasing year to year.

This lay back approach glosses over the 14.7%-17.8% of cases in each year from 2021 to 2024 where even the basic form from the attending/prescribing physician has not been lodged and for which even the supposed assurance given by all the boxes being ticked is not provided. There was 16.7% (one in six) non-compliance with this legal requirement in 2024 with no completed form for 85 cases out of 510.

Conclusion

Colorado’s experiment in providing a safe regime for assisted suicide is a failure because it lacks any possibility of identifying problems and six years in authorities remain lackadaisical about significant non-compliance even with the minimal reporting requirements.

²³³ <https://jeatdisord.biomedcentral.com/articles/10.1186/s40337-022-00548-3>

District of Columbia (2017-)

Assisted suicide became lawful in the District of Columbia effective from 6 June 2017.

[The law](#) is modelled on Oregon's including referral, at the discretion of the attending physician or consulting physician, to a psychiatrist or psychologist for assessment of whether or not the "the patient is suffering from a psychiatric or psychological disorder or depression causing impaired judgment".²³⁴

DC Health has created [online modules](#) for patients and physicians which each of these participants must sign off as having been viewed. The modules are in power point format and basically set out the [requirements](#) of the Act.²³⁵

Minimal reporting

The annual reports to [date](#) report a total of 31 prescriptions for a lethal substance with 25 deaths resulting from ingestion of the lethal substance – 8 of these deaths (0.15% of all deaths in D.C.) occurred between 19 February 2021 and 18 February 2022.

Lethal prescriptions

The [Pharmacist Education Module](#), which it is not mandatory for a pharmacist to view before dispensing the lethal substance, recommends that "Pharmacists should educate themselves to recognize prescriptions that apply to Death with Dignity and pre-medications. Medications should be taken on empty stomach to help with absorption. Medications must be ingested swiftly (i.e., less than ninety (90) seconds). Examples of possible medications include, but are not limited to, the following: – Secobarbital capsules with the contents removed and collected in a glass, then mixed with four (4) oz. of room temperature water or juice (note: do not use grapefruit juice); – Protocol of diazepam, digitalis, morphine sulfate and propranolol (aka DDMP)".

A pharmacist may dispense the lethal substance to any agent nominated either orally (presumably by phone) or in writing by the person who is intended to use it.²³⁶

The official form for patients allows for the optional appointment of a person to be responsible for discarding any unused lethal substance. The [DC Health website](#) suggests disposing of such substances mixed with coffee grounds or cat litter in, say, an empty margarine tub in the regular trash.²³⁷

Partnership with Compassion & Choices

A Death with Dignity and Best Practices for the Medical Community seminar jointly sponsored with Compassion and Choices and DC Health was held for health care professionals on August 10, 2018.²³⁸

²³⁴ <https://code.dccouncil.us/dc/council/code/titles/7/chapters/6B/>

²³⁵ <https://dchealth.dc.gov/page/death-dignity-act-2016>

²³⁶

https://dchealth.dc.gov/sites/default/files/dc/sites/doh/page_content/attachments/Death%20with%20Dignity%20-%20Education%20Modules.Pharmacist.DC%20HEALTH%20Version.06.18.18.pdf

²³⁷ <https://dchealth.dc.gov/service/safe-disposal-medications>

²³⁸

https://dchealth.dc.gov/sites/default/files/dc/sites/doh/page_content/attachments/DWD%20Report%202018%20Final%20%202019.pdf

Suicide promotion

In October 2018 –during Suicide Prevention Month!! – [a public service announcement](#) promoting assisted suicide was run in the District of Columbia by advocates concerned at the lack of residents using the deadly law.²³⁹

Conclusion

The promotion of assisted suicide during Suicide Prevention Month is a new low in the crassness of the assisted suicide experimenters desperate to find guinea pigs for their experiment in the American capital.

²³⁹ <https://www.washingtontimes.com/news/2018/oct/10/the-deadly-advocacy-of-doctor-assisted-suicide/>

Hawaii (2019-)

Assisted suicide became legal in Hawaii from 1 January 2019. The [Our Care, Our Choice Act](#) is modelled on the Oregon and Washington laws but has some differences.²⁴⁰

Competency to suicide assessed by telehealth

The Act requires the “attending provider” to refer every person who requests assisted suicide for “counselling” which is defined as “one or more consultations, **which may be provided through telehealth**, as necessary between a psychiatrist, psychologist or clinical social worker and a patient for the purpose of determining that the patient is capable, and that the patient does not appear to be suffering from undertreatment or nontreatment of depression or other conditions which may interfere with the patient's ability to make an informed decision pursuant to this chapter.

The use of telehealth for this purpose [has been criticised](#) by Katherine Drabiak, an assistant professor in the College of Public Health at the University of Southern Florida. She writes:

*“Understanding the patient’s psychological condition is important because research in Oregon has found that patients considering PAS [physician assisted suicide] have concerns relating to loss of autonomy, ability to engage in activities that make life enjoyable, and loss of dignity. (Contrary to popular belief, excruciating pain is not a substantial factor in patient decisions to seek PAS.) Under Hawaii’s law, however, a patient may obtain a consultation via telehealth. While telehealth promises to reduce cost and increase efficiency to address other health care issues, **we should pause to consider the sufficiency and ethics of a remote consultation with patients to discuss their motivations and screen for potential problems.**”*

I take issue with what I see as a pro forma requirement. It looks like a protection, but it’s not designed to address underlying issues such as a patient’s depression and whether it could be relieved. Patients facing psychological, social, or existential concerns deserve compassion in the form of reassurance, social support, and practical solutions to address feeling like a burden on others. Needing connection and validation throughout our life—and especially at our most vulnerable when we require assistance from others—translates to knowing that we are meaningful and loved.”²⁴¹

Minimal reporting

The [Act](#) requires an annual report to be issued, however, there is no requirement under the Act for any information to be reported to the Department of Health on the reasons for requesting assisted suicide (apart from the underlying condition), on the length of the patient-doctor relationship, on the length of time from first request to death or from ingestion to either unconsciousness or death.

²⁴⁰ <https://health.hawaii.gov/opppd/files/2018/11/OCOC-Act2.pdf>

²⁴¹ <https://www.thehastingscenter.org/hawaiis-new-end-life-law-additional-safeguards-withstand-scrutiny/>

Complications

The [form](#) to be completed by the prescribing physician 30 days after the death – whether by ingestion of the lethal substance or otherwise – does ask: *Were there any complications or barriers?*²⁴²

However, there is no requirement for the physician – or indeed any witness – to be present at the ingestion of the lethal substance, even though the Act refers to the physician who writes the lethal prescription as the “attending provider”. Nor does the form ask whether or not the physician was present.

The claim in the [July 2020 Legislative Report](#) that in 2019 “There were no reported complications due to ingesting the medications” is therefore of little value.²⁴³

Nonetheless it is reported that in the first half of 2020 one person took **more than six hours to die** after ingesting a prescribed lethal dose of DDMP2 and that in the second half of 2020 “*there was one complication with ingesting DDMP2*”.

There was one complication reported for 2021 where the prolonged **time to death was** approximately **12 hours**.

Numbers

According to the [July 2024 Legislative Report](#) in 2023, 51 people died after ingesting a lethal substance prescribed under the Act (over double the 25 who died in 2020, and a 37.8% increase from 2022). This represents 0.4% of all deaths in Hawaii. It took Oregon 18 years to reach this rate.

According to the [2024 Annual Report](#) in 2024, 38 people died after ingesting a lethal substance prescribed under the Act. This was a decrease from the 51 people reported for 2023.

In the 2024 the Department of Health called for a change in the legislation to remove the obligation on it to report annually on “the number of known deaths in Hawaii from a prescription written pursuant to this chapter per five-thousand deaths in Hawaii” partly on the grounds that “not all deaths by ingestion of medication dispensed pursuant to Chapter 327L are documented”.

No safe place?

Although the Act contains explicit provisions protecting the right of a health care facility to prevent health care providers in its employ or on its premises from “participating” in the provision of assisted suicide there may be gaps in these provisions.

The American Civil Liberties Union [threatened a law suit against Kahala Nui](#),²⁴⁴ a continuing care retirement community, which is run by a non-profit organisation and is situated on land owned by the Catholic Church, [to force it to repeal a provision](#) in its residents agreement which makes it clear that acts of assisted suicide under Hawaii’s new law are not permitted in the community.²⁴⁵

²⁴² https://health.hawaii.gov/opppd/files/2018/12/Attending-Physician-Follow-up-Form-eff.-1_1_19.pdf

²⁴³ <https://health.hawaii.gov/opppd/files/2020/06/2020-Annual-OCCOA-Report-1.pdf> p.2

²⁴⁴ <https://www.aclu.org/news/aclu-hawaii-calls-kahala-nui-retirement-community-stop-religious-discrimination> ; <https://acluhawaii.files.wordpress.com/2018/11/2018-11-1-letter-to-kahala-nui.pdf>

²⁴⁵ <http://www.tribtown.com/2018/11/01/us-retirement-home-medically-assisted-suicide-the-latest/>

Kahala Nui [subsequently announced](#) that while no assisted suicide could take place in its assisted living and nursing center, it would not prevent residents in its independent living wing from accessing assisted suicide.²⁴⁶

The proponents of assisted suicide bitterly and aggressively object to any organisation seeking to preserve a life-affirming ethos.

Waiting periods and let nurses write lethal prescriptions

Effective from 1 July 2023 the Act was changed to allow qualified Advanced Practice Registered Nurses to write lethal prescriptions; to reduce the waiting period a patient's first and second oral requests to just five days and allow even this to be waived if the provider states the person may not live that long.

A nurse was the attending provider for one case in 2024 and the consulting provider for 4 cases.

Conclusion

The lack of data from Hawaii's experiment with assisted suicide prevents any proper scrutiny. The novel use of telehealth in assessing competence to request assisted suicide is disturbing.

²⁴⁶ <https://apnews.com/f981b6d1dfe64ed4aaef0ac56c9f502f>

Victoria (2019-)

Assisted suicide and euthanasia become legal in Victoria on 19 June 2019 when the [Voluntary Assisted Dying Act 2017](#),²⁴⁷ which [passed the Legislative Council on 22 November 2017](#) by just two votes (22-18) came into full operation.²⁴⁸

[Regulations](#) were gazetted in September 2018.²⁴⁹

There have been nine reports on its operations issued to date by the Voluntary Assisted Dying Review Board, with the [latest](#) covering 1 July 2024-30 June 2025.

As of 30 June 2025, 1,675 people had their lives intentionally ended under the Act – 293 by euthanasia and 1,382 by assistance to suicide.

In the twelve-month period, July 2024-June 2025, 371 people died under the Act – an increase of 4.8% from the 371 deaths in July 2023- June 2024. 301 (77.4%) deaths in 2024-25 involved assistance to suicide and 88 (22.6%) were by euthanasia.

Deaths by euthanasia and assistance to suicide in the twelve months July 2024-June 2025 represent over 0.86% of all deaths in Victoria for that period, a rate only reached by Oregon after 26 years of legalised assisted suicide.

Eligibility criteria

The core eligibility criterion is set out in Section 9 (1) (d) of the Act:

the person must be diagnosed with a disease, illness or medical condition that—

- (i) is incurable; and*
- (ii) is advanced, progressive and will cause death; and*
- (iii) is expected to cause death within weeks or months, not exceeding 6 months; and*

²⁴⁷

[http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubStatbook.nsf/f932b66241ecf1b7ca256e92000e23be/B320E209775D253CCA2581ED00114C60/\\$FILE/17-061aa%20authorised.pdf](http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubStatbook.nsf/f932b66241ecf1b7ca256e92000e23be/B320E209775D253CCA2581ED00114C60/$FILE/17-061aa%20authorised.pdf)

²⁴⁸ https://www.parliament.vic.gov.au/images/stories/daily-hansard/Council_2017/Council_Daily_Extract_Tuesday_21_November_2017_from_Book_20.pdf

²⁴⁹

http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubStatbook.nsf/93eb987ebadd283dca256e92000e4069/D550921996E9F89BCA258313001B4FE5/%24FILE/18-142sra%20authorised.pdf

- (iv) *is causing suffering to the person that cannot be relieved in a manner that the person considers tolerable.*

The first three elements of this criterion are to be assessed by two doctors, only one of whom is required to have “*relevant expertise and experience in the person's disease, illness or medical condition*”, the nature of such expertise and experience to be stated on Form 1 or Form 2 as set out in Schedule 1 of the Act.

None of the terms used in this provision are further defined in the Act nor is any guidance given in the Regulations as to how they are to be assessed.

During debate on the Bill it became clear that there are uncertainties around the meaning of “*incurable*” and “*will cause death*” so that, for instance an insulin dependent diabetic who declines to take insulin may qualify under this criterion. There have been some deaths under the Act (number not given) of people with diabetes.

In 2024-25, 29 applicants were categorised as having ‘Other’ life limiting conditions which were defined as including cardiovascular disease, dementia, diabetes, end stage kidney disease, end stage liver disease, HIV/AIDS, multiple organ failure, sepsis, stroke, and other rare non-malignant conditions.

The inclusion of diabetes, stroke and dementia are concerning.

It was also accepted that there are [misdiagnoses](#)²⁵⁰ and [errors in prognosis](#)²⁵¹ so that there will inevitably be some wrongful deaths.

It is important to note that the fourth element in the criterion relating to “suffering” is specifically NOT to be assessed by the two doctors. It is entirely subjective and therefore entirely meaningless. A person is suffering in the required sense simply if the person asserts that this is the case.

This approach applies in Canada but notably not in the Netherlands or Belgium where the objective nature of the suffering – and the incapacity to relieve it – is a matter for professional assessment by the physician, including a relevant specialist.

There is no definition of suffering and therefore nothing to exclude forms of existential suffering such as loss of autonomy, lack of capacity to enjoy former hobbies, feeling a burden on family or financial concerns to be the only suffering experienced. [There is absolutely no requirement for the person to be experiencing pain or other physical symptoms.](#)²⁵²

Reasons for requesting assisted suicide or euthanasia

The [Jan-June 2020 report](#) states that “Loss of autonomy was frequently cited by applicants as a reason for requesting” assisted suicide or euthanasia, with other commonly reported reasons including “being less able to engage in activities that make life enjoyable, losing control of body functions, and loss of dignity”. Notably physical pain was not mentioned in this report.

²⁵⁰ https://www.australiancarealliance.org.au/a_wrong_diagnosis

²⁵¹ https://www.australiancarealliance.org.au/a_wrong_prognosis_part_1

²⁵² https://www.australiancarealliance.org.au/access_to_palliative_care

No information on reasons for requests are given in any later reports.

One contact person is quoted as reporting of a person who requested and was given a prescription for a lethal poison but did not use it before dying naturally, peacefully and calmly: *“She had always planned to have the medication as **a plan B should her disease progress past bearable**, however she died peacefully and calmly from natural causes in hospital.”*

It is evident from this account that lethal poisons are being prescribed and supplied for people who are not experiencing unbearable suffering and whose fear of a difficult death could be addressed with expert care rather than palliated with the prescription of a placebo which is actually a lethal poison.

The [Jan-Jun 2021 report](#) mentions that reasons for withdrawal of requests may include an *“improvement in condition and thus no longer meeting eligibility criteria”*. Of course, this possibility of an improvement in condition is excluded for the 25 percent of applicants who progress to a final request within 11 days of first raising it.²⁵³

Mental illness

Section 9 (2) of the Act provides that:

*A person is not eligible for access to voluntary assisted dying only because the person is diagnosed with a mental illness, within the meaning of the **Mental Health Act 2014**.*

The force of the word “only” is the key to understanding the limited usefulness of this provision in protecting persons with mental illness.

It does not preclude a person with a profound mental illness but who also has another *“a disease, illness or medical condition”* that meets the criterion set out in section 9 (1) (d) of the Act from accessing assisted suicide or euthanasia.

Nor does it explicitly preclude a mental illness from itself being considered to be *“a disease, illness or medical condition”* that meets the criterion set out in section 9 (1) (d) of the Act. For example, a person with anorexia who is expected to die within 6 months as a result of refusing treatment could qualify or even a person with treatment resistant suicidal ideation. It remains to be seen whether the Act will be applied in this way.

Sections 18 (1) and 27 (1) provide respectively that if the co-ordinating medical practitioner or the consulting medical practitioner:

is unable to determine whether the person has decision-making capacity in relation to voluntary assisted dying as required by the eligibility criteria, for example, due to a past or current mental illness of the person, [he or she] must refer the person to a registered health practitioner who has appropriate skills and training, such as a psychiatrist in the case of mental illness.

It is entirely up to the assessing doctors to form their own view as to their expertise in assessing decision-making capacity. This provision is weaker than the [corresponding provision in Oregon](#) which

²⁵³ <https://www.bettersaferecare.vic.gov.au/sites/default/files/2021-08/VADRB%20August%202021%20report%20FINAL.pdf>

refers to “*impaired judgement*”²⁵⁴ rather than a lack of “*decision-making capacity*” which is defined in section 4 in purely cognitive terms, taking no account of the effects, say, of depression or demoralisation on a person judging what is truly in his or her best interests.

Under section 36 of the Act the two people witnessing the signature on the written declaration must certify in writing “*that, at the time the person signed the declaration, the person appeared to have decision-making capacity in relation to voluntary assisted dying*”. This hardly adds any extra assurance to the process as the witnesses do not need to have any expertise or prior knowledge of the person.

There is a provision in section 68 of the Act for a person who is considered by VCAT (Victorian Civil and administrative Tribunal) to have “*a special interest in the medical treatment and care of the person*” assessed as eligible for assisted suicide or euthanasia to apply to VCAT for a review of the decision that the person has decision-making capacity.

The [July-December 2020 Report](#) stated that over the first 18 months of the Act’s operation 17 people (3% of 562 applicants) had been referred for a specialist opinion on their decision-making capacity. This dropped to 14 in the second 18 months (1.75% of 801 applicants). There is no information available on the outcome of these referrals. There were no referrals for specialist opinion on decision-making capacity of applicants in the 12 months from July 2024-June 2025 and just **35 (1%)** in total between 19 June 2019 and 31 July 2025.

The section in the prescribed training which doctors must undergo before participating as assessing or consulting doctors that covers assessing decision making capacity totals less than 5 minutes – a [video](#) that runs for 2 minutes 10 seconds and then a series of slides that takes about 2 minutes 20 seconds to read through⁵

The amount of this brief material that addresses “red flags” totals about 41 seconds.

Disability

Section 9 (3) of the Act provides that “A person is not eligible for access to voluntary assisted dying only because the person has a disability, within the meaning of section 3(1) of the **Disability Act 2006**.”

Once again the key word is “*only*”.

Nothing precludes a person with a disability – physical or intellectual – from accessing assisted suicide or euthanasia provided the person meets the other eligibility criteria.

Nothing precludes the person’s disability from being considered as “*a disease, illness or medical condition*” expected to cause death within 6 months.

There are no explicit provisions to protect people with disability from discriminatory assessment under the required processes by doctors who would consider a person with a particular disability as “better off dead”.

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<https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/statute.pdf>

People with disability [are more likely to experience undiagnosed depression](#) especially following initial acquisition of a disability or adverse developments in their physical, psychological or social condition.²⁵⁵

The Act explicitly provides for requests for assisted suicide or euthanasia to be made by gestures. It is not made explicit in the Act whether or not an accredited interpreter is required in this case. A [recent court case in the Netherlands](#) determined that “*hand squeezes, nods, eye blinking and crying were all sufficient signs of*” a request for euthanasia.²⁵⁶

The January-June 2020 Report cites “fear of losing bodily functions” as a reason given for requests for assisted suicide or euthanasia. The loss of bodily functions, such as incontinence or difficulties in walking, are disabilities. It is disability discrimination to approve of a fear of such disabilities as a reasonable motive for assistance to end a person’s life.

Coercion

The Act requires the two assessing doctors, as well as the witness to an administration request in the case of euthanasia, to certify that the person requesting assisted suicide or euthanasia is “*acting voluntarily and without coercion*”.

Assessing doctors will be required to complete training approved by the Secretary of the Department of Health on “*identifying and assessing risk factors for abuse or coercion*”.

The section in the prescribed training which doctors must undergo before participating as assessing or consulting doctors that covers assessing voluntariness, including assessing the absence of coercion, totals just over 5 minutes, including a 2 minute 20 second video and slides which take a further 2 minutes 50 seconds to read. This obviously cannot guarantee that assessing doctors never miss the signs of coercion or abuse [given the well-documented evidence of failure by professionals in Australia to identify elder abuse](#).²⁵⁷

There is no provision for anyone to seek a review at VCAT of an assessment by the two doctors that a person is acting “*voluntarily and without coercion*” in requesting assisted suicide or euthanasia. A family member or friend who becomes aware that a person is being coerced has no formal recourse under the Act at all.

There is no mention of coercion in the six-monthly reports.

A death on April Fool’s Day 2020

Most of the alleged “safeguards” under the Act could be reasonably characterised as “tick a box” safeguards. There are several forms to be filled in by the “coordinating medical practitioner” and lodged with the Voluntary Assisted Dying Review Board, culminating in an application for either a self-administration permit or a practitioner administration permit.

²⁵⁵ https://www.australiancarealliance.org.au/better_off_dead

²⁵⁶ https://www.australiancarealliance.org.au/euthanasia_consent_by_gestures

²⁵⁷ https://www.australiancarealliance.org.au/bullying_or_coercion

Under section 49 of the Act, and clause 7 of the *Voluntary Assisted Dying Regulations 2018* the Secretary for Health and Human Services (or their delegate under s113 of the Act) has 3 business days to issue the permit or refuse to issue the permit.

Section 49 (3) states that *“the Secretary may refuse to issue a voluntary assisted dying permit if the Secretary is not satisfied the request and assessment process has been completed as required by this Act”*.

It is a matter of concern that the Act does not make it explicit that the Secretary must not issue a permit unless satisfied the request and assessment process has been completed as required by this Act.

On 1 April 2020 (April Fool’s Day) a person died by ingestion of a lethal substance prescribed for the person by Dr Nick Carr after he had been issued with a self-administration permit for the person by the Secretary on Friday, 11 February 2020, the same day the application for the permit, along with an allegedly complete set of the required forms, was submitted at 12.31pm. Assuming the Secretary knocked off issuing permits authorising Victorians to commit suicide by 5.00 pm on a Friday afternoon this was a 4 hour 29 minute or less turnaround time.

Clearly all the Secretary could do in that time was see if all the boxes were ticked.

In this case it turns out that Dr Carr had falsely ticked several of the key boxes so that his application for a permit for a person to be prescribed with a lethal substance to cause the person’s death falsely asserted that the two witnesses required under section 36 of the Act had witnessed that *“the person making the declaration appeared to freely and voluntarily sign the declaration; and that, at the time the person signed the declaration, the person appeared to have decision-making capacity in relation to voluntary assisted dying; and that, at the time the person signed the declaration, the person appeared to understand the nature and effect of making the declaration.”*

This is clearly a key alleged safeguard in relation to decision-making capacity, voluntariness, and the absence of coercion.

However, Dr Carr – who had previous to this case already been involved with between 8 and 10 other applications for permits under the Act – clearly did not explain to the two witnesses what they were supposedly solemnly testifying to or check whether they actually read and understood the relevant sentences in the Written Declaration (Form 3, Schedule 1 of the Act) as both purported “witnesses” signed the form notwithstanding that the person had NOT signed the form. In other words, both witnesses explicitly committed perjury by signing a false declaration.

This suggests that there may well be other cases where both the applicant and the witnesses do sign the form – even in the right order – but the assertions made by the witnesses are of little or no weight.

In this case, the witnesses dated their signatures 6 February 2020.

On or before 8 February, Dr Carr submitted the Written Declaration – with no signature by the person by whom it had purportedly been made – to the Voluntary Assisted Dying Review Board. On 8 February 2020 he submitted a Final Review Form in which he falsely asserted that the Written Declaration had been signed by the person; and that it had been witnessed by the required two witnesses. On 9 February 2020 he submitted an application for a self-administration permit which included a claim that he had checked all the required forms.

On 10 February 2020, an officer of the Secretariat of the Voluntary Assisted Dying Review Board identified the Incomplete Written Declaration and communicated to Dr Carr as follows:

We are process checking your case VAD161 and have noted the Witness declaration is not signed and dated by the patient. Could you please arrange for the patient to sign and date this document before we can progress the case.

Now while it is commendable that the officer actually noticed that the signature was missing it is concerning that this was seen as merely a clerical issue to be remedied by getting the missing signature. The officer did not demonstrate any concern that Dr Carr had made several false declarations; nor any concern that the two purported witnesses had committed perjury; nor any concern that an application for a permit for a lethal substance to cause the person's death had been made by Dr Carr without any evidence that the person was voluntarily requesting this.

The officer's instruction to Dr Carr surely should have made some reference to the need for witnesses to the person's signature.

In any case, Dr Carr continued with his cavalier approach to this serious matter. On 11 February he had the person sign the Written Declaration and falsely date the signature "06/02/20" and he then emailed it to the Voluntary Assisted Dying Review Board at 12.31 pm that day.

The extraordinary reply (within a minute as it is also recorded at 12.31pm) by an officer of the Secretariat was "*Dear Nick, Thank you, we have attached this to the file now and can progress the case.*"

This was extremely negligent of the officer as it should have been apparent that there was still no properly witnessed signature by the person and therefore still no independent evidence that the request was being made voluntarily and without coercion.

The file was then progressed and the permit issued later that day.

This means that the Secretary (or delegate) either was not informed or paid no attention to the fact that a signature noted as missing on the Written Declaration Form on 10 February and subsequently inserted on the same form was falsely dated 6 February – the same date as the witnesses signatures, - and that therefore there was still no evidence, as required under the Act, that the person had freely and voluntarily made a declaration, while having the required decision-making capacity and appearing to understand the nature and effect of making the declaration.

In other words, a permit for the supply and use to cause the person's death of a lethal substance was issued by the Secretary (or delegate) on behalf of the State of Victoria for a person in violation of a key alleged "safeguard" under the Act dealing with the core requirements of voluntariness and decision-making capacity.

It is sadly ironic that this person died on April Fool's Day 2020. The Parliament and people of Victoria were fooled by the proponents of the *Voluntary Assisted Dying Act 2017* into believing that with its 68 alleged safeguards it was absolutely safe. Checking that boxes have been ticked can never make killing safe.

While the Medical Board [made findings](#) of unprofessional conduct against Dr Carr and fined him \$12,000 no action seems to have been taken against the officers of the VARDB Secretariat or the Secretary of Health and Human Services for their egregious failures in this case.²⁵⁸

Dr Carr's \$12,000 fine didn't cost him a cent as a pro-euthanasia fund raiser gave the money. The fund raiser described the failure by Dr Nick Carr to have the forms completed in accordance with the Act and to make honest declarations when submitting the forms, was described on the fundraiser page as "*a small, inadvertent error in the paperwork for a Voluntary Assisted Dying request. For an action early in 2020, that did not harm the patient nor benefit Dr Carr*".²⁵⁹

Euthanasia and assisted suicide enthusiasts see every alleged safeguard as a clerical hoop of no real importance to jump through. If you miss the hoop who cares!

State-issued permits

Form 3 in the [Regulations](#) sets out what a VADSAP or "voluntary assisted dying self-administration permit" will look like.²⁶⁰

"This self-administration permit in respect of Mary Brown authorises Dr John Smith for the purpose of causing Mary Brown death, to prescribe and supply the substance specified in this permit to Mary Brown that is able to be self-administered; and is of a sufficient dose to cause death".

The permit will be signed by the Secretary of the Department of Health and Human Services or his or her delegate.

The permit will also directly authorise Mary Brown to "*use and self-administer the substance*" specified in the permit in order to cause her death.

This is clearly not just State sanctioned suicide but – in a world first since ancient times – **State authorised suicide of a particular, named person using a specified lethal substance.**

²⁵⁸ *Medical Board of Australia v Carr (Review and Regulation) [2023] VCAT 945 (14 August 2023),*

<http://www.austlii.edu.au/cgi-bin/viewdoc/au/cases/vic/VCAT//2023/945.html>

²⁵⁹ <https://www.mycause.com.au/p/320343/pay-nicks-vcata-fine>

²⁶⁰

http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubStatbook.nsf/93eb987ebadd283dca256e92000e4069/D550921996E9F89BCA258313001B4FE5/%24FILE/18-142sra%20authorised.pdf

Form 4 in the [Regulations](#) sets out what a VADPAP or “voluntary assisted dying practitioner administration permit” will look like.

“This practitioner administration permit is issued to Dr John Smith ... this practitioner administration permit in respect of Jim Brown for the purpose of causing Jim Brown death, authorises Dr John Smith to administer the substance to Jim Brown.”

This is **State authorised euthanasia of a named individual by a named doctor using a specified lethal substance**. It was last done in Germany in the 1940s.

The [Regulations](#) specify that the Secretary of the Department of Health and Human Services or his or her delegate will have 3 business days from receiving a VADSAP or VADPAP application form (accompanied by five other forms) to either issue the permit or refuse to do so.

All that the Secretary or his or her delegate will do is to check that two doctors have ticked the right boxes and filled in the blanks on the six forms.

None of this checking of ticked boxes can possibly guarantee that the person who the Secretary or delegate will authorise to commit suicide or to be killed by euthanasia really:

- has the [alleged condition](#);²⁶¹
- actually has [only six months to live](#);²⁶²
- is not being [coerced overtly or subtly](#) by impatient heirs or weary caregivers;²⁶³
- is not [depressed](#);²⁶⁴
- is not [missing out on effective treatment](#);²⁶⁵
- is not being discriminated against due to [disability](#);²⁶⁶ and
- could not [have had their suffering relieved](#) with appropriate palliative care²⁶⁷.

The [July 2023-June2024](#) Report notes that while the Secretary, Department of Health and Human Services, or delegate, has three business days to determine an application, 98.66 per cent of permits were issued within two business days - such efficiency in ticking boxes!

Euthanasia

Section 48 of the Act allows for euthanasia (practitioner administration of the poison) as an alternative to assisted suicide in the case where a single doctor certifies that he or she is satisfied that “*the person*

²⁶¹ https://www.australiancarealliance.org.au/a_wrong_diagnosis

²⁶² https://www.australiancarealliance.org.au/a_wrong_prognosis_part_2

²⁶³ https://www.australiancarealliance.org.au/bullying_or_coercion

²⁶⁴ https://www.australiancarealliance.org.au/mentally_ill_at_risk

²⁶⁵ https://www.australiancarealliance.org.au/unaware_of_available_treatment

²⁶⁶ https://www.australiancarealliance.org.au/better_off_dead

²⁶⁷ https://www.australiancarealliance.org.au/access_to_palliative_care

is physically incapable of the self-administration or digestion of an appropriate poison or controlled substance or drug of dependence” and provides a reason for this incapacity in completing Form 8 of schedule 1 of the Act and Form 2 as set out in the [Regulations](#) .

The Board actively encouraged recourse to euthanasia in its January-June 2020 Report:

“While self-administration might be appropriate for the applicant initially, it may not always be when close to death. Coordinating medical practitioners can apply for a new practitioner administration permit if the applicant has lost the physical capacity to swallow or digest the medication. Before an application for a practitioner administration permit can be made, the unfilled prescription must be destroyed, or if the medication has already been dispensed, it will need to be returned to the Statewide Pharmacy Service and disposed of. ‘I was worried she wouldn’t be able to swallow the medication.’ – Contact person.”

The Reports do not provide any data on how often, if ever, this has occurred to date. It does indicate that the threshold for justifying euthanasia as the method of bringing about death is so low that vague concerns about an ability to swallow the (liquid) medication would be sufficient.

[Assisted suicide](#)

The processes for assisted suicide are deeply flawed.

The *“poison or controlled substance or a drug of dependence specified in a voluntary assisted dying permit for the purpose of causing a person’s death”* approved by the Secretary, prescribed by the doctor and issued by a pharmacist to the person will be 15 g of sodium pentobarbital.

On 5 January 2019 the Minister for Health, Martin Foley, [announced](#) that The Alfred Hospital pharmacy would be “the sole service for dispensing” the lethal poison across Victoria. *“For people too sick to travel, the pharmacy service will deliver them their medication and provide information on administration”*.²⁶⁸

The notion of a kind of “uber-poison” service to country Victoria - where there is a chronic shortage in ready access to palliative care medicines as needed - is particularly disturbing.

There is no requirement for any doctor or other health practitioner to be present when the poison is ingested.

The six-monthly (now annual) reports provide no data on how many people were alone when the prescribed lethal poison was ingested, or how many had just one other person present. There is no data provided on complications, on the length of time to loss of consciousness or the length of time to death.

The 2022/23 report mentions that there were “a number of cases where the time to death has been prolonged” but provides no data.

In [Oregon](#), under a similar scheme, in 2018 for nearly two out of three (62.5%) people there was no physician or other healthcare provider known to be present at the time of death. One in eight (12.5%) of those for whom information about the circumstances of their deaths is available either had difficulty ingesting or regurgitated the lethal dose or had other complications or regained consciousness and died subsequently from the underlying illness. The interval from ingestion of lethal drugs to

²⁶⁸ <https://www.premier.vic.gov.au/voluntary-assisted-dying-a-step-closer/>

unconsciousness was as long as four hours while the time from ingestion to death was as long as 21 hours.

Imagine these complications occurring for a person who is home alone when they ingest the poison.

The Act does not require any assessment of decision-making competence or absence of coercion at the time of ingestion nor does it set any time limit on the length of time between the poison being prescribed under a VADSAP and it being ingested. In [Oregon](#) the longest duration between initial request and ingestion recorded is 1009 days (that is 2 years and 9 months).

The [Regulations](#) provide the specifications for the locked box in which the Act requires the lethal poison issued under a VADSAP to be stored. It must be made of steel. It must be “*not easily penetrable*”. It must be “*lockable with a lock of sturdy construction*”.

The last two requirements are entirely subjective. What counts as “*not easily penetrable*” or as a “*lock of sturdy construction*”? Who knows? Almost any steel petty cash box could be thought to qualify.

There are no requirements for where the box containing the lethal poison is to be kept. However, section 126 of the Act does specifically exclude it from the usual protective requirements for dangerous medication in aged care services - so it may have **to be kept under grannie’s bed in her aged care room**. Nor are there any limits on how many keys there can be to the box or on who can have a key (or the code in case of a combination lock).

Where there is no witness we will never know if the person really self-administered the poison or if it was administered to them by a family member or other person under duress, surreptitiously or violently.

Seizures – link to pentobarbital dismissed by VADRB despite evidence from Oregon and from its use in executions

Three cases of people experiencing seizures after self-administration of a prescribed lethal substance have been reported in Oregon since 2017.²⁶⁹

In the Voluntary Assisted Dying Review Board minutes for 19 January 2023²⁷⁰, it is initially minuted that after discussing a reported case of seizure following ingestion of a prescribed VAD substance “Board members with clinical expertise advised **it could not be** a result of the substance”. Curiously this was subsequently revised to read “Board members with clinical expertise advised it **was probably not** as a result of the substance.”

In either case this illustrates an extremely dismissive attitude by the Voluntary Assisted Dying Review Board to a report of a complication that has also been reported from Oregon and in relation to the use of pentobarbital in executions.

²⁶⁹ Oregon Public Health Division, *Oregon Death With Dignity Act: 2022 Data Summary, Table 1*, p.14 <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year25.pdf>

²⁷⁰

https://assets.nationbuilder.com/australiancarealliance/pages/171/attachments/original/1706315292/92/VARDB_Meetings_Jan-Jun_2023.pdf?1706315292

Pentobarbital has been used as a lethal substance in executions in the United States both as the first (sedative) drug in a two or three drug protocol and also in a one drug protocol.

Given the rarity of its use in medical procedures and the resulting paucity of data on its effectiveness, anaesthesiologists have repeatedly raised concerns over its use in executions. By extension these concerns are also relevant to its use in Victoria as a suicide drug to be taken at home, possibly alone, under the *Voluntary Assisted Dying Act 2017*.

Dr. David Varlotta, who is on the board of directors of the **American Society of Anesthesiologists**, has noted that pentobarbital “is not used in a clinical setting for clinical anesthesia.” Dr. David Waisel, an anaesthesiologist and Harvard Medical School professor, said, “Pentobarbital has almost never been used for induction of anesthesia. If you look at the literature, there’s one report from the ’40s, maybe 2. We’re experimenting, and we’re taking a huge risk here just for the big desire to make sure we’re killing people.”²⁷¹

Anecdotal reports from eyewitness of its use in executions suggest there are possible problems with the use of pentobarbital that could result in an inhumane death.

After the drug was administered to Eric Robert in South Dakota in October 2012, he “appeared to be clearing his throat and then began gasping heavily,” and “his eyes remained opened throughout.” His heart beat for 10 minutes after he stopped breathing, suggesting the drug was not fully effective.

When compounded pentobarbital was administered to Michael Lee Wilson on Jan. 9, in Oklahoma, he cried out, “I feel my whole body burning.”²⁷²

Pentobarbital is considered a controversial substitute for sodium thiopental because its manufacture is often poorly regulated, and contaminated batches can cause excruciating pain prior to death.

Tanya Greene, advocacy and policy counsel on criminal justice issues for the ACLU, said the use of pentobarbital in executions is unconstitutional as it violates the Eighth Amendment’s protection against cruel and unusual punishment. Use of the drug in executions, she said, is “basically an experiment on human beings; the risk of extended, painful death is very high. The European manufacturer of pentobarbital objects to its use to kill and has stopped selling the drug to US states for use in executions.”²⁷³

Richard Dieter, executive director of the Death Penalty Information Center in Washington, D.C., a group opposed to the death penalty, says Ohio's approach may be the direction other states follow.

Ohio is one of two states that use only a single drug in their executions, but Dieter says it's not clear whether pentobarbital will do what it's supposed to do. Dieter says the issue here, the effectiveness of the anesthesia, is not yet known.

²⁷¹ <https://deathpenaltyinfo.org/executions/lethal-injection/state-by-state-lethal-injection-protocols>

²⁷² <https://www.nytimes.com/2014/04/14/opinion/secret-drugs-agonizing-deaths.html>

²⁷³ <http://nation.time.com/2014/01/10/oklahoma-convict-who-felt-body-burning-executed-with-controversial-drug/>

"So a new drug, you know, may have the same purpose, but it doesn't mean it has the same effect on human beings. And there's no way to experiment on executions except by doing them, so there's going to be challenges," he says.²⁷⁴

Anaesthesiologist, Joel Zivot, M.D. swore an affidavit in the case of *Johnson v Lombardi* explaining in that pentobarbital carried a risk of causing seizures. *"Once it enters his bloodstream, the pentobarbital will interact with his scarring tissue, brain defect, and remaining meningioma, thereby triggering seizures. These seizures, in turn, will give Johnson muscle pain described as severe, extreme, and excruciating. This is in part because pentobarbital, pharmacologically, makes pain worse. The seizures will not be quick, and will prolong the execution"*²⁷⁵

Anaesthesiologist and Harvard Medical School professor, Dr David Waisel, has testified on the execution of Ray Blankenship "I can say with certainty that Mr. Blankenship was inadequately anesthetized and was conscious for approximately the first three minutes of the execution and that he suffered greatly. Mr. Blankenship should not have been conscious or exhibiting these movements, nor should his eyes have been open, after the injection of pentobarbital. [...] Only when a drug has been tested systematically on thousands of subjects, with their consent, can one begin to reliably assess how an untested use of a drug will affect human subjects. We do not have relevant data in similar populations for pentobarbital. Because we do not have sufficient data, there is no way to know, in any given case, how an overdose of pentobarbital will affect basically healthy inmates. Mr. Blankenship's reaction to the pentobarbital injection may be indicative of other inmates' reactions."²⁷⁶

On November 20, Missouri will perform a similar experiment on death row inmate Joseph Paul Franklin. Missouri will become the third state, after Texas and South Dakota, to inject an inmate with pentobarbital synthesized in a compounding pharmacy—a type of drug manufacturer that is not subject to Food and Drug Administration safety regulations. The pentobarbital may simply stop Franklin's heart, as intended. But if it is contaminated by tiny particles—as drugs manufactured by compounding pharmacies often are—the insides of Franklin's veins will feel as though they're being scraped with sandpaper as he dies, warns David Waisel, an associate professor of anesthesiology at Harvard Medical School.

Waisel says that pentobarbital that is not potent enough could result in a lingering death that "drags on and drags on and drags on. It would be awful."²⁷⁷

²⁷⁴ <https://www.npr.org/2011/01/29/133302950/new-lethal-injection-drug-raises-concerns>

²⁷⁵

<http://courtweb.pamd.uscourts.gov/courtwebsearch/mowd/ka7EsuYBhf.pdf#xml=http://courtweb.pamd.uscourts.gov/courtweb/PDFResult.aspx>

²⁷⁶ https://reprieve.org.uk/press/2011_06_30_execution_pentobarbital_blankenship/

²⁷⁷ <https://www.motherjones.com/politics/2013/11/ohio-lethal-injection-cocktail-execution-drugs/>

No suicide prevention but likely suicide contagion

Legalising assistance to suicide for some people in Victoria undermines the commitment to **suicide prevention for all** by affirming that such people would be better off dead and supporting their suicide as a rational choice to be facilitated rather than prevented.

People diagnosed with a terminal illness are at greatest risk of suicide within the first six months of diagnosis and often miss out on accurate diagnosis of depression and anxiety for which effective treatments are available.²⁷⁸

A study of US data comparing States which had legalised assisted suicide with those which have not has shown that legalising assisted suicide is associated with an increase in the overall rate of suicides of 6.5% and of the elderly (65 years and older) by 14.5%.²⁷⁹

This conclusion is supported by **evidence from Victoria**.

When arguing for the legalisation of assistance to suicide, then Minister for Health and Human Services, the Hon Jill Hennessy, claimed:

*Evidence from the coroner indicated that one terminally ill Victorian was taking their life each week.*²⁸⁰ She argued legalisation would prevent these 50 suicides each year.

Not only has there been no such decline, but there were 62 more suicides in Victoria in 2022 than in 2017, when this claim was made. The suicide rate among those aged over 65 years increased from 2019 to 2022 by 42 per cent in Victoria, where “voluntary assisted dying” was legal—five times the increase over the same period in New South Wales where it remained illegal.²⁸¹

²⁷⁸ Nafilyan V, et al., “Risk of suicide after diagnosis of severe physical health conditions: a retrospective cohort study of 47 million people”, *The Lancet Regional Health - Europe* 2023;25: 100562, Published Online 14 December 2022,

<https://www.thelancet.com/action/showPdf?pii=S2666-7762%2822%2900258-7> ;

Fulton JJ, et al., “Psychotherapy targeting depression and anxiety for use in palliative care: a meta-analysis”, *Journal of Palliative Medicine*, Jul 2018, Vol. 21: 1024-1037,

<https://www.liebertpub.com/doi/10.1089/jpm.2017.0576> ;

Schweighoffer R. et al., “A systematic review and bayesian network meta-analysis investigating the effectiveness of psychological short-term interventions in inpatient palliative care settings.”, *Int J Environ Res Public Health*, 2022;19, <https://www.mdpi.com/1660-4601/19/13/7711/pdf>

²⁷⁹ Jones, David A and D. Paton. “How Does Legalization of Physician-Assisted Suicide Affect Rates of Suicide?” *Southern Medical Journal* 108 (2015): 599–604, <https://nottingham-repository.worktribe.com/OutputFile/981911>

²⁸⁰ https://www.parliament.vic.gov.au/images/stories/daily-hansard/Assembly_2017/Assembly_Daily_Extract_Thursday_21_September_2017_from_Book_12.pdf

²⁸¹

<https://jemh.ca/issues/open/documents/Did%20the%20Voluntary%20Assisted%20Dying%20Act%202017.pdf>

Claims made that “voluntary assisted dying”, that is the intentional causing of a person’s death by self- or practitioner-administration of a lethal substance is not “suicide” were given shrift in the recent decision by the Federal Court in *Carr v Attorney-General (Cth)* [2023] FCA 1500 which formally declared:

*The term “suicide” ... does apply to the ending of a person's life in accordance with, and by the means authorised by, the Voluntary Assisted Dying Act 2017 (Vic) and Voluntary Assisted Dying Regulations 2018 (Vic).*²⁸²

Amendment of the Act

The Voluntary Assisted Dying Amendment Act 2025 passed the Victorian Parliament and received assent on 25 November 2025. When it commences (on a day or days to be proclaimed or otherwise on 19 April 2027) the prognosis for eligibility for all conditions will be 12 months or less; health practitioners will be able to propose euthanasia to people; there will be a free choice between euthanasia and assistance to suicide; conscientiously objecting medical practitioners will be required to supply information about accessing euthanasia and assistance to suicide. These changes are likely to lead to a significant increase in euthanasia in Victoria.

Conclusion

On 19 June 2019 Victoria embarked on the fifteenth in a series of experiments in legalised euthanasia or assisted suicide begun in the Northern Territory in 1996. Each of these experiments has proved to be fatally flawed resulting in wrongful deaths. There is nothing in the design of the Victorian experiment or the data from the first 5 years of its operation to justify any expectation of better results.

²⁸² <https://www.judgments.fedcourt.gov.au/judgments/Judgments/fca/single/2023/2023fca1500>

New Jersey (2019-)

Assisted suicide became legal in New Jersey from 1 August 2019.

The [Medical Aid in Dying for the Terminally Ill Act](#) is essentially modelled on the Oregon and Washington laws.²⁸³

Minimal reporting

Section 13 of the Act requires an annual statistical report to be issued based on reports from attending physicians. The Commissioner of Health is empowered to make regulations as to the documentation required following the death of a person who has been prescribed a lethal substance under this Act.

The [2019 Data Summary](#) indicates that between 1 August 2019 and 31 December 2019 twelve cases of people dying after being prescribed a lethal dose under the Act were reported. In [2020](#) 33 cases of people dying after being prescribed a lethal dose under the Act were reported. In [2021](#) 50 cases were reported. In [2022](#), 91 cases were reported. In [2023](#), 101 cases were reported. In [2024](#), 122 cases were reported, representing 0.16% of all deaths in new Jersey.

Nine different experimental lethal cocktails were reported as used in 2022. In 2024 for 115 out of 122 people the lethal cocktail involved “Morphine, Diazepam, Phenobarbital, Amitriptyline, Digoxin, Zofran and Reglan”.

The 122 people who died from ingesting a lethal substance prescribed under the Act were prescribed the lethal substance by just 11 medical practitioners.

There is no information provided about complications, length of relationship with the physician, time between first request and ingestion of the lethal dose, time between ingestion of the lethal dose and unconsciousness or time between ingestion of the lethal dose and death.

²⁸³ https://www.njleg.state.nj.us/2018/Bills/A2000/1504_R2.PDF

Maine (2019-)

Assisted suicide became legal in Maine from 17 September 2019.

The [Maine Death With Dignity Act](#) is essentially modelled on the Oregon and Washington laws and creates the same risks of wrongful deaths. It passed the House by just one vote (73-72) and the Senate by just two votes (19-16) before being signed by the Governor on 12 June 2019.

Minimal reporting

Section 17 of the Act requires an annual statistical report to be issued based on reports from attending physicians. The Department of Health and Human Services issued an [emergency rule](#) for reporting requirements on 19 September 2019.

The [End-of-Life Closure Form](#), mandated by the rule, unlike Oregon or Washington, does not provide for any detailed information whatsoever.

In Maine we will not know why people request assisted suicide, how long they take to lose consciousness and die after ingesting the prescribed poison, if there were any complications and so forth.

No demographic data apart from age and sex is recorded and the only medical information is the underlying condition.

Numbers

A total of 1470 people have died after ingesting a lethal substance prescribed under the Act – 1 in [2019](#); 30 in [2020](#); 46 in [2021](#) (0.26% of all deaths); 40 in [2022](#) and 53 in [2023](#) (0.3% of all deaths).

In April 2024, six of the nine people who had made a request for a lethal substance in 2023 and were still alive had made the request more than six months ago and so had outlived the legally required prognosis of death within six months.

Germany (2020-)

On 26 February 2020 a unanimous [decision](#)²⁸⁴ of the eight judges of the second senate of the Federal Constitutional Court overturned Section 217 of the [German Criminal Code](#) which had been in effect since 10 December 2015.

Section 217 read:

Facilitating suicide as recurring pursuit

(1) *Whoever, with the intention of assisting another person to commit suicide, provides, procures or arranges the opportunity for that person to do so and whose actions are intended as a recurring pursuit incurs a penalty of imprisonment for a term not exceeding three years or a fine.*

(2) *A participant whose actions are not intended as a recurring pursuit and who is either a relative of or is close to the person referred to in subsection (1) is exempt from punishment.*²⁸⁵

It had been introduced to stop the increasing practice of groups involved in the facilitation of suicide and to prevent the normalisation of suicide.

Suicide facilitation

The complainants in the case included two organisations based in Germany and one based in Switzerland.

The Swiss organisation Dignitas, is reported in the judgement as claiming that from May 1998 to 2017 the organisation had assisted, in Switzerland, the suicide of 1,150 Germans. Of these 724 suicides had been facilitated between 2005 and 2016 by Dignitas-Deutschland, an organisation based in Hanover, Germany. It had ceased this active facilitation after Section 217 came into effect.

Another German based group is reported to have facilitated 254 suicides of Germans in Switzerland between 2009 and 2015.

A fundamental human right to be helped to commit suicide

Essentially, the eight judges decided that Article 2 (1) of the [Basic Law for the Federal Republic of Germany](#) necessarily includes not just a right to commit suicide but also a right to obtain direct aid in doing so, including by persons or organisations who offer such aid on a commercial basis.

Article 2 (1) reads:

Article 2 [Personal freedoms]

(1) *Every person shall have **the right to free development of his personality** insofar as he does not violate the rights of others or offend against the constitutional order or the moral law.*²⁸⁶

²⁸⁴ BVerfG, judgment of the Second Senate of February 26, 2020- 2 BvR 2347/15 -, para. (1-343), http://www.bverfg.de/e/rs20200226_2bvr234715.html

²⁸⁵ https://www.gesetze-im-internet.de/englisch_stgb/englisch_stgb.html#p1951

²⁸⁶ <https://www.btg-bestellservice.de/pdf/80201000.pdf>

The judgement is very thin on how the free development of one's personality includes extinguishing one's life. Rather it simply asserts:

The decision of the individual to end his life in accordance with his understanding of the quality of life and the meaningfulness of his own existence must be respected as an act of autonomous self-determination by the state and society.

The freedom to commit suicide also includes the freedom to seek help from third parties and to seek help where it is offered.

The judgement did acknowledge the weightiness of the argument for laws protecting people from being coerced or enticed into committing suicide but absolutely ruled out any such law (such as Section 217) that prohibited all organised, third party assistance and even specifically declared that:

due to the constitutional recognition of the right to suicide, which includes the motives underlying an individual's decision to commit suicide and thus detract from an assessment based on objective reasonableness (see margin no.210), it is forbidden to subject the admissibility of help for suicide to material criteria to make them dependent on the existence of an incurable or fatal illness.

This judgement of Germany's highest court goes beyond both the Canadian and Colombian court decisions by rejecting any nexus whatsoever between a right to assistance in suicide and a medical condition involving suffering.

Indeed, it effectively gives legal effect to Phillip Nitchke's notorious [declaration](#):

people have a right to dispose of [their] life whenever they want ... all people qualify ... and someone needs to provide this knowledge, training, or recourse necessary to anyone who wants it, including the depressed, the elderly bereaved, [and] the troubled teen. If we are to remain consistent and we believe that the individual has the right to dispose of their life, we should not erect artificial barriers in the way of sub-groups who don't meet our criteria.²⁸⁷

The judgement specifically provided that no one – including a doctor – can be “obliged to provide suicide assistance”.

It also left untouched Section 216 of the German Criminal Code that provides that:

Section 216

Killing upon request

(1) Whoever is induced to kill at the express and earnest request of the person killed incurs a penalty of imprisonment for a term of between six months and five years.²⁸⁸

²⁸⁷ Kathryn Jean Lopez, “Euthanasia sets sail”, *National Review Online*, 5 June 2002, <https://www.nationalreview.com/2001/06/euthanasia-sets-sail-kathryn-jean-lopez/>

²⁸⁸ https://www.gesetze-im-internet.de/englisch_stgb/englisch_stgb.html#p1951

So euthanasia remains unlawful, as does the provision of lethal drugs such as sodium pentobarbital which are subject to narcotic legislation.

As of July 2023, the Federal Institute for Drugs and Medical Devices (BfArM) has [rejected 240 applications](#) to access sodium pentobarbital for the purpose of committing suicide.

A challenge to the position taken by the BfArM failed in the Higher Administrative Court in Munich, with the judgement delivered on 2 February 2022 ruling that, unless the Bundestag explicitly changes the law, and despite the Constitutional Court finding a right to seek assistance in committing suicide, there is no obligation on the BfArM to approve the supply of drugs for the purpose of suicide.

<https://www.bverwg.de/de/pm/2023/81>

On 7 November 2023 the Federal Administrative Court in Leipzig [rejected](#) an appeal against this judgement and upheld the validity of the Narcotics Act.

In the balancing of interests, the burdens associated with the lack of access to sodium pentobarbital for persons wishing to die who have decided in a self-determined manner to end their lives are not disproportionate to the protection of legal interests that can be achieved as a result. The legislature has leeway in the weighting of the dangers of narcotics trafficking and in the design of the protection concept to prevent misuse and abuse. Its limits are not exceeded with the ban on the acquisition of sodium pentobarbital for suicide. The restriction of self-determination in the choice of means does indeed carry weight; it is about shaping one's own end of life. However, the dangers that can arise from the acquisition of sodium pentobarbital and the storage of the drug by those wishing to die are great. In view of these dangers and the existing alternatives to the use of the desired means, it is not objectionable that the law does not permit its acquisition for the purpose of suicide.

On 6 July 2023 the Bundestag [rejected](#) two different proposals for legislative schemes to regulate access to assisted suicide.

Numbers

There is no central recording of the number of assisted suicides in Germany.

The German Society for Humane Dying, which provides assistance to suicide, [charges](#) € 4000 per single or € 6000 for a “double assisted suicide”. The Society has [assisted](#) in “nearly 1100” suicides since 2020: 18 in 2020; about 140 in 2021; 229 suicides in 2022, 419 in 2023 and 290 between 1 January and 30 June 2024.

The Euthanasia Association (Sterbehilfe) has [assisted](#) 710 suicides between 2020 and 2024, with 196 in 2023 and 171 in 2024.

A comprehensive death certificate [study](#) conducted in Munich found that there was a total of 37 assisted suicides in the three years 2020-2022 of which 36 cases involved an assisted suicide organization.

[Seven cases](#) involved a person who had previously attempted suicide and in three of these cases no psychiatric assessment was carried out prior to assisting the suicide. In one of these cases a gynecologist had a 55-minute conversation with a woman and assisted her to suicide the next day. In a second case the doctor who assisted the suicide was a first degree relative.

New Mexico (2021-)

Assisted suicide became [legal](#) in New Mexico from 18 June 2021.

The law allows nurse practitioners and physician assistants, as well as physicians, to prescribe a lethal dose of poison to enable a person to commit suicide.

The poison can be supplied 48 hours after the request is approved, or sooner if the prescriber asserts the person may die within the 48-hour period.

In an acknowledgement that mental illness and intellectual disability could impact decision-making capacity, an amendment requires referral for assessment if there is a history of either of these conditions.

The law limits the data that can be collected and published to basic demographic information so there will be no information available about complications, length of relationship with the physician, time between first request and ingestion of the lethal dose, time between ingestion of the lethal dose and unconsciousness or time between ingestion of the lethal dose and death.

The law requires that before being prescribed the lethal poison a person must acknowledge that death is expected after ingesting the poison but that “although most deaths occur within three hours, my death may take longer”.

Numbers

No official reports have been published to date.

However, End of Life Options New Mexico claimed in [2022 Annual Report](#) to know of more than 200 New Mexicans who had ended their lives under the Act.

In its [2023 Annual Report](#) it is claimed that those using the Act to end their lives now exceeded 500.

If there were 300 deaths by assisted suicide in 2023 this would represent 1.27% of all deaths – a much higher rate than Oregon or any other US State.

No claims are made in relation to numbers using the Act in the 2024 Annual Report.

Spain (2021-)

Euthanasia and assisted suicide both became legal in Spain from 24 June 2021.

Access to euthanasia or assisted suicide is available on request for any person assessed by two doctors as having a "serious or incurable illness" or a "chronic or incapacitating" condition that causes "intolerable suffering".

There is no requirement for a terminal diagnosis so people with a mental illness or with a disability will be eligible.

In the [first six months](#) of legalisation (24 June-31 December 2021) 75 people died by euthanasia. Three of these people were not competent at the time of euthanasia, which was carried out based on an advanced directive. All 75 cases (100%) involved euthanasia rather than assisted suicide.

In 2022, 288 people died under the Act – 11 by self-administration and 277 by euthanasia.

In [2023](#), 334 people died under the Act – 18 by self-administration (16 of these intravenously; only 2 by oral administration) and 316 by euthanasia. Of these 334 deaths, 15 involved advanced directives.

In 63 cases the 15 day cooling off period between a first and second request was waived on the grounds that loss of capacity was thought to be imminent.

The rate of deaths under the Act as a percentage of all deaths was 0.06% in 2022 rising to 0.08% in 2023.

Organ extraction for transplantation following euthanasia occurred in 7 cases in 2021, 42 in 2022 and 42 in 2023.

In [Navarra](#), deaths by euthanasia accounted for 0.2% of all deaths in 2022.

[Less than half](#) of the people who have died by euthanasia in Spain up to 31 December 2022 were terminally ill.

On 23 August 2022, Marin Eugen Sabau, was [euthanased](#) in prison effectively ending the possibility of compensation claims against him from his victims. The 46-year-old Romanian security guard shot three colleagues and a police officer in December 2021 in Tarragona. Several others were injured in the chase.

Western Australia (2021-)

Euthanasia and assistance to suicide became legal in Western Australia from 1 July 2021.

Increase in numbers

In the [first year](#) of legalised euthanasia and assistance to suicide, 191 people had their lives ended by these acts – 96 by intravenous administration of a lethal poison by a medical practitioner; 52 by oral administration of a lethal poison with the assistance of a medical practitioner; and 43 by self-administration of a lethal poison. These deaths accounted for approximately 1.14% of all deaths in Western Australia in 2021-22.

In the [second year](#), 2022-23, the number of deaths increased by 33.5% to 255, representing 1.4% of all deaths in Western Australia that year. 45 deaths (17.65%) were by assistance to suicide (self-administration) and 210 (82.35%) by euthanasia (practitioner administration).

In the [third year](#), 2023-24, the number of deaths increased by 14.5% to 293, representing 1.63% of all deaths. Just 15 of these deaths (5.1%) were by assistance to suicide, with 277 (94.9%) by euthanasia.

In the [fourth year](#), 2024-25, the number of deaths increased by a massive 63.8% to 480, representing 2.68% of all deaths. Just 29 (6%) were self-administered with 451 (94%) of deaths by euthanasia.

132 of the deaths in 2024-25 took place in the fourth quarter (April-June 2025), representing 2.94% of all deaths in that quarter.

The rate in Western Australia of deaths by euthanasia and assistance to suicide (2.94%) after four years of legalisation is well over three times the rate of 0.86% in Victoria in its sixth full year of legalisation.

There are several factors that could be leading to this higher rate of deaths by assisted suicide and euthanasia compared to Victoria.

Where euthanasia is available as well as assisted suicide the international evidence suggests that there will be a significantly higher take up rate overall, with most people choosing euthanasia over assistance to suicide.

Between 1 July 2024 and 30 June 2025, the majority (94%) of cases in Western Australia involved practitioner administration, that is euthanasia, with 6% of cases involving self-administration.

This rate of euthanasia compared to assisted suicide is over 5 times that in Victoria (18.9%) in 2023-24. In Victoria, practitioner administration is only permitted where the person lacks the physical capacity to self-administer or digest the lethal poison (*Voluntary Assisted Dying Act 2017*, Section 46 (c)(i)) whereas under Western Australia's Act, a patient's concerns about self-administration are sufficient to justify practitioner administration (*Voluntary Assisted Dying Act 2019*, Section 56(2) (b))

Unlike in Victoria, the Act allows a medical practitioner to **initiate** a conversation about euthanasia or assistance to suicide without any indication that a person has even considered it or would be likely to consider it without such prompting.

Additionally, the Act attempts to conscript all medical practitioners into facilitating euthanasia and assistance to suicide by mandating that if a person makes a request for euthanasia or assistance to suicide the medical practitioner must either accept the request and begin the assessment process or refuse the request and hand them [a 16 page promotional pamphlet](#) which includes contact details for

the Statewide Care [sic] Navigator Service which is funded to facilitate access to euthanasia and assistance to suicide.

Death practitioners

Of the 63 practitioners who have actively killed a person between 2021 and 2025 by administering a prescribed lethal substance, 17 of them have killed 21 or more people each and a further 12 have killed between 11 and 20 people each.

Of the 41 practitioners who actively killed a person in 2024-25 by administering a prescribed lethal substance, 7 of them killed 233 people between them – an average of 33 per killer at an average rate of one person every 11 days.

It is not surprising that the Board reports concerns about practitioner “fatigue”.

From 1 July 2024 the State of Western Australia has been directly paying administrative practitioners a fee for service to kill people.

90.8% of people assessed between 2021 and 2025 had no previous relationship with the medical practitioner who assessed them. This lack of any previous knowledge of the person increases the chances of missing depression, coercion or lack of decision-making capacity, as well as errors in diagnosis from lack of familiarity with a person’s medical history.

Eligibility criteria and inevitable wrongful deaths

The [Voluntary Assisted Dying Act 2019](#) allows the prescription by a medical practitioner for self-administration, or administration by a medical or nurse practitioner, of a lethal dose of poison in order to cause the death of an adult who has requested the prescription and who is assessed by two medical practitioners as having a condition that will “*on the balance of probabilities*” cause death within 6 months or, in the case of a neurodegenerative condition cause death within 12 months.

So, people with a 49% chance of living longer than 6 (or 12) months qualify. Given that doctors make errors in both [diagnosis](#) of a terminal condition and in [prognosis](#), the law will inevitably lead to unnecessary premature deaths of people who were either not terminally ill or may have had years to live.

In one case in 2022-23 the person took the lethal poison 503 days (1 year 4 months) after making a first request and being assessed as having 6 months (or possibly 12 months for a neurological disorder) to live.

There were at least two cases each in 2023-24 and 2024-25 of people dying more than two years after being assessed as having 6 months (or possibly 12 months for a neurological disorder), including one case where death was 2 years 8 ½ months after the assessment and one where death was 2 years 4 ¼ months after the assessment.

As neither of the two assessing medical practitioners is required to have any specialist qualifications relevant to the alleged condition or even have any experience in caring for people with that condition there is an increased chance of such errors as well as of a failure to inform the person of [all available treatments](#).

Nor does either practitioner need to have any expertise in [palliative care](#) and there is no requirement to refer the person for a specialist palliative care consultation.

In 2024-25, 16.5% of people assessed as eligible for euthanasia and assistance to suicide had not received any palliative care in the past 12 months and a further 2.6% were not currently receiving any palliative care. The report does not provide any information on why palliative care was not being received. If it was not needed at all what was the nature of the “unrelievable suffering” justifying euthanasia? If it was needed but not available why is the delivery of a lethal poison by the Statewide Pharmacy Service funded by the State but not the delivery of pain and symptom relief through palliative care?

Access to palliative care is uneven in Western Australia – especially in regional and remote communities. However, the WA Government has established the Western Australian Voluntary Assisted Dying Statewide Care Navigator Service and a Regional Access Support Scheme to provide financial and logistical support to people in remote and regional communities to easily access euthanasia and assistance to suicide. Equal access to euthanasia and assistance to suicide is established under the [Access Standard](#). The Statewide Pharmacy Service “*will actively engage with regional residents to ensure safe, timely and appropriate supply of the*” lethal poison.

In 2023-24 the Statewide Pharmacy Service reported meeting its benchmark for delivery of the lethal poison to persons in regional Western Australia of 5 days or less in 100% of cases.

There is no equivalent support for access to gold standard palliative care, or palliative medicines, so some people will die unnecessarily by euthanasia and assistance to suicide for [lack of financial resources](#) to access effective treatment or palliative care.

[Decision-making capacity and freedom from coercion](#)

Sections 26 and 37 of the Act provide for a referral by either assessing medical practitioner to “a registered health practitioner with the appropriate skills” to assess the person’s decision-making capacity – but only at the discretion of the assessing medical practitioner if he or she “is unable to determine” if the person has the required decision-making capacity.

There were NO referrals for expert assessment of decision-making capacity or freedom from coercion in Western Australia in 2021-22; only 2 in 2022-23; 1 in 2023-24 and none in 2024-25.

The medical literature shows that diagnosis with a terminal condition can adversely impact on decision-making capacity and that even specialists are not always experts in [accurately determining decision-making capacity](#).

The Act requires practitioners who wish to participate in assessing for or administering euthanasia and assistance to suicide to undergo approved training. The approved training consists of online modules prepared by Ben White and others from the Queensland University of Technology.

Under similar approved online training modules prepared by the same team for Victoria, there is a very brief section that covers assessing voluntariness, including assessing the absence of coercion, totalling just over 5 minutes, made up of a 2 minute 20 second video and a set of slides which take a further 2 minutes 50 seconds to read.

This minimal, perfunctory “training” obviously cannot guarantee that Western Australian practitioners will never miss the signs of coercion or abuse [given the well-documented evidence of failure by professionals in Australia to identify elder abuse](#).

So, there will inevitably be wrongful deaths of Western Australians [coerced or subtly pressured into requesting euthanasia or assistance to suicide](#).

Waiving the waiting period

One of the claimed safeguards in the Act is a requirement for a nine-day period between making a first request and a final request.

In 2024-25 this was waived in over one out of four (26.3%) cases of final requests. For 64 (10% of all cases) people the nine-day period was waived on the grounds the person was likely to die within that period and for 106 (16% - one in six of all cases) people the nine-day period was waived on the grounds the person was likely to lose decision-making within that period.

If a medical practitioner assesses a person as likely to lose decision-making capacity within 9 days, there must already be signs of that impending loss. These signs should raise doubts about the current decision-making capacity of the person.

In at least two cases each in 2022-23 and in 2023-24 the person was assisted to suicide or euthanased within 2 days of making a first request.

Complications

In 2021-22, of the 52 acts of “assisted oral ingestion” of the poison, 4 (7.7%) resulted in complications including “regurgitation/vomiting, coughing and the length of time for the substance to take effect.

In 2022-23, of the 210 acts of practitioner administration, 12 (5.7%) involved complications, including 7 cases of intravenous live complications; and at least one case each of coughing, burning of the throat following assisted oral ingestion, transient agitation and pain following injection following intravenous administration. There was also one case where the person was described as experiencing “worsening of pain or discomfort”.

In 2023-24 of the 277 acts of practitioner administration, 12 (4.3%) involved complications, including 5 cases of intravenous live complications; one case of regurgitation/vomiting; one case of worsening of pain or discomfort; and at least one case each of coughing and/or burning of the throat following assisted oral ingestion, hiccups with gastric reflux, involuntary muscular contractions, and delayed loss of consciousness. All patients with reported complications died after administration of the voluntary assisted dying substance.

In 2024-25 of the 433 acts of practitioner administration 18 (4%) involved complications. This included 6 cases of intravenous line complications; 3 cases of regurgitation/vomiting, one case of seizure; one case of worsening pain or discomfort; with other complications including coughing following administration of the voluntary assisted dying substance; delayed loss of consciousness; transient pain following intravenous administration and syringe assembly difficulties.

No data is collected on the time between administration and loss of consciousness.

However, from July 2021 to June 2025, in 19 (9.9%) of the 191 cases of assisted oral or PEG tube ingestion, the person took more than one hour to die. In 2022-23 one person took 6 hours and 29 minutes to die and in 2024-25 one person took 4 hours and 44 minutes.

No data on administration location, length of time to death or complications is collected by the Voluntary Assisted Dying Board regarding deaths occurring via self-administration of the prescribed lethal poison. However, it is likely that there is a similar or higher rate of complications. We will never know.

No witness for assisted suicide

Additionally, there is nothing in the Act to require any independent witness when the prescribed lethal poison is ingested when “self-administration” is chosen. This can take place weeks, months or even years after it is prescribed without any requirement for an updated assessment of decision-making capacity, diagnosis, prognosis, suffering or voluntariness.

Without a witness required we will never know if the lethal poison was ingested voluntarily or whether the person was cajoled, bullied, tricked or even physically forced to ingest it.

Section 82 of the Act prohibits any mention of the ingestion of the prescribed lethal poison on the death certificate of a person who dies from ingesting it and Section 168 ensures that any such death is not reportable to the Coroner.

Together these provisions make it almost impossible that wrongful deaths by improper – even murderous – administration of a prescribed lethal substance will ever be identified, let alone prosecuted.

Reckless of this danger, the Board is advocating to allow non-practitioners – presumably including family members – to actively assist a person to “self-administer” the deadly poison!

Legal fiction – not a death by suicide

Section 12 of the Act provides that ingesting a lethal poison prescribed under the Act to be ingested to cause death is not legal suicide. This means it will not appear in the suicide statistics for Western Australia.

In Victoria, as in Western Australia, there were claims made during debate on the euthanasia legislation that it would prevent the suicides of people with terminal illness by providing them with an alternative. In Victoria, it was claimed that the new law would prevent 50 such suicides each year.

Not only has there been no such decline, but there were 62 more suicides in Victoria in 2022 than in 2017, when this claim was made. The suicide rate among those aged over 65 years increased from 2019 to 2022 by 42 per cent in Victoria, where “voluntary assisted dying” was legal—five times the increase over the same period in New South Wales where it remained illegal.

So, we have no reason to expect a reduction in the official suicide rate in Western Australia as a result of the legalisation of assistance to suicide and euthanasia, but, sadly, can anticipate a rise in the total number of suicides if deaths by ingestion (or administration) of a lethal poison prescribed under the Act are also counted.

New Zealand (2021-)

Euthanasia and assistance to suicide became legal in New Zealand from 7 November 2021 under the *End of Life Choices Act* which passed the Parliament by 69 votes to 51 in December 2019 and was endorsed at a referendum in 2020 by 65.1% of voters.

Eligibility criteria

The key eligibility criteria are that the person is an adult New Zealand citizen or permanent resident who, according to two assessing medical practitioners, “*suffers from a terminal illness that is likely to end the person’s life within 6 months*”.

Neither medical practitioner needs to have any specialist qualification in a field relevant to the particular terminal illness.

If either or both assessing practitioners are uncertain of the person’s competence to make an informed decision then the person must be examined by a psychiatrist to determine this matter.

Only 19 (1.6%) of the 1175 applicants in 2024-25 were referred to a psychiatrist and of these 3 were found not to be competent to make an informed decision.

Health practitioner

Health practitioners are not permitted to initiate a discussion with or make a suggestion to a patient about accessing euthanasia or assistance to suicide under the Act.

A medical practitioner with a conscientious objection can refuse to participate but must advise a person who requests access of the person’s right to ask the SCENZ Group for the name and contact details of a replacement medical practitioner. The SCENZ (Support and Consultation for End of Life in New Zealand) Group maintains a register of health practitioners willing to provide access to people seeking euthanasia or assistance to suicide.

Administration

If the person chooses to self-administer the prescribed lethal poison it is only supplied to them shortly before a time specified by the person for self-administration (suicide).

Regardless of whether the lethal poison is self-administered or administered by an attending medical or nurse practitioner, the attending medical or nurse practitioner (or a substitute practitioner) must be in “*close proximity to the person*”, but not necessarily in the same room or area, until the person’s death.

Annual report

The only elements required by the Act to be in the annual report from the Registrar (Assisted Dying) are the total number of deaths and the number of deaths occurring through each of the four methods described in the Act and the number of complaints received about breaches of this Act and how those complaints were dealt with.

The first [annual report](#) covered the period 7 November 2021 to 31 March 2022 and reported on 66 deaths by assisted suicide or euthanasia.²⁸⁹

²⁸⁹ <https://www.health.govt.nz/system/files/documents/publications/registrar-assisted-dying-annual-report-jun22.pdf>

The [second annual report](#) covers the period from 1 April 2022 to 31 March 2023 and reports on a further 328 deaths by assisted suicide or euthanasia. This represents 0.84% of all deaths in New Zealand in this period.

The [third annual report](#) covers the period from 1 April 2023 to 31 March 2024 and reports on a further 344 deaths by assisted suicide or euthanasia.

The [fourth annual report](#) covers the period from 1 April 2024 to 31 March 2025 and reports on a further 472 deaths by assisted suicide or euthanasia. This represents 1.25% of all deaths in New Zealand in this period – a 49% increase since 2022-23.

Of these 472 deaths, 450 (95.3%) were by euthanasia. Of the 1210 deaths in total since legalisation, 1130 (93.4%) were by euthanasia.

The four methods of administration of the lethal poison set out in s19(2)(a) of the Act are, and the number of deaths by each method between 1 April 2024 and 31 March 2025 and in total to 31 March 2025 were:

- (i) ingestion, triggered by the person – 17,60
- (ii) intravenous delivery, triggered by the person – 5,20
- (iii) ingestion through a tube, triggered by the attending medical practitioner or an attending nurse practitioner – 9,14
- (iv) injection administered by the attending medical practitioner or attending nurse practitioner – 441,1116

Multiple Co-morbidities

In 2023-24, 4.44% of applicants were reported as having “multiple co-morbidities” as the underlying condition. In 2024-25 this represented 2.44% of applicants. This category is used in the Netherlands and Belgium for a range of common conditions in the aged none of which is terminal in itself – fragility, loss of vision or hearing, etc. How rigorous is the test of likely death in six months from a terminal illness being applied to these cases?

Palliative Care

In 2024-25, 20.92% of applicants were not receiving palliative care at the time of the application. How can you have suffering unable to be relieved if you are not accessing palliative care which is directed at providing such relief?

Statutory Review

The [report](#) of the first statutory review of the Act was published in December 2024.

It made a series of recommendations under five headings:

- Supporting access and safety, including lifting the ban on a health practitioner raising the matter first before a patient does, but also strengthening obligations to check for lack of coercion;
- Improving the process to receive assisted dying;
- Aligning the Act with the wider health system, that is eroding the rights to conscientious objection by individual practitioners and for facilities including residential aged care;

- Ensuring a capable and effective workforce for assisted dying, on the one hand the qualifications set by the Act are too low so unqualified practitioners are providing the “service”; on the other hand more practitioners are needed;
- Clarifying organisational roles and responsibilities in the Act “the Registrar lacks explicit powers to fulfil its safeguarding function. With its current scope, the Review Committee is unable to be an effective oversight body.”

Government parties agreed that any changes to the Act will be proposed through members’ bills. No amendment bill has yet been introduced, although in August 2024 the ACT Party foreshadowed a bill to remove the six months to death requirement. Member’s bills can only progress through a ballot process.

Austria (2022-)

In a [decision](#) handed down on 11 December 2020, the Constitutional Court of Austria held that section 78 of the Criminal Code which provided that “*Anyone who induces another to kill himself or helps him to do so is punishable by imprisonment from six months to five years*”, was unconstitutional in relation to the words “*helps him to do so*”.

The Court claimed that this provision violated the right to self-determination and other rights under the European Charter of Human Rights.

The Court set an expiry date for the provision effective from 31 December 2021 to give the legislature the opportunity to make a law governing assisted suicide and euthanasia that was compatible with the (alleged) right to these means of ending one’s life.

On 16 December 2021 the Parliament of Austria passed the [Federal Law on the Establishment of Death Wills](#), effective from 1 January 2022.

On 12 December 2024 the Constitutional Court modified the law by removing the provision that a “death directive” expired 12 months after it was made if it had not been acted on as well as a provision banning “offering or announcing” means and methods of suicide while retaining a ban on advertising or “promoting” such things.

Eligibility criteria

The new law will permit the prescription and supply of a lethal dose of sodium pentobarbital – or other lethal poison specified by regulation - to a person who either has a terminal illness likely to cause death in 6 months or a serious chronic illness.

Once a person has been examined by two medical practitioners – one of whom must have a qualification in palliative medicine – and assessed by them both as qualifying under the Law, the person can sign a “death will” with a notary.

The supply of the lethal poison authorised by a “death will” can, in the case of a terminal illness likely to cause death in 6 months, be made 2 weeks after the first medical examination and in the case of a chronic illness, 12 weeks after that examination.

The “death will” can specify persons who are authorised to assist the person end the person’s life by ingesting the prescribed lethal poison – including by actively administering it, apparently even if the person loses decision-making capacity.

This makes Austria the first jurisdiction to legalise euthanasia by lay persons (non-health practitioners), including family members, of a person who is unable to self-administer the lethal poison or who has lost decision-making capacity.

Tasmania (2022-)

Euthanasia and assistance to suicide became legal in Tasmania from 23 October 2022 under *the End-of-Life Choices (Voluntary Assisted Dying) Act 2021*.

Prognosis

The Tasmanian law goes further than those in Victoria and Western Australia by providing for an exemption from the requirement that the person has a medical condition which is “*expected to cause the death of the person within 6 months; or if the disease is neurodegenerative within 12 months*”, if the State-appointed Voluntary Assisted Dying Commission, after consulting a medical practitioner with specialist knowledge as to the person’s medical condition and who has reviewed the person’s medical records, is satisfied that this requirement should not apply.

This opens the door to euthanasia and assisted suicide for people who may have years to live.

One application received by the Commission under this provision was [reported](#) for the period 23 October 2022-23 April 2023 but no details were given of the circumstances of the application, the Commission’s decision or the outcome.

Compulsory participation

Any medical practitioner who is asked to determine whether a person is eligible for euthanasia or assistance to suicide under the law, is required to give the person a copy of a State-prepared document called “[Voluntary Assisted Dying in Tasmania: Relevant facts](#)”, which includes contact details for the Voluntary Assisted Dying Navigation Service which will facilitate access to euthanasia and assistance to suicide.

A medical practitioner who refuses a First Request for euthanasia or assistance to suicide must also record this request and refusal in the person’s medical records as well as notify the Commission on the [prescribed form](#).

Euthanasia option available on request

Like Western Australia, but unlike Victoria, the person can choose either self-administration of the lethal poison (suicide), with or without assistance from a health practitioner, or be administered the lethal poison (euthanasia) by the health practitioner. In jurisdictions where euthanasia is available as well as assistance to suicide, the overwhelming majority choose euthanasia and the overall take-up rate is higher than in jurisdictions where only assistance to suicide is authorised by the law.

Complications

The Tasmanian law provides for a person who is to be euthanased or assisted to suicide to authorise in advance the administration of a further substance to cause death more quickly or reduce pain if unexpected complications arise following the initial administration or self-administration of the poison.

There is also a provision where the person can request in advance, that in these circumstances, the health practitioner takes reasonable action to preserve the person’s life. It seems unlikely that this option will be elected by a person making a final request for administration of a lethal poison for the purpose of causing the person’s death.

Reports and Review

The Act requires an initial report after six months of operation as well as ongoing annual reports. It is to be reviewed after 3 years of operation and every 5 years after that.

The [first six monthly report](#) covering the period 23 October 2022 to 23 April 2023 was released on 26 July 2023.

16 people died following administration of a lethal poison prescribed under the Act.

A further 11 people are [reported](#) as dying under the Act by 30 June 2023, making a total of 27 people in eight months, accounting for 0.77% of all deaths.

In [2023-24](#), 62 people died under the Act accounting for 1.2% of all deaths. In [2024-25](#), 109 people died under the Act, up 73% from 2023-24 and accounting for 2.1% of all deaths.

The reports do not indicate how many of these deaths were caused by suicide (self-administration) and by euthanasia (practitioner-administration).

However, it is reported that in 2024-25, 79 out of the 159 (49.7%) of substance authorisations were for substances to be administered by a practitioner. Given there were 109 deaths in 2024-25 and it is rare for administration not to proceed in the case of planned practitioner administration, it is likely up to 72.5% of these deaths were by euthanasia.

Loss of decision-making capacity

The Act requires two 48-hour periods between a first and second request and a second and final request. However, these can be waived if the Primary Medical Practitioner is of the opinion that the participant is likely to die within seven days or is likely to cease to have decision-making capacity within 48 hours.

In 2024-25, the first 48-hour period was waived in 15 cases (9%) and the second 48 hour period was waived in 18 cases (11%), increasing significantly from 5% and 7% in 2023-24.

The Commission observed in its first six-monthly report:

There is no clear mechanism in the Act to address the possible loss by a person of decision-making capacity following the issue of a Private Self-Administration Certificate and supply to the person of the VAD Substance. This makes it possible for a person to access the VAD Substance after the point that they have lost decision-making capacity.

This is a fundamental flaw in all jurisdictions who legalise the supply of a lethal poison for the purpose of self-administration at any time after supply for the purpose of causing a person's death. Loss of decision-making capacity while in possession of a lethal poison leaves a person at risk of ingestion by error or by persuasion, deception or force by another person.

Retiring from medicine but not from assisting suicide

The 2024-25 report states that "Feedback from medical practitioners who choose to deliver voluntary assisted dying services is that they derive tremendous satisfaction from their involvement [in assisting people kill themselves]. Many practitioners approaching retirement have suggested that they would be interested in" continuing this involvement after retirement but the costs of maintaining registration make this "untenable". The report recommends subsidising these costs so they can continue assisting suicides.

Queensland (2023-)

Euthanasia and assistance to suicide became legal in Queensland from 1 January 2023 under the *Voluntary Assisted Dying Act 2021*.

Numbers

A [report](#) on the first six months of legalisation states that there were 245 deaths under the Act - 139 deaths (56.73%) by “practitioner administration”, that is euthanasia and 106 by “self-administration”, that is assisted suicide.

245 deaths in six months represents about 1.32% of all deaths - higher than WA after one year and twice Victoria's rate after 4 years.

A [second report](#), covering 1 July 2023-30 June 2024 states that there were 793 deaths under the Act - 532 deaths (67%) by “practitioner administration”, that is euthanasia and 261 (33%) by “self-administration”, that is assisted suicide.

This represents about 2.05 % of all deaths in 2023-24 – a 45% increase on the rate for the first six months of operation.

The [2024-25 annual report](#) reported a total of 1072 deaths under the Act with 779 (72.67%) by euthanasia and 293 (27.33%) by assistance to suicide. This represents 2.84% of all deaths – an increase of 38.5% on the 2023-24 rate.

Queensland also produces quarterly reports which show a continued steady increase in the rate of euthanasia and assistance to suicide.

The [quarterly](#) report covering 1 July 2024-30 September 2024 states that there were 241 deaths under the Act – representing 2.34% of all deaths in Queensland in that period, a 26% increase on the rate for 2023-24.

There were a further 264 deaths from 1 October 2024 to 31 December 2024 – 2.69% of all deaths; a further 273 between 1 January 2025 and 31 March 2025 (2.82% of all deaths), with 75% of these deaths by euthanasia and 25% by self-administration; and a further 288 deaths between 1 April 2025 and 30 June 2025 (3% of all deaths).

The [quarterly report](#) for July-September 2025 reports 236 deaths – 177 (75%) by euthanasia and 59 by self-administration.

One relevant factor in this higher rate compared to other Australian states could be that the eligibility criteria in Queensland include a prognosis that the condition is " expected to cause death within 12 months" whereas it is six months (except for neuro-degenerative conditions) in the other states.

Practitioners

Registered nurses are allowed to administer the prescribed lethal substance to cause a person’s death. 218 registered nurses have done the training (compared to 226 medical practitioners and 26 nurse practitioners). 35 nurses and nurse practitioners administered a lethal substance to a person in 2024-25, compared with 51 medical practitioners. Of these 86 State trained professional killers, 39 were serial killers in 2024-25, killing five or more people each.

Of the 121 practitioners involved in 2024-25 as coordinating or consulting practitioners 50 of them were involved in 21 or more cases (that is an average of at least one case every 17 days).

Prognosis

Unlike other United States and Australian jurisdictions which limit assisted suicide (and, in Australian jurisdictions, euthanasia) to those with a prognosis of 6 months or less to expected death, the Queensland law allows access to those with a prognosis of expected death within 12 months.

This increases the likelihood of [wrongful deaths from errors in prognosis](#).

Refusing treatment and symptom management

The Queensland Government [explicitly states](#) that those seeking euthanasia or assistance to suicide may meet the eligibility criteria of a terminal illness that is causing suffering by refusing medical treatment and symptom management.

This makes it clear that this regime is about facilitating the intentional ending of life and not about relieving unavoidable suffering at the end of life.

Under these provisions people with otherwise non-terminal conditions such as a young person with insulin-dependent diabetes could be euthanased.

24.5% of people making a first request for euthanasia or assistance to suicide had no engagement with palliative care.

Timeframe

The law generally requires a nine-day period between a first and final request but this can be waived if two medical practitioners agree the person may die or lose decision-making capacity within that period.

In 2023-24, 275 people had the nine-day waiting period waived. This is 34.7 % of those who died under the Act.

Where a person is assessed as likely to imminently losing decision-making capacity there must be a real doubt as to the person's current decision-making capacity so this provision increases the likelihood of wrongful deaths from lack of decision-making capacity.

Government facilitation of suicide and euthanasia

The Queensland Government has established [Queensland Voluntary Assisted Dying Support Service](#) which will only provide information and assistance on suicide and euthanasia and will not provide any assistance or information on *"any other health concerns, including your underlying conditions"*.

The QVAD-Support service will directly link a person seeking to end their life with a medical practitioner willing to help them do so.

Any registered health practitioner who has a conscientious objection to facilitating the suicide of or euthanasing his or her patients must if asked by any person for such assistance or information give the person either the details of QVAD-Support Service or of a registered health practitioner willing to facilitate the person's death.

The [Queensland voluntary assisted dying pharmacy](#) is funded to supply the lethal poisons for suicide to individuals and for euthanasia to administering medical practitioners or nurses.

Reporting

Clause 8 of the [Voluntary Assisted Dying Regulations 2022](#) requires the Voluntary Assisted dying Board to collect some minimal information that is then required to be published in an annual report to be provided by 30 September each year.

This includes basic demographic data (age, sex and region) of applicants and data on the underlying condition as well as the number of deaths from self-administration or practitioner administration of lethal poisons prescribed under the Act.

The time between first and final request is to be reported.

No data on referrals for additional assessments of eligibility or decision-making capacity is to be collected. Nor is there any provision for reporting on complications, the time between administration of the poison and loss of consciousness, or the time between administration of the poison and death.

Given the general complication rate of 7% or higher reported from other jurisdictions this is a concerning lack of transparency that undermines any future claim that there are no problems with the practice of assistance to suicide and euthanasia in Queensland. We will never know.

No safe space

The Act imposes on all hospitals, nursing homes and residential aged care facilities in Queensland the obligation to allow suicide and euthanasia by lethal poison on their premises for any permanent resident of the facility and for any other resident where a “*deciding medical practitioner*” determines transferring the person for this purpose is not “*reasonable*”.

This is a violation of the human rights of freedom of association, freedom of religion and freedom of conscience. The sick and elderly should be able to choose to be treated or to live in a place where no-one is intentionally killed or helped to commit suicide.

Lethal poisons at large

One of the obvious risks of prescribing and supplying lethal substances to be kept in the community is that the lethal substance may be ingested by a person other than the person for whom it is prescribed. The Queensland coroner is [reportedly](#) investigating an incident, in which after a woman was prescribed lethal drugs under the Act but died in hospital before ingesting the drugs, her husband subsequently used the drugs to kill himself.

South Australia (2023-)

Euthanasia and assistance to suicide became legal in South Australia from 31 January 2023 under the *Voluntary Assisted Dying Act 2021*.

Numbers

There have been [ten quarterly reports](#) and three [annual reports](#) to date, covering 31 January 2023-30 June 2025.

446 people have died following the administration of a lethal substance prescribed under the law – 369 by assisted suicide (self-administration) and 65 by euthanasia (practitioner administration).

For the twelve months 1 July 2024-30 June 2025, there were 200 deaths by assisted suicide and 51 by euthanasia, accounting for 1.6% of all deaths in South Australia.

Prognosis

Eligibility criteria include a prognosis that death is expected within 6 months (or 12 months in the case of a neurodegenerative condition) from an incurable disease, illness or medical condition.

One of the two assessing medical practitioners “*must have relevant expertise and experience in the disease, illness or medical condition expected to cause the death of the person being assessed*”.

Timeframe

The law generally requires a nine-day period between a first and final request but this can be waived if two medical practitioners agree the person may die within that period.

Euthanasia

Euthanasia (practitioner administration of a lethal poison) may only be applied for if a medical practitioner professes to be satisfied that the person “*is physically incapable of the self-administration or digestion of an appropriate [lethal] poison*”.

Government facilitation of suicide and euthanasia

Under the Act no person may commit suicide with a prescribed lethal poison or be administered a lethal poison by a medical practitioner without a permit issued by the Chief Executive of the Department for Health and Wellbeing! This power to issue suicide/euthanasia permits can be delegated to any person or body.

The South Australian Government has established the [South Australian Voluntary Assisted Dying Care Navigator Service](#) which will directly link a person seeking to end their life with a medical practitioner willing to help them do so.

The [South Australian voluntary assisted dying pharmacy service](#) is funded to supply the lethal poisons for suicide to individuals and for euthanasia to administering medical practitioners.

Reporting

The only data required to be collected and made public in an annual report is on the number of permits issued, the number of people who die after self-administration or practitioner administration of a prescribed lethal poison, their age at time of death and the underlying condition for which they were assessed as eligible.

No data on referrals for additional assessments of eligibility or decision-making capacity is to be collected. Nor is there any provision for reporting on complications, the time between administration of the poison and loss of consciousness, or the time between administration of the poison and death.

Given the general complication rate of 7% or higher reported from other jurisdictions this is a concerning lack of transparency that undermines any future claim that there are no problems with the practice of assistance to suicide and euthanasia in South Australia. We will never know.

No safe space

The Act imposes on all residential aged care facilities in South Australia the obligation to allow suicide and euthanasia by lethal poison on their premises for any permanent resident of the facility and for any other resident where a “*deciding medical practitioner*” determines transferring the person for this purpose is not “*reasonable*”.

This is a violation of the human rights of freedom of association, freedom of religion and freedom of conscience. The elderly should be able to choose to live in a place where no-one is intentionally killed or helped to commit suicide.

New South Wales (2023-)

Euthanasia and assistance to suicide became legal in New South Wales on 28 November 2023, when the *Voluntary Assisted Dying Act 2022* came into operation.

Euthanasia and assistance to suicide

The Act provides for the Voluntary Assisted Dying Board, which it established as an “agent of the Crown”, to issue a “a voluntary assisted dying substance authority” to a medical practitioner to prescribe a lethal poison either for the purpose of the patient named in the authority ingesting the poison in order to cause the person’s own death (suicide) or for the lethal poison to be administered to the person by a medical or nurse practitioner (euthanasia).

The patient may freely choose either suicide or euthanasia.

Numbers

An [Interim Report](#) covering 28 November 2023-29 February 2024 reports that 131 people had their lives ended under the Act. – 91 (69.5%) by receiving a lethal injection from a medical or nurse practitioner and 40 (30.5%) by ingesting a lethal substance prescribed by a medical practitioner. This represented 0.95% of all deaths in NSW in the three months December 2023-February 2024 – almost 50% higher (46.1%) than the rate in Victoria after four years of legalization. In 3 months, NSW ended the lives of the same number of people (131) as Victoria did in the first year of legalisation.

The first [annual report](#) covering 28 November 2023-30 June 2024 reports that 398 people had their lives ended under the Act - 315 (79.1%) by receiving a lethal injection from a medical or nurse practitioner and 83 (20.9%) by ingesting a lethal substance prescribed by a medical practitioner.

This means that in the four months March 2024-June 2024, 267 people had their lives ended under the Act, representing 1.33% of all deaths in NSW in this period.

The [second annual report](#) covering 1 July 2024-30 June 2025 reports that 1028 people had their lives ended under the Act - 839 (81.6%) by receiving a lethal injection from a medical or nurse practitioner and 189 (18.4%) by ingesting a lethal substance prescribed by a medical practitioner.

This means that in 2024-25, 1.76% of all deaths in NSW were by euthanasia or assistance to suicide. This is more than double the 0.86% reached in Victoria after five years of legalisation.

The difference may be related to two factors.

Firstly, in Victoria medical practitioners cannot suggest assisted suicide or euthanasia to a patient – the request has to come from the person whereas in NSW the option of euthanasia can be offered by a medical practitioner with no initial suggestion from the person that are considering this

Secondly, in Victoria administration of a lethal injection by the practitioner is only available if there is an identified issue with self-administration. In NSW death by practitioner administration can be freely chosen. Only 22.6% of Victorian cases in 2024-25 involved practitioner administration – compared to 81.6% in NSW. International evidence indicates that overall rates are higher when euthanasia is freely on offer compared to jurisdictions where assisted suicide is the only or default option.

The Voluntary Assisted Dying Amendment Act 2025 passed the Victorian Parliament and received assent on 25 November 2025. When it commences (on a day or days to be proclaimed or otherwise

on 19 April 2027) these two differences will be removed with health practitioners now able to suggest euthanasia or assistance to suicide and an unrestricted choice between self-administration and practitioner administration of the lethal substance.

Underlying condition

The First Annual Report gives no details of the conditions involved in the 78 cases described as “other” conditions (that is, not cancer, neurodegenerative or respiratory conditions).

The Second Annual Report states that the 133 cases described as “other” conditions (that is not not cancer, neurodegenerative respiratory or cardio-vascular conditions), include “all diagnosis codes that do not fit within the other four categories. For example, this includes kidney conditions such as chronic kidney disease and liver conditions such as fibrosis and cirrhosis of liver. Many patients applying for voluntary assisted dying have complex presentations that involve multiple comorbid conditions’.

Prognosis

The eligibility criteria include a prognosis - determined by two medical practitioners neither of which need to have any specific qualification or experience in the relevant condition – on “the balance of probabilities” that death will occur within 6 months (or within 12 months for neuro-degenerative conditions).

The [handbook](#) prepared by NSW Health acknowledges that “predicting when a person is entering the final months of their life can be difficult”.

This means that there will inevitably be [wrongful deaths](#) of people who may have had years to live from errors in prognosis.

Curiously the NSW Health handbook states that a Board authority to prescribe will remain valid for six months (or 12 months in the case of a neurodegenerative disorder) but that the patient can wait a further six months from when the prescription is written to have it filled. NSW Health is envisioning patients given a prognosis of six months to live still being alive 12 months after this prognosis has been given.

In the case of authority to suicide by prescribed poison there is no time limit on how long the supplied poison may be kept before it is ingested.

Designated period

The designated period starts on the day of the first request and ends five days after that day. The designated period can be waived if both the coordinating and consulting practitioners agree that the patient is likely to die or to lose decision-making capacity in relation to voluntary assisted dying before the end of the designated period.

In 2024-25 the designated period was waived for 15.1% of applicants.

If death is imminent within five days why the haste to directly kill the person instead of simply providing a comfortable natural death?

If decision-making capacity is about to be lost how can we be sure the person has sufficient capacity when the lethal substance was administered?

In 2024-25 the median timeframe from first request to death following administration of a voluntary assisted dying substance was 20 days. That means 514 people died from the administration of a lethal substance in less than 3 weeks after first requesting it.

Decision-making capacity

The NSW Health handbook states “In the event that a coordinating practitioner becomes aware that a patient has permanently lost decision-making capacity after supply of the voluntary assisted dying substance for self-administration, the substance must be returned and disposed of as the patient is no longer eligible for voluntary assisted dying.”

This admission points to a serious risk in the scheme set up under the Act. Once the final review is completed before the coordinating practitioner applies for an authority to prescribe the lethal poison for self-administration there are no further checks on a person’s decision-making capacity and no requirement for any further contact between the coordinating practitioner and the patient.

The person may well lose decision-making capacity before ingesting the lethal poison. In this case there is simply no protection and no way of ever knowing if the person was subsequently cajoled, bullied, tricked or even physically forced to ingest the lethal poison.

Agents

The Act provides for the collection of the lethal poison for self-administration from the pharmacy by an “agent” of the patient, without imposing any restrictions or qualifications – not even an age restriction – on who can be designated by the patient. The agent is authorised by the Act to collect and store the poison, and also to prepare it and supply it to the patient to ingest – but not to actually administer it to the patient. As there is no witness required to be present at the time the lethal poison is ingested, we will never know if agents (or others) breach this provision.

Homeless, prisoners and forensic mental health detainees

NSW Health is keen that no one miss out on access to euthanasia or assistance to suicide.

Its handbook suggests that “as a particularly vulnerable group” what the homeless need is a “respectful approach that honours their autonomy and treats them with genuine kindness at the end of life” by providing support if they request “assisted dying”. No hint is given in the handbook that the vulnerability of a homeless person may mean that any request for euthanasia or assistance to suicide is a desperate cry for real help.

NSW Health’s [Policy Directive](#) charges the Justice Health and Forensic Mental Health Network with the task of making sure prisoners and those in forensic mental health detention don’t miss out on euthanasia or assistance to suicide by linking them with “authorised practitioners, and assist[ing] those services and practitioners with accessing the patient in appropriate settings and circumstances.”

Euthanasiasts everywhere

NSW Health’s [Policy Directive](#) mandates every Local Health District to “endeavour to have a sufficient number of authorised coordinating, consulting and administering practitioners within their services to support timely access to each step of the voluntary assisted dying process for patients”. NSW Health has full time jobs for medical practitioners employed solely to facilitate assistance to suicide and perform euthanasia.

In 2024-25 of the 188 medical or nurse practitioners who were actively involved as a coordinating, consulting or administering practitioner for one or more applicants, 73 (38.8 %) were involved in 21 or more cases.

No safe space

NSW Health has also issued "[guidance](#)" for private residential aged care and health facilities which reflects the Act's ultimate refusal to allow any private facility to remain truly euthanasia and suicide free. Even health facilities which are operated on the basis of an ethic which rejects euthanasia, must allow the State's "care navigators" on to their premises to link up patients with doctors willing to kill them. In making a decision about whether transferring a patient out of the facility for euthanasia or assistance to suicide, the patient's treating physician must consult with the patient's "coordinating, consulting or administering practitioner".

Residential facilities must allow the suicide and euthanasia of permanent residents on their premises. There is no recognition of the distress this may cause other residents and the stress on staff in a facility founded and operated on the basis of an ethic that rejects these acts as contrary to the human good of respect for life.

The *Voluntary Assisted Dying Amendment (Residential Facilities) Bill 2025* introduced by the Hon Susan Carter, which would have allowed residential facilities to be free of euthanasia and assistance to suicide, was defeated 23-16 in the Legislative Council on 19 November 2025.

Ecuador (2024-)

Article 144 of the [Organic Integral Penal Code of Ecuador](#) provides a penalty of between 10 and 13 years imprisonment for simple homicide.

On 5 February 2024 the Constitutional Court of Ecuador in its [Sentence 67-23-IN/24](#) declared an exception to this offence where a physician kills a person who expressing unequivocal, free, and informed consent (or through their representative when they are unable to express it), requests access to an active euthanasia procedure due to intense suffering resulting from a necessarily bodily injury that is serious and irreversible, or a serious and incurable illness.

The Court claimed that the right to a dignified life under Article 66 -2 of the Constitution “protects the ability of individuals to self-determination and to shape their own life plans in accordance with their values, beliefs, worldview, and the circumstances surrounding them, with no limitations other than the rights of others.” This includes the right to request and receive euthanasia in the specified circumstances.

The Court’s decision was split 2-1 with Judge Carmen Corral Ponce dissenting.

This dissenting opinion, respecting what the plaintiff feels and thinks, demonstrates that Article 144 of the COIP is not unconstitutional; That the Constitutional Court exceeded its jurisdiction by creating, with manifest and contradictory conceptual errors, an exception to the criminal offense; that the presumption of constitutionality was not violated; that it was not the appropriate course of action; that human dignity is tied to life, not to living conditions; that the free development of personality should not undermine human dignity; that active euthanasia is not the solution; on the contrary, euthanasia opens the door to a culture of death, instead of a culture of life.

The plaintiff in the case died of natural causes on 11 March 2024.

In response to an order from the Court, on 12 April 2024 the Ministry of Health issued [Regulations of the Procedure for the Application of Euthanasia](#). The regulations provide for euthanasia following either a request from the person or, where there is an advanced directive, from the person’s representative. A “technical committee” in each institution must approve or deny the request within 2 days. Approval must be acted on within 10 days or becomes void.

“At least one doctor and one nurse must participate in the execution. These professionals must use drugs that guarantee that the procedure is short and accurate, with simple and lethal administration. Death as a result of the application of euthanasia will be considered a natural death.”

As of June 2024 there had been no cases of euthanasia using these procedures.

The Court ordered the Ombudsman’s Office to prepare a Bill within six months of the decision for presentation to the National Assembly, which would have 12 months to consider the Bill. The [Bill](#) was presented on 28 June 2024 but did not proceed.

On 13 March 2025 Assemblyman Camilo Salinas introduced a new Bill to regulate euthanasia procedures and advanced directives.

Tuscany (2025-)

Article 580 of the Criminal Code of Italy prohibits inciting, reinforcing or facilitating in any way a person's suicide.

In its decision [no 242 of 2019](#) the Constitutional Court of Italy considered the constitutionality of Article 580 and concluded, firstly, that "criminalisation of assisting suicide is not, in itself, contrary to the Constitution but is justified by the need to protect the right to life, especially of the weakest and most vulnerable persons, which the system seeks to protect by avoiding external interference in an extreme and irreparable choice, such as suicide."

However, the Court "identified a limited area in which such criminalisation is not compliant with the Constitution, namely when help is given to a person being kept alive by life-support treatments such as hydration and artificial nutrition and who suffers from an incurable illness that is a source of intolerable physical or psychological suffering but remains wholly capable of making free and informed decisions."

The Court ruled, somewhat confusedly, that, in the absence of any positive law, such "help" be given in accordance with the procedures provided for in Articles 1 and 2 of the Law on Advanced Medical Directives which deal with the waiver of life-preservation treatments and the guaranteed provision of suitable pain management and palliative care. However, the "help" in this case includes the provision of a lethal substance to be self-administered to end life (suicide).

In a subsequent decision [no 279 of 2024](#), the Constitutional Court refused to expand its exception to Article 580 to cover a case involving multiple sclerosis in which the person was not dependent on any life-support treatment. The Court explicitly rejected the broader approach to a so-called right to assistance in suicide as reflected in the decisions of constitutional courts in Germany, Austria, Spain, Colombia, Canada and Ecuador.

Tuscan law

On 14 March 2025, [legislation](#) came into effect in the Tuscan Region to implement the processes envisioned by the Constitutional Court in its decision no. 242 of 2019, including providing access to "self-administration of the drug that can guarantee a rapid, painless and dignified death".

In May 2025 the national government announced it was challenging the constitutionality of the regional law.

On [11 June 2025](#), a 60 year old man with Parkinson's disease who was dependent on a percutaneous endoscopic gastrostomy tube for nutrition, was approved under the Tuscan law and died after self-administering a lethal substance through an infusion pump.

Australian Capital Territory (2025-)

From 1997 when the Commonwealth's *Euthanasia Laws Act 1997* took effect to December 2022 when the *Restoring Territory Rights Act 2022* was passed by the Commonwealth Parliament the Legislative Assembly of the Australian Capital Territory (ACT) had "no power to make laws permitting or having the effect of permitting (whether subject to conditions or not) the form of intentional killing of another called euthanasia (which includes mercy killing) or the assisting of a person to terminate his or her life".

Euthanasia and assistance to suicide became legal in the ACT from 3 November 2025 when the *Voluntary Assisted Dying Act 2024* came into effect.

Eligibility criteria

Unlike all other Australian jurisdictions, there is no time period set under the Act for which death must be considered likely in order to access euthanasia or assistance to suicide. The relevant criterion (Section 11) reads:

An individual meets the eligibility requirements if ... they have been diagnosed with a condition that, either on its own or in combination with 1 or more other diagnosed conditions, is advanced, progressive and expected to cause death.

'Advanced' is further defined (Section 11 (4)):

an individual's relevant conditions are advanced if— (a) the individual's functioning and quality of life— (i) have declined or are declining; and (ii) are not expected to improve; and (b) any treatments for the conditions that are reasonably available and acceptable to the individual have lost any beneficial impact; and (c) the individual is approaching the end of their life.

This is a deliberately very fuzzy definition: "have declined or are declining" and "not expected to improve" would apply to anyone ageing. Treatments must be "acceptable to the individual" – with no objective test. Every individual is "approaching" the end of their life – that is none of us are getting further away from it.

It remains to be seen how this works out in practice but it seems likely that this will result in a rate of euthanasia higher than other Australian jurisdictions where the six or even twelve months prognosis act as some kind of limit.

Euthanasia or assistance to suicide

The Act allows a person to freely choose between having a "health practitioner" directly administer a substance in sufficient dose to cause the death of the individual or to prescribe a substance in sufficient dose to cause the death of the individual for the person to self-administer.

In jurisdictions like Queensland and Western Australia where this applies the rate of deaths under the relevant Act is more than three times that in Victoria where self-administration is the default and "practitioner administration" may only be used when the person is unable to self-administer the lethal substance.

The reason for the difference is because a significant proportion of those prescribed a lethal substance for self-administration choose never to actually use it to end their life whereas very few people cancel an appointment with a practitioner scheduled to administer the lethal substance.

Doctors and nurse practitioners may act as coordinating or consulting practitioners as well as administering practitioners. Registered nurses can also administer the lethal substance.