
The Legalization of Euthanasia and Assisted Suicide: *An inevitable slippery slope*

Jean-Paul Van De Walle
Sophia Kuby



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ADF INTERNATIONAL

Summary

This paper makes the case for the protection of life and the societal norms of caring for one another through the prohibition of euthanasia and assisted suicide. Rather than requiring the legalization of these troubling practices, international law robustly protects the right to life – particularly for the most vulnerable. The threat posed by a number of legislative proposals across Europe is highlighted through the example of those countries which have already gone down this road. An investigation into the most recent developments in Belgium, the Netherlands and Canada shows that where euthanasia and assisted suicide are legalized, the number of people euthanized, and the number of qualifying conditions increase with no logical stopping point. The paper concludes by refuting the main arguments relied upon in support of legalization.

About the Authors

Jean-Paul Van De Walle serves as legal counsel, Europe, for ADF International in Belgium (Brussels), advocating for religious freedom, life, and the family at the European Union. Prior to joining ADF International, Van De Walle served as a lawyer before the Brussels Bar, handling lawsuits in torts law, insurance law, and contract law. Having a long-time interest in bioethics, Van De Walle has been closely monitoring, from a legal and bioethical perspective, the life-related issues in Belgium during the last decade, in particular the debate on the end-of-life and the debate on the possible legalization of surrogacy. He has regularly spoken on those topics in the media and as a guest speaker at conferences.

Sophia Kuby serves as director of Strategic Relations & Training for ADF International and is based in Vienna, Austria. She oversees and develops the organization's training programs and alliance relations internationally. From 2015 to 2018, Kuby served as the director of European Union Advocacy in Brussels, Belgium, where she built up the EU advocacy team and led the advocacy work of ADF International at the various EU institutions. She holds a M.A. and B.A. in philosophy.

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1) Introduction

This White Paper presents the main legal provisions and arguments in favour of the prohibition of euthanasia and assisted suicide under the following headings:

- (1) It first clarifies the terminology used.
- (2) Second, it gives a short overview of current legislation and proposals for the introduction of euthanasia or assisted suicide.
- (3) Third, it determines to whom belongs the legal competences in the area, and reviews the positive wording that exists in international law concerning the right to life of all persons.
- (4) Fourth, it illustrates with national experiences in Belgium, the Netherlands and Canada how laws legalising euthanasia and/or assisted suicide function in practice.
- (5) Fifth, it shows how the legalization of euthanasia inevitably leads to further liberalisation with no logical stopping point.
- (6) Sixth, it outlines and answers the main arguments in favour of legalization. This brief will mainly focus on Europe, although examples beyond the European continent will be drawn occasionally.

2) Terminology

Euthanasia comes from the Greek words *Eu* (good) and *Thanatos* (death) and means 'good death'.¹ In contemporary medical practice, laws, and publications, however, this term is often used in different, equivocal ways, and the relation or distinction with other end-of-life related concepts tends to be blurred. This overview² therefore aims at providing clarification on some key terminologies in this field.³

A. Euthanasia – Active and passive

Euthanasia can be commonly defined as 'every act or omission that, as such and with that intent, ends the life of a sick person in order to release him or her from suffering'.⁴

Active euthanasia occurs when the means used to induce death consist in the oral or intravenous administration of a substance or **combination** of substances. **Passive euthanasia**, also called **euthanasia by omission**, occurs when the lethal outcome results of the refusal to give life-preserving treatment for the purpose of hastening death, as a primary end.

The common point between active euthanasia and passive euthanasia, which is also the main characteristic of any euthanasic act, is *the intention to end someone's life in order to release them from suffering*.

B. Euthanasia – Voluntary, non-voluntary, and involuntary

A distinction can further be made with regards to *who makes the decision* to euthanize, and if that decision accords with the concerned person's will.

Voluntary euthanasia occurs when the concerned person gives their explicit consent to be euthanized. The consent can be given orally or in written form and can be given in advance (typically through an anticipatory euthanasia declaration).

Non-voluntary euthanasia is sometimes used to refer to situations in which the concerned person does not give their explicit consent, and thus another person makes the decision on their behalf.

Involuntary euthanasia is used by some to describe euthanasia performed against the explicit will of the concerned person.

C. Euthanasia and (medically assisted) suicide

Suicide is commonly understood as being the act by which someone deliberately ends their own life.⁵ **Assisted suicide** occurs when another person provides assistance or aid in doing so.

In the context of ending the life of a person with a medical condition, **medically or physician assisted suicide** refers to the situation in which the lethal act as such, rather than being performed by a healthcare practitioner, is performed by the concerned person him- or herself, whether by releasing a lethal substance intravenously or by swallowing a lethal product. The *assistance*, to be distinguished from the *lethal act as such*, provided by the healthcare practitioner can be of various natures, such as prescribing the lethal drug, setting up an intravenous infusion (without releasing the lethal substance), helping with the person's self-injection, etc.

Euthanasia and (medically or physician) assisted suicide only differ slightly in nature: they both take place in a similar context, have the same life-ending purpose, and use similar means to achieve that purpose. As a result, legal, ethical, and medical analyses often consider them similar enough to be considered together.

D. Sedation – From intermittent to terminal

Euthanasia has to be carefully distinguished, both from a medical and ethical point of view, from sedation, which is characterized by *the absence of any intention to deliberately end someone's life*: its goal is to relieve the

patient's suffering while respecting the natural process that leads to death.⁶

Sedation is, more precisely, a pain-management technique, used in the context of palliative care, which consists of 'deliberately administering well defined doses and combinations of well-chosen drugs in order to reduce the level of consciousness of a patient in preterminal or terminal stages, to the extent that is necessary to appropriately relieve refractory symptoms, with the patient's explicit, implicit or delegated consent.'⁷

Intermittent sedation can vary in intensity and is normally reversible. The application of the technique is constantly monitored and adjusted in order to achieve the degree of pain management most suitable to the person's actual condition and response to the technique.

As an *ultima ratio* of pain management, provided that intermittent sedation is no longer appropriate, at the very final stage of a patient's life, and when the patient manifests symptoms that resist all other forms of treatment and cause severe pain, **terminal sedation**, which consists of inducing and maintaining sedation until the patient dies, without deliberately provoking death, *may* carefully and proportionately, on a case-by-case basis and only at the patient's request, be applied by the medical team. This can be distinguished from **continuous deep sedation** which, when applied with the intention to shorten life, could be considered a form of euthanasia.

E. Euthanasia and (aggressive life-sustaining) treatment

A **treatment** is aimed at relieving the patient condition. **Aggressive life-sustaining treatment** consists of implementing disproportionate means in order to extend the life of a patient at the end of their life.

If the patient's life is shortened as an unintended side effect of a (reasonably justified and proportionate) treatment, it cannot be considered as euthanasia (not even indirectly), *since there was no intention to end someone's life in order to release (them) from suffering.*

Likewise, the reasonably made decision to stop existing therapeutic treatment cannot be called (passive) euthanasia since, in allowing a person to die in the absence of aggressive life-sustaining treatment, there is no intentional ending of the patient's life.

3) Overview of Laws and Current Proposals

A. Europe

The national parliaments of three countries⁸ have adopted a law specifically authorizing euthanasia: the **Netherlands** (2001),⁹ **Belgium** (2002),¹⁰ and **Luxembourg** (2009).¹¹ The Dutch and Luxembourg laws also expressly authorize assisted suicide, while the Belgian law does not.¹²

In three other countries, recent court decisions marked a significant step towards the (indirect) legalization of euthanasia and assisted suicide. In **Italy**, the Constitutional Court declared a provision criminalizing assistance to suicide in certain circumstances as unconstitutional (2019).¹³ The Court's decision concerned the case of an Italian celebrity disc jockey who, with the help of a friend, travelled to Switzerland for assisted suicide after being left blind and tetraplegic in a car crash.¹⁴ In **Germany**, the Constitutional Court similarly ruled (2020)¹⁵ that a law banning so-called commercial assisted suicide services was unconstitutional, thereby recognizing a 'right to a self-determined death'. Most recently (December 2020),¹⁶ in **Austria**, the Constitutional Court partially struck down a provision of the Austrian Criminal Code that would punish those who provide assistance to 'someone ending his own life'.¹⁷ These decisions are paving the way for a legislative intervention that, in each of those three jurisdictions, would most likely move towards legalizing euthanasia or (and) assisted suicide.

Although it has no law formally authorizing these practices, **Switzerland** is nevertheless known for having permissive criminal legislation (since 1937), under which assisting someone to commit suicide is only criminalized when the assistance is offered out of a selfish motivation.¹⁸ Moreover, recent guidelines for physicians (2018) expressly declared it 'admissible under certain conditions'¹⁹ for physicians to offer assistance to suicide to unbearably suffering patients who have no other therapeutical options left.²⁰ Those same guidelines in turn, quite

paradoxically, also state: 'A patient's request for euthanasia is to be refused, even if it is genuine and insistent'.²¹

B. United States

In the **United States**,²² the Supreme Court ruled (1997)²³ that States could, without violating the Constitution (14th Amendment), either prohibit or allow assisted suicide or euthanasia. To this day, eight states and Washington DC have adopted legislation decriminalizing assisted suicide: Oregon (1994), Washington (2008), Vermont (2013), California (2015), Colorado (2016), Washington D.C. (2016), Hawaii (2018), New Jersey (2019), and Maine (2019).

C. Rest of the world

Colombia legalized euthanasia (2015)²⁴ long after the practice was decriminalized through a decision of its Supreme Court (1997).²⁵ Similarly, following a Supreme Court decision (2015)²⁶ partially invalidating a prohibition on assisted suicide, **Canada**²⁷ adopted a law legalizing euthanasia and assisted suicide (2016). In **Australia**, the State of Victoria legalized both euthanasia and assisted suicide (2017).²⁸ Most recently, following the parliamentary adoption of a proposed law²⁹ and a subsequent national referendum, both euthanasia and assisted suicide have been legalized in **New Zealand** (2020).³⁰

D. Recent legislative proposals and ongoing debates in Europe

The debate on the end of life has made its way into the political agenda of many countries. Legislative proposals have been announced or are currently under discussion *inter alia* in several European countries.

In France, the Parliament rejected legalizing euthanasia and assisted suicide in January 2016, and a compromise was reached through adopting an amendment of the existing legislation³¹ that allows doctors to keep terminally ill patients sedated until death. Two law proposals were

nevertheless tabled (2017³² and 2020³³) regarding the recognition of a so-called 'right to die in dignity' which, in practice, would encompass 'active help in dying' through either euthanasia or assisted suicide.

In **Portugal**, the Parliament initiated a debate on the decriminalization of euthanasia and assisted suicide in 2019, and a bill was passed in January 2021.³⁴ However, in March 2021, it was declared unconstitutional by the Constitutional Court, for reasons related to lack of clarity, rigour, and controllability of the legal conditions.³⁵ The President of Portugal furthermore vetoed the bill.

In **Spain**, in March 2021, the Congress of Deputies adopted a bill³⁶ 'regulating euthanasia', legalizing both euthanasia and assisted suicide. However, in June 2021, an appeal was lodged before the Spanish Constitutional Court,³⁷ which rejected the request to temporarily suspend the application of the bill, and is expected to issue a final ruling in 2022.

In **Ireland**, a bill aimed at legalizing euthanasia and assisted suicide was presented to the National Assembly in September 2020.³⁸

In the **United Kingdom**, both assisted suicide and euthanasia remain illegal.³⁹ However, repeated private member's bills have been proposed in recent years and lobbying organisations have increased their efforts.⁴⁰ Most recently (2021), a bill⁴¹ to 'enable adults who are terminally ill to be provided at their request with specified assistance to end their own life' was tabled before the House of Lords.

In light of the most recent developments in Europe, seemingly disclosing a more or less coordinated movement seeking to achieve the legalization of euthanasia and assisted suicide, it must be recalled that *the vast majority of countries, both in Europe and worldwide, do not consider that euthanasia and assisted suicide should be made available.*

Given that euthanasia and assisted suicide are legal in only a handful of countries throughout the world, the principle hence firmly remains that ending one's life intentionally, even when this would be an

expression of an alleged 'right to self-determination' or motivated by an alleged intent to 'release from suffering', is unacceptable.

4) Legal Competences in the Area of Euthanasia

No international institution is competent to legislate on the matter of euthanasia. In the absence of an international agreement or binding treaty obligation, *the competence to legislate on the matter pertains exclusively to national parliaments.*

However, helpful language can be found in international law, non-binding international resolutions, and international jurisprudence, that rather supports the right to life of all persons as being incompatible with the practices of euthanasia and assisted suicide. As demonstrated in the most notable legal provisions below, international human rights law upholds the right to life. *This right to life cannot, by definition, include a right to the diametrically opposed outcome.* It is evident that a so-called 'right to die' has no basis in international human rights law.

A. United Nations

The International Covenant on Civil and Political Rights (ICCPR), Article 6(1): '[e]very human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life.'⁴²

The Convention on the Rights of the Child (CRC), Article 6(1): 'every child has the inherent right to life'.⁴³

The Convention on the Rights of Persons with Disabilities (CRPD), Article 10: 'States Parties reaffirm that every human being has the inherent right to life and shall take all necessary measures to ensure its effective enjoyment by persons with disabilities on an equal basis with others.'⁴⁴

Moreover, rather than recognizing a 'right to die', UN treaties implicitly reject this notion by including strong protections for the sick, disabled, and elderly – the people most often affected by the legalization of euthanasia and assisted suicide. For example, Article 23 of the CRC recognizes: '[a] mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community.'

Alongside the absence of a 'right to die' within international treaties, the bodies in charge of interpreting these treaties have never produced any analysis or opinion lending support for euthanasia or assisted suicide.

On the contrary, UN treaty monitoring bodies have expressed concerns regarding the practice of euthanasia, despite its legality in only a small minority of countries. For example, the Concluding Observations of the Human Rights Committee on the Netherlands state: '[t]he Committee remains concerned at the extent of euthanasia and assisted suicides in the State party. The Committee reiterates its previous recommendations in this regard and urges that this legislation be reviewed in light of the Covenant's recognition of the right to life'.⁴⁵

B. The European Union

Article 2 of the Charter of Fundamental Rights of the European Union recognizes that 'everyone has the right to life.' The EU only has the power to legislate where competence has been conferred on it by the EU treaties. Where the treaties do not confer competence, they remain with the Member States.⁴⁶ The EU treaties determine that health policy belongs to the Member States:

Union action shall respect the responsibilities of the Member States for the definition of their health policy and for the organisation and delivery of health services and medical care.⁴⁷

This excludes the possibility of harmonizing national legislation in the field of health policies (even assuming it could be contended that this is the sphere into which it would fall). The regulation of it falls within Member States' competences, and EU institutions cannot therefore take any direct action in this area.

C. Parliamentary Assembly of the Council of Europe

In 1999 the Parliamentary Assembly of the Council of Europe, comprised of national parliamentarians from 47 nations, stated that Member States should 'respect and protect the dignity of terminally ill or dying persons in all respects [...] by upholding the prohibition against intentionally taking the life of terminally ill or dying persons'.⁴⁸

In 2012, the Assembly reaffirmed its categorical opposition against any form of legalized euthanasia: '[e]uthanasia, in the sense of the intentional killing by act or omission of a dependent human being for his or her alleged benefit, must always be prohibited'.⁴⁹

D. Medical associations

The World Medical Association (WMA) has consistently and categorically refused to condone or accept the practice of euthanasia and assisted suicide as a justifiable medical activity:

Euthanasia, that is the act of deliberately ending the life of a patient, even at the patient's own request or at the request of close relatives, is unethical. This does not prevent the physician from respecting the desire of a patient to allow the natural process of death to follow its course in the terminal phase of sickness.⁵⁰

Physicians-assisted suicide, like euthanasia, is unethical and must be condemned by the medical profession. Where the assistance of the physician is intentionally and deliberately directed at enabling an individual to end his or her own life, the physician acts unethically. However the right to decline medical treatment is a basic right of the patient and the physician does not act unethically even if respecting such a wish results in the death of the patient.⁵¹

BE IT RESOLVED that:

The World Medical Association reaffirms its strong belief that euthanasia is in conflict with basic ethical principles of medical practice, and

The World Medical Association strongly encourages all National Medical Associations and physicians to refrain from participating in euthanasia, even if national law allows it or decriminalizes it under certain conditions. In 2013, at its 194th World Medical Association Council Session in Bali, Indonesia, the WMA, reaffirming a number of earlier resolutions and affirmations (from 1987 onwards to 2005), resolved that it reaffirms its strong belief that euthanasia is in conflict with basic ethical principles of medical practice, and strongly encourages all National Medical Associations and physicians to refrain from participating in euthanasia, even if national law allows it or decriminalizes it under certain conditions.⁵²

In 2019, the WMA, on the occasion of its 70th General Assembly, adopted the following Declaration⁵³ on euthanasia and physician-assisted suicide:

The WMA reiterates its strong commitment to the principles of medical ethics and that utmost respect has to be maintained for human life. Therefore, the WMA is firmly opposed to euthanasia and physician-assisted suicide.

For the purpose of this declaration, euthanasia is defined as a physician deliberately administering a lethal substance or carrying out an intervention to cause the death of a patient with decision-making capacity at the patient's own voluntary request. Physician-assisted suicide refers to cases in which, at the voluntary request of a patient with decision-making capacity, a physician deliberately enables a patient to end his or her own life by prescribing or providing medical substances with the intent to bring about death.

No physician should be forced to participate in euthanasia or assisted suicide, nor should any physician be obliged to make referral decisions to this end.

Separately, the physician who respects the basic right of the patient to decline medical treatment does not act unethically in forgoing or withholding unwanted care, even if respecting such a wish results in the death of the patient.

E. European Court of Human Rights Jurisprudence

The European Court of Human Rights (ECtHR) has been asked a number of times to consider possible breaches of Articles 2 (right to life), 3 (prohibition of torture) and 8 (right to respect for private and family life) of the Convention regarding the legal prohibition of euthanasia as well as the limits of the law within the countries where it is legalized.

The Court has repeatedly affirmed that a 'right to die' is not contained in the foregoing Articles.

In the case of *Pretty v. United Kingdom*,⁵⁴ Diane Pretty was suffering from a motor-neurone disease and wanted her husband's assistance in committing suicide. UK law regards assistance in suicide as a crime.⁵⁵ She asked the Director of Public Prosecutions to agree not to prosecute her husband. After her request was refused and her appeal failed in the House of Lords, she took the case to the ECtHR. The Court ruled that there is no 'right to die' under the Convention and that countries are not in breach of the Convention if their national legal order prescribes prosecution for aiding or abetting suicide. Furthermore, the Court upheld that the right to life (Article 2) cannot be read as to include the exact opposite, a so-called 'right to die':

Article 2 cannot, without a distortion of language, be interpreted as conferring the diametrically opposite right, namely a right to die; nor can it create a right to self-determination in the sense of conferring on an individual the entitlement to choose death

rather than life. The Court accordingly finds that no right to die, whether at the hands of a third person or with the assistance of a public authority, can be derived from Article 2 of the Convention.⁵⁶

The Court was also asked to examine whether prohibiting euthanasia amounts to torture as prohibited under Article 3 of the Convention. The Court reasoned that, because it was not the State itself that was inflicting any kind of ill-treatment nor was it withdrawing adequate medical care, Article 3 was not engaged. Furthermore, it emphasized that Article 3 must be read in harmony with Article 2 of the ECHR:

Article 2 of the Convention is first and foremost a prohibition on the use of lethal force or other conduct which might lead to the death of a human being and does not confer any right on an individual to require a State to permit or facilitate his or her death.⁵⁷

The attempt to create a 'right to die' under Article 8 also failed. In *Pretty*, while the Court accepted that Article 8 could be read as including the 'choice to avoid what [the applicant] considers will be an undignified and distressing end to her life',⁵⁸ ultimately no violation of Article 8 was found. The Court held that the 'law in issue' (the State's prohibition on assisted suicide) had the legitimate aim of protecting vulnerable people.⁵⁹

Although subsequently in *Haas v. Switzerland*,⁶⁰ the Court recognized that an individual's decision on how and when to die may fall within the scope of Article 8,⁶¹ the Court concluded that there may be a legitimate interest in protecting individuals from exercising their autonomy, for example, to protect individuals from harm, and especially, to protect vulnerable persons.⁶²

In the case of *Lambert and Others v. France*⁶³ referred to the French Conseil d'Etat judgment from 24 June 2014⁶⁴ to discontinue Vincent Lambert's artificial nutrition and hydration. Mr Lambert was left tetraplegic following a road traffic accident in 2008. In 2013, a decision was made

to withdraw his nutrition and reduce his hydration. The applicants, Lambert's parents, half-brother and sister, lodged an application to the ECtHR. They advanced arguments that to withdraw the artificial nutrition and hydration from Mr Lambert would constitute a breach of the Member State's obligation to protect life under Article 2 of the Convention, and that such a course could amount to a breach of Articles 3 and 8.

By twelve votes to five, the Grand Chamber held that implementing the Conseil d'Etat's judgment would not constitute a violation of Article 2 (right to life). The ECtHR held that, in relation to life supporting treatments, Member States are to be afforded a wide margin of appreciation. However, this margin of appreciation is not unlimited, and the Court reserves the power to review whether or not the State has complied with its obligations under Article 2. In this case the ECtHR seemed content to assess artificial nutrition and hydration as 'life sustaining treatment'. This interpretation has been widely criticized as undermining both the wording and spirit of Article 2 of the Convention.

The case of *Mortier v. Belgium*,⁶⁵ in which the Court is due to deliver its decision, concerns the euthanasia of Mr Mortier's (applicant) mother that took place in 2012.

After years of depression, she received a lethal injection in 2012, although she was not terminally ill, but rather suffered from a psychiatric condition. The circumstances surrounding her death raise particularly serious questions regarding the (in)adequacy of the protection of her right to life under the Belgian euthanasia law.

The doctor performing euthanasia had only relatively recently met her and neither knew nor treated her prior to her request for euthanasia. Furthermore, he had no specialization in psychiatric conditions (he was an oncologist) and failed to consider the potential influence of the medication she was taking (which, as side effects, include an increased risk of suicidal thoughts). To fulfil a legal requirement, the doctor sought two 'independent' opinions on the request for euthanasia. However, these doctors appeared to have clear links with the physician performing the euthanasia, as well as with the euthanasia-promoting association ('LEIF'),

founded by said doctor, which had received a donation of 2,500 EUR from the applicant's mother.

The applicant, on his side, was never informed by the physician that his mother had made a request for euthanasia and was never involved in the decision-making process that eventually led to the euthanasia.

Belgian law does not formally require the relatives to be informed of a request for euthanasia, which appears to be problematic in regard to, amongst other things, the right to private and family life of those relatives. This also contributed, in this case, to a violation of the right to life of the applicant's mother, given that her depression, which was characterized by regular ups and downs, was partially rooted in family tensions that could potentially have been addressed through a dialogue, which might have prevented the euthanasia from being requested or carried out. One can also question whether all reasonable therapeutic options had truly been exhausted, as required by the Belgian euthanasia law, in this case of psychological suffering by a non-terminally ill patient.⁶⁶

The Court will have to assess whether the right to life of Mortier's mother was adequately protected under Belgian law and by the Belgian authorities, and whether the right to respect for private and family life of the applicant has been violated.

5) **Examples of Countries Where Euthanasia has been Legalized**

Wherever euthanasia has been legalized, a steep increase in the number of cases and an extension of possible reasons for euthanasia can be observed, as illustrated not only by the national examples of Belgium and the Netherlands, where euthanasia was legalized twenty years ago, but also by the more recent example of Canada.

A. Belgium

1. Decriminalization in 2002

The Belgian law on euthanasia passed on 28 May 2002.⁶⁷ Belgium became the second country in the world to legalize euthanasia, defined in the law as the 'deed by which a third person intentionally ends the life of another person at the request of the latter'.⁶⁸

The legalization consists in a partial decriminalization of euthanasia: while intentionally ending someone's life remains punishable, no criminal offence is committed in the case of euthanasia, provided that all the applicable legal conditions are met, and a physician performs the euthanasia.⁶⁹

The Belgian law stipulates⁷⁰ those seeking euthanasia must be *conscious* and *legally competent* at the moment of making the request to end their lives and must be, as a *result of a severe pathology or accident*, in a condition of *durable and unbearable physical or mental suffering that cannot be alleviated*. The request must be voluntary and made *without any external pressure*.

The physician handling the euthanasia request *must inform* the patient about their medical condition and life expectancy and possible therapeutic treatments, including palliative care. The physician must have *several conversations* 'spread out over a reasonable period of time'

in which he (the physician, with the patient) must 'come to the belief that there is *no reasonable alternative* to the patient's situation'.

The physician must also 'consult *another physician* about the *serious and incurable character* of the disorder', who must be '*independent*' in respect of the patient as well as the physician handling the euthanasia request and must be *qualified* with regard to the concerned pathology.

Euthanasia can be performed on patients whose death is estimated to occur 'at short notice', as well as on patients that, in the opinion of the physician, are not expected to die 'at short notice'. In that case, the law requires a waiting period of *one month* prior to executing the euthanasia, and a consultation with another physician (in addition of the first consulted physician), who must be *specialized* in the concerned pathology.

After performing euthanasia, the physician is required to *report the case for review* to the Federal Control and Evaluation Commission (hereafter: the Control Commission).⁷¹ The Control Commission determines whether the 'euthanasia was performed in accordance with the conditions and procedure stipulated in the Act'.⁷²

2. *Vague, subjective and uncontrollable conditions: no real 'safeguards'*

Although the decriminalization of euthanasia was said to be surrounded by so-called strict conditions, intended to act as 'safeguards' against any abuse of the law, it rapidly became clear that their vagueness and subjective nature made it nearly impossible to effectively control the practice.⁷³

For instance, the law requires the patient to be in a state of 'unbearable' physical or mental suffering for the euthanasia to be legally performed.

However, the Control Commission's first report, following the adoption of the euthanasia law, considered that 'although some objective factors may contribute to the assessment of the unbearable nature of the

suffering, the latter is largely subjective and depends on the personality, the views and the values of the patient⁷⁴ – the Control Commission is in essence admitting that it is, in practice, impossible to objectively determine whether the threshold of ‘unbearable’ suffering is (or had been) reached.

Other aspects of the law similarly render an objective assessment of the fulfilment of the legal conditions very hard, if not impossible, both for the concerned physician (prior to the euthanasia) and the Control Commission (*after* the euthanasia took place).

For example: what is to be considered a ‘severe’ pathology? What does the requirement of ‘independence’ of the consulted physician entail? How can one determine that no ‘reasonable’ alternative to euthanasia is available? How can one ensure that a request for euthanasia is in no way a result of any ‘external pressure’? How is it possible to affirm with certainty that mental suffering cannot be alleviated through other treatments?

The main legal conditions then appear to be useless to achieve any real control of the euthanasia law and practice.

This is all the more evident in the context of criminal law (euthanasia being an exception to the criminal offence of murder by poisoning⁷⁵): if the exact meaning of the legal terms is unclear, doubt can easily be cast on the criminal intent of the person charged of unlawful euthanasia, which then leads to acquittal.

As a matter of fact, three physicians, accused of collaborating in the (allegedly) unlawful euthanasia on Tine Nys, a 38-year-old lady who suffered from chronic depression and autism, were acquitted in 2020 by a jury on the basis of reasonable doubt as to their criminal intent.⁷⁶

To this day, this remains the only trial for unlawful euthanasia in almost twenty years of legalized euthanasia in Belgium, which not only raises questions about the ability of the Control Commission and the Prosecutor to effectively control if the (unclear) legal conditions were met, but also about their willingness to do so.⁷⁷

The Control Commission furthermore seems, without any authority or mandate to do so, to decide by itself how legal conditions are or are not

to be interpreted—and one can observe that those interpretations lead to a more permissive approach towards euthanasia.⁷⁸

For instance, the Control Commission found no objections in cases of euthanasia performed *absent a severe pathology* (legal requirement), indicating that in those cases a so-called ‘polypathology’ could be considered as a sufficiently severe medical condition to lawfully resort to euthanasia. ‘Polypathology’, a term used by the Control Commission, was recently described by its president, Dr Distelmans, as being related to ‘people who are often of an advanced age and have an accumulation of all kind of minor conditions that as such are maybe not truly serious but when added one upon the other become unbearable for the concerned person’.⁷⁹ The examples cited by the Commission’s president included people who requested euthanasia for suffering of ‘conditions’ such as ‘less good sight, less good hearing, incontinence, needing help to drink or to eat, a walking frame, etc.’.⁸⁰

One can easily observe the aforementioned ‘symptoms’, rather than being the result of a pathology, let alone a ‘severe’ pathology, are often and primarily related merely to ageing—a phenomenon that, in the context of euthanasia, in the Control Commission’s reasoning, would nevertheless end up (being perceived) as a lawful reason for euthanasia.

The fact that, even in cases where it clearly appeared that *objective* conditions were not met, no action was undertaken by the Control Commission to refer those cases to the Prosecutor, nor by the latter to open an investigation, raises even more concerns.

One of the objective legal requirements concerns the euthanasia request itself, which must be established in writing by the patient,⁸¹ as an (alleged) guarantee against involuntary euthanasia. Euthanasia cases have been reported to the Control Commission without the latter finding any trace of a written request upon examination of the documents.⁸² Despite the clear violation of an objective legal requirement, the cases were not referred to the Prosecutor.

Similarly, while the wording of the law only permits physicians to perform the lethal act, cases of physician assisted suicide—characterized

by the patient *him- or herself* performing the lethal act with the assistance of a physician, which is in clear violation of the law—were reported to the Control Commission. Nevertheless, the Control Commission found no reason to refer these cases to the Prosecutor, but on the contrary, considered physician assisted suicide as falling inside the scope of the law.⁸³

Given the particularly permissive approach of the Control Commission, it is of no great surprise that, despite reviewing more than 22,000 (declared) euthanasia cases in about twenty years of its legalization, only *once* did it refer a case to the Prosecutor, in 2015.

The said case concerned the euthanasia of a healthy, 85-year-old lady, grieving about the death of her daughter from a heart attack. Her euthanasia was filmed and recorded in a documentary by the Australian SBS TV Network,⁸⁴ and consisted in drinking a lethal substance with the assistance, and in the presence, of her physician, who was literally sitting at her side.

The formal grounds of the referral to the Prosecutor by the Control Commission are unknown, although its president later unofficially admitted the concerns were related to the absence of a severe medical condition.⁸⁵

Following an investigation, the Prosecutor ultimately decided in 2019 not to refer the physician to a criminal tribunal for sentencing, but rather to dismiss the charges on the grounds that this was a case of physician assisted suicide which, in the view of the Prosecutor, fell outside the scope of euthanasia and therefore did not require meeting the legal conditions set forth by the euthanasia law.⁸⁶ It is worthy to note, in this regard, that the physician reported this case *as a euthanasia* case to the commission.

This case highlights, *inter alia*, that even the fulfilment of an *objectively verifiable legal condition*—namely the lethal act having to be performed by a physician and not by the patient *him- or herself*—leads to a contradiction between the two main Belgian bodies tasked with preventing any abuse of the euthanasia law (Control Commission

and Public Prosecutor). Although adopting two incompatible stances as to whether physician assisted suicide falls within the scope of the euthanasia law, the two nevertheless, in practice, *amounted to the same consequence of impunity for the physician deliberately "helping" a person not affected by a severe condition to die.*

3. Most recent numbers

The Belgian euthanasia law stipulates that the Control Commission is to present a report to the legislature every two years.⁸⁷

According to the most recent report (issued in 2020), covering the years 2018 and 2019, since 2002, 22,082 persons have been euthanized in Belgium.⁸⁸ This number however does not include euthanasia cases not declared to the Control Commission.⁸⁹

As a way of comparison, during the first eight years following the legalization, an average of 493 euthanasia cases per year were recorded. This number more than tripled during the 2010-2014 period (an average of 1,450 cases), and further increased to an average of 2,275 cases per year over the 2015-2019 period. The numbers have been consistently increasing each year, with a 14% increase in 2017, compared to 2015, and another 14% increase in 2019, compared to 2017.

In 2019, euthanasia accounted for 2.5% of all deaths in Belgium (2,656 euthanasia cases). The vast majority of cases (76%) concerned 60 to 90-year-old persons. In 17% of the cases, natural death was not expected to occur in the near future.

During the 2018-2019 period, the most frequently invoked conditions for euthanasia were cancer (62%), 'polypathologies' (17.9%), diseases of the nervous system (8.5%), of the circulatory system (3.6%) and of the respiratory system (2.8%), with psychiatric conditions accounting for 1.1% of the cases. About 2.1% of all cases were related to 'mental or behavioural disorders'.

The Control Commission furthermore indicates in the 2020 report that, in the cases in which euthanasia was performed on the basis of

mental suffering, the suffering was characterized as: 'related to current life and vision of the future (e.g. awareness that no improvement is possible, feeling of weakening), the loss of autonomy, and dependency (e.g. others need to take care of me), the impossibility of maintaining social contacts (e.g. due to the loss of mobility, hearing ability, sight), a feeling of anxiety (e.g. I am alone), my system of values has become useless (e.g. my references disappeared), my life has no sense anymore (I can't continue, this is the end).'⁹⁰

Regarding 'polyopathologies', the Control Commission mentioned the number will likely increase in the future 'given the growing ageing population and the *mechanism of appearance of polyopathologies*.'⁹¹

Regarding the control of the (declared) euthanasia cases for the 2018-2019 period, the Control Commission mentions that '75.2% of the euthanasia declaration forms were correctly *filled in*, and have *thus* been straightaway accepted', with no violation of the law found upon a short analysis of the remaining 24.8% of the cases, and no cases referred to the Prosecutor for further investigation.

In March 2021, the Control Commission issued a press release⁹² regarding the numbers for the year 2020. A total of 2,444 cases of euthanasia have been declared to the Control Commission in 2020, which represents a 7.9% decrease compared to the year 2019, and the first decrease ever since the legalization.

The Control Commission's President considered, in a subsequent interview,⁹³ this decrease to be related to a criminal trial regarding a euthanasia case that was held in January 2020,⁹⁴ which allegedly rendered physicians 'less keen to perform euthanasia', as well as to the period of lockdown due to the Covid pandemic: 'Non-terminal patients in particular *postponed euthanasia*, in order to wait for the moment where they could receive visit again from their family'. No evidence of those alleged reasons has been provided, however.

The Control Commission furthermore stated all 'essential' (*sic*) conditions of the law had been respected in every case – hence no case was referred to the Prosecutor.

4. *Successive enlargements of the euthanasia legislation*

Although upon adoption of the law, it was said that euthanasia would only be accessible to adults, the Belgian euthanasia law was amended in 2014,⁹⁵ making Belgium the first and only country in the world to allow the euthanasia of children *without any age limit*.⁹⁶ Parental consent is required, though it remains unclear what would be done in the event of a serious and persisting divergence in views between the minor requesting euthanasia, and their parents, or in the event one of the parents disagrees with the request while the other agrees.

The amendment was motivated by the allegation that there was an urgent need to allow children to access to euthanasia, with the underlying idea that numerous children were facing unbearable suffering. Seven years later, the (reported) numbers show that this was obviously not the case: *only five* cases of child euthanasia have been recorded since the practice was legalised.

Making euthanasia available to children marked, however, another step, some argue, towards the recognition of an emerging general 'right to euthanasia'—although such a right, in theory, was said *not* to exist at the time euthanasia was decriminalized.

In 2020, six years after its first amendment, and eighteen years after the euthanasia law was adopted, the Belgian law was amended a second time,⁹⁷ in a way that treats the practice as if it were now just an ordinary medical procedure.

One of the modifications concerned the anticipatory declaration—a document through which a person pre-emptively gives their consent to euthanasia, in the event that he or she should be in a situation of 'irreversible unconsciousness'⁹⁸ (provided the other applicable legal conditions are also met). While this document previously had a five-year validity, and as a matter of consequence had to be renewed every five years, the amended law now automatically grants an indefinite validity to the document, generating the idea that once euthanasia is 'anticipatorily'

requested, the principle is that it should be carried out no matter how much time or what events might have occurred in the time elapsed since the initial request.

The initial version of the euthanasia law expressly intended to protect the right to conscientious objection regarding euthanasia, indicating that ‘no physician can be held to perform an euthanasia’ and that ‘no other person can be held to collaborate to an euthanasia’.⁹⁹ This provision, allegedly with the purpose of guaranteeing ‘access to euthanasia’ for those ‘in need’, was modified in order *to oblige* the physician, who might refuse to perform an euthanasia for conscientious reasons, to provide the patient with the contact details of a ‘centre or association specialized *in the right to euthanasia*’.¹⁰⁰

This amendment formally introduced the concept of a ‘right to euthanasia’ in Belgian legislation. However, in principle, when the law was originally adopted, euthanasia was said to be, and intended to remain, an *exception* to criminal law.

It furthermore appears to be highly problematic in that it largely diminishes, if not renders useless, the protection initially granted to the physician objecting to euthanasia for reasons of conscience—a protection the physician is entitled to enjoy through international human rights law. Under the current legislation, an objecting physician can nevertheless be forced to collaborate in euthanasia, by having to refer the patient to a centre that actively promotes euthanasia.¹⁰¹

Finally, an article was added, following which ‘no written or unwritten provision can prevent a physician to perform a euthanasia with due respect for the legal conditions’. This article tends to prevent healthcare institutions from, by way of general policy, objecting to an act of euthanasia being performed within their walls.

In practice, this means that under current legislation, even care institutions which have had a long tradition of refusing euthanasia based on ethical, philosophical, or religious convictions, or another reason, can no longer effectively prevent euthanasia from taking place inside their care units—or they could be sanctioned for doing so. It goes without saying

this provision poses a clear threat not only to the very identity and ethical stances of the concerned institutions, and therefore to the institutions themselves, but it also poses a threat to the personal decisions of inter alia staff and patients who, for various legitimate reasons, do not wish to collaborate or engage in euthanasia.

In the most recent legislative sessions, proposals were made to further extend the scope of the euthanasia law to people suffering from dementia, and calls were made to authorise assisted suicide for people who are 'tired of life'.

B. The Netherlands

1. Decriminalization in 2001

The Netherlands became the first country in the world to legalize euthanasia in 2001, with the adoption of the 'Termination of Life on Request and Assisted Suicide (Review Procedures) Act',¹⁰² which entered into force on 1 April 2002. Since then, both euthanasia and assisted suicide were no longer punishable under the criminal offence of murder, provided that the six so-called legal 'care criteria', listed hereafter, were followed.¹⁰³

The law states¹⁰⁴ the need for a '*voluntary and well-considered request*'. The patient's suffering should be '*lasting and unbearable*', the patient should be informed about his/her situation and prospects, the physician and patient must '*hold the conviction that there was no other reasonable solution*', an '*independent physician must be consulted*', and the '*life has to be ended, or the suicide must be assisted, 'with due care*'.

Minors may request euthanasia from the age of 12, although the consent of the parents or guardians is mandatory until they reach the age of 16. Sixteen and seventeen-year-olds do not need parental consent in principle, but their parents must be involved in the decision-making process.¹⁰⁵

In cases of termination of life on request and assisted suicide, doctors notify a regional review commission which assesses whether the physician acted in accordance with the requirements of due care.¹⁰⁶

2. Some numbers

Beginning in 2003, the Dutch Regional Review Commission (hereafter: 'the Dutch Euthanasia Commission'—a national body bringing together the five regional review commissions) has published annual reports on the number of cases of euthanasia and assisted suicide¹⁰⁷. Those numbers do not include the unreported cases.

In 2019, 6,092 euthanasia and assisted suicide cases were recorded, amounting to 4.2% of all deaths. By way of comparison, in 2009, 2,636 cases of euthanasia and assisted suicide were recorded, which means that, in ten years, the number of cases has *more than doubled*—and *even more than tripled* in a fifteen-year period, if we consider the number of cases recorded in 2004 (1,886 cases).

In 2019, 67.3% of cases concerned patients with cancer, 4.1% with cardiovascular disease, 6.7% with neurological disorders, 3% with pulmonary disorders, 2.7% with dementia, 1.1% with other psychiatric conditions, 13.9% for a 'combination of conditions', and 1.8% for multiple geriatric syndromes.

There has been a notable increase in euthanasia cases for dementia. In 2012, 41 persons affected by dementia were euthanized. By 2016, this number had tripled, accounting for 141 people. In 2019, this number further increased to 162, out of which 160 were 'at the beginning stages of dementia' while two others were at an 'advanced stage of dementia'.¹⁰⁸

Concerning euthanasia for psychiatric conditions, 68 people were euthanized in 2019, a sharp rise in contrast to the 14 individuals in 2012.

The 2016 report also highlighted the increasing involvement of doctors from the so-called 'End of Life Clinic', which collaborated in euthanizing around 400 people in 2016, compared to 107 in 2013. In 2019,

this institution changed its name to the ‘Euthanasia Expertise Centre’, to emphasize its core activity, which is stated to be ‘to assess euthanasia requests’.¹⁰⁹ The centre claimed it received 3,122 requests for euthanasia in 2019, equalling an average of 13 requests per day, which constitutes a record number and represents a 22% increase from 2018.¹¹⁰ Out of those requests, 898 were carried out, amounting to one out of three requests.¹¹¹ According to one of its directors, the constant increase in numbers over the years demonstrates there is ‘an increasing need for an organization specialized in *euthanasia care*’.¹¹²

3. An increasingly permissive approach towards euthanasia

The Netherlands euthanasia and assisted suicide law has, to this day, not been amended, unlike the Belgian law.

However, Dutch policy makers, including the (outgoing) minister in charge of Health, recently committed to amending the law. The law would be modified to permit access to euthanasia to children *under* the age of 12 in order to prevent ‘unnecessary suffering’.¹¹³ In July 2020, a proposal was furthermore tabled in the Dutch Parliament, aimed at legalizing ‘ending the life of elderly people on request’¹¹⁴ in cases where a person could, from the age of 75, claim their life was ‘complete’. No formal agenda has been set on how to move forward with those proposals.

In 2018, the Dutch Euthanasia Commission published the first version of a ‘Euthanasia Code’, which provides a set of guidelines (not legally binding) on the practice and control of euthanasia and assisted suicide, based on the findings and views expressed by the Dutch Euthanasia Commission until 2018.¹¹⁵

Amongst other things, the Code mentions the possibility for couples, to request a so-called ‘couple euthanasia’¹¹⁶—where both individuals are euthanized simultaneously, provided that conditions of the law are met for both. The 2018 report of the Dutch Euthanasia Commission mentions 18 cases of ‘couple euthanasia’ were reported, a number that almost doubled in 2019 (34 reported cases).

In 2020, this Code was amended, following a euthanasia case known as the 'coffee euthanasia'.¹¹⁷

The case concerned the euthanasia of a 74-year-old lady suffering from dementia (Alzheimer's disease), who had anticipatively requested euthanasia to be performed if she were to be admitted to a nursing home.¹¹⁸ After she had effectively been admitted, it appeared she gave contradictory signals as to whether she still truly desired euthanasia during her stay there: on some occasions, she asked to die; while on other occasions, she expressed she did not want to die. The euthanasia was eventually carried out in 2016, at the request of her husband, based on the anticipatory declaration.

The physician, who had been taking care and observing the lady since her admission to the nursing home seven weeks prior to the euthanasia being performed, was later heard by the Dutch Euthanasia Commission.

He explained that in order to tranquilize the lady before the euthanasia, a sedative was added to her coffee around 10 am without her knowledge, because the lady, who ordinarily took no medication, might have refused were she asked to take the sedative by herself. About 45 minutes later, after she finished drinking her coffee 'in a pleasant atmosphere', the physician nevertheless found that a second dose of sedative had to be administered. The record notes that the lady, who already started to feel tired, experienced the injection as 'unpleasant'. Half an hour later, the lady was finally in a state of lowered consciousness, and an intravenous perfusion was administered—it was noted that she 'slightly retracted' when this was done. When the lethal substance (thiopental) was eventually injected, the lady attempted to get up and withdraw her hands, which frightened the physician. He indicated that, at the sight of the infusion, the lady 'got scared and looked at it with anxious eyes', yet he did not think of interpreting this 'as a sign that the patient possibly did not want the euthanasia'. The physician added in that regard, that even if the lady had, at that time, said, 'I don't want to die', he would nevertheless

have continued the ongoing life-ending procedure and did not consider it 'appropriate' to interrupt the process at that stage.

The family of the lady then intervened to hold her still while the physician rapidly injected the rest of the lethal substance, after which the lady's life came to an end.

That morning, prior to the euthanasia, the physician had not spoken with the lady about the euthanasia, nor about adding a sedative to her coffee. He claimed to do this in order to avoid provoking her, and because the physician did not believe she had mental capacity. That morning, while the patient was with her family, she expressed intent and made plans to have dinner with them outside the facility—which, to the physician, illustrated the inconsistency of her utterances.

After the Dutch Euthanasia Commission examined the circumstances of the case, it found that the physician had not respected the euthanasia law, as the anticipatory declaration did not clearly indicate the patient's intention to be euthanized while in a state of lacking mental capacity.¹¹⁹ It also concluded the euthanasia had not been performed with due care.¹²⁰

Criminal proceedings were then initiated. However, the Dutch Supreme Court eventually acquitted the concerned physician on the basis 'that an anticipatory request for euthanasia, in the case of a patient suffering from dementia, had to be interpreted not only with regard to the wording of the declaration, but also with regard to other circumstances from which the patient's will can be deduced.'¹²¹

Following that decision, the Dutch Euthanasia Commission, although having previously considered this to be an unlawful euthanasia, aligned its view with the Supreme Court's ruling and, without expressing any further concerns, subsequently amended the Euthanasia Code.

Whereas the initial Code (2018) required that euthanasia in the case of dementia would only be performed in the presence of an anticipatory declaration that was '*clear and without any doubt* applicable to the present situation' (2018),¹²² the new requirement (2020) imposed the responsibility upon the physician to (independently) interpret the

declaration, taking ‘into account all circumstances and *not only the literal words of the written request*’¹²³—thus facilitating the euthanasia of people suffering from dementia, *even in a context where doubt could reasonably arise as to the patient’s current will*.

The other amendments similarly tended to make it easier to carry out a euthanasia request.

For instance, it clarified that in the case of dementia and in the presence of an anticipatory declaration, provided the patient is unable to express their wishes, it is no longer mandatory for the physician to inquire about a patient’s ‘current wish to live or to die’.¹²⁴ It furthermore detailed that ‘counter-indications’ to the euthanasia, which can consist in utterances or particular behaviours of the patient, ‘that originated in the period in which the patient was unable to express his will, *cannot* be understood as a withdrawal or modification of the written request’.¹²⁵

The physician performing the euthanasia is also officially allowed to resort to so-called ‘pre-medication’ (i.e. sedatives) when there are indications ‘agitation or unrest’ may occur during the execution of euthanasia.¹²⁶

The final amendment, which concerns all euthanasia cases (not only dementia), confirms that the performing physician is to be considered as the sole authority needed to determine, based on a ‘medico-professional’ analysis, whether or not ‘unbearable’ suffering exists, and that the Commission can only exercise limited oversight in that regard¹²⁷—this despite the requirement of unbearable suffering as being one of the central requirements of the euthanasia law, as well as the main reason for the legalization of euthanasia in the Netherlands, twenty years ago.

C. Canada

In the province of Quebec, an Act ‘respecting end-of-life care’ was adopted by the National Assembly on 5 June 2014. The act grants every person the right to receive ‘end-of-life care’, which includes ‘the administration by

a physician of medications or substances to an end-of-life patient, at the patient's request, in order to relieve their suffering by hastening death'.¹²⁸ The Act thus allows a person to request euthanasia (euphemistically called 'medical aid in dying').

The patient needs to be 'of full age and capable of giving consent to care', be 'at the end of life', 'suffer from a serious and incurable illness', 'be in an advanced state of irreversible decline in capability', and 'experience constant and unbearable physical or psychological suffering which cannot be relieved in a manner the patient deems tolerable'.¹²⁹

A Canadian Federal Government challenge to this Act failed following the Canadian Supreme Court's ruling in *Carter v. Canada* in February 2015.¹³⁰

The Court ruled that the provision criminalizing help provided to a person in committing suicide, as contained in the Canadian Criminal Code, infringed on the Canadian Charter of Rights and Freedoms (Part I of the Canadian Constitution) by prohibiting the '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'. A one-year period was granted to the Canadian Federal Government to legislate on the matter in order to amend the Criminal Code.

On 17 June 2016, a bill to legalize and regulate euthanasia and assisted suicide nation-wide passed in the Canadian Parliament.¹³¹

Under that law, individuals qualify if they are at least 18 years of age, 'have a grievous and irremediable medical condition', 'have made a voluntary request for medical assistance in dying', and 'give informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care'.¹³² Grievous and irremediable medical conditions are further defined as being 'serious and incurable', causing the person to be in 'an advanced state of irreversible decline in capacity' with 'natural death ... reasonably foreseeable'. The person providing or administering the lethal substance,

in the case of euthanasia, must be a medical practitioner or a nurse practitioner.

Following a law proposal introduced by the Minister of Justice and Attorney General of Canada, subsequent to a decision of the Superior Court of Quebec declaring unconstitutional the 'reasonable foreseeability of natural death' eligibility criterion,¹³³ the House of Commons passed an act to amend the regulation of euthanasia and assisted suicide on 10 December 2020, adopted by the Senate on 17 February 2021.¹³⁴

The amendment opened the possibility for persons whose natural death is *not foreseeable* to resort to euthanasia or assisted suicide. It set forth specific conditions that must be met in each case (depending on whether or not natural death is foreseeable).

It also specified that euthanasia may be carried out in the event a person loses their capacity to consent, provided the person and the medical practitioner made an agreement prior to the loss of capacity. Under current law, as amended, resorting to euthanasia is furthermore also allowed in the event a person loses the capacity to consent due to the self-administration of a lethal substance prescribed to that person with the aim of committing assisted suicide (under the conditions of the legislation).

Regarding the requirement of an irremediable medical condition, the amended legislation specifies that persons whose sole underlying medical condition is a mental illness are not eligible for 24 months, i.e. until 17 March 2023. During this two-year period, the Canadian Government must 'cause an independent review to be carried out by experts respecting recommended protocols, guidance and safeguards to apply to requests made for medical assistance in dying by persons who have a mental illness'.¹³⁵

One can observe that all but one of the amendments entail a significant enlargement of the 2016 conditions for euthanasia and assisted suicide, which moreover comes less than five years after those practices were first legalized.

In December 2018, the Council of Canadian Academies issued a report entitled 'The State of Knowledge on Medical Assistance in Dying for Mature Minors' as a response to a request from the Canadian Ministry of Justice on whether euthanasia and assisted suicide of minors should (or could) be legalised in Canada in the future.¹³⁶ Until now, no legislative action has been taken, although calls have been made to amend the legislation.

Although euthanasia and assisted suicide were legalized in 2016, it took the Canadian authorities one-and-a-half years (until January 2018) to put the so-called 'federal monitoring system for medical assistance in dying' in place under the auspices of the Ministry of Health, which was tasked with gathering data and reporting on the application of the legislation. Prior to the system being in place, data was provided by territories and provinces on a 'voluntary' basis, raising doubt as to the accuracy of the data.

The first report¹³⁷ covered the year 2019. In that year, 5,361 cases of euthanasia and assisted suicide were reported, which accounts for 2% of all deaths in Canada, and represents an increase of 26.1% compared to the numbers available for the year 2018. The second report¹³⁸ covered the year 2020. In that year, 7,595 cases of euthanasia and assisted suicide were reported, which accounts for 2,5% of all deaths in Canada and represents an increase of 34.2% compared to the numbers available for the year 2019.

It is estimated, since the adoption of the federal legislation, 21,589 persons died as a result of either euthanasia or assisted suicide.

6) Legal Exceptions, Safeguards and Controls: A slippery slope

The 'slippery slope' argument asserts that one exception to a law is followed by more exceptions until a point is reached that would initially have been considered unacceptable.¹³⁹

When applied to the legalization of euthanasia and assisted suicide, the slippery slope implies that whereby the introduction of euthanasia is normally predicated upon it being very rare and truly exceptional, albeit gradually, an overarching acceptance and approval for euthanasia and assisted suicide can be observed.

A. Amendments expanding the euthanasia legislation

This trend can be observed particularly in the successive amendments made to the Belgian euthanasia law over the course of just under twenty years. Where initially, only adults could request euthanasia, this has now been extended to minors. Where initially, no physician could be compelled to collaborate with euthanasia; now, even a physician who conscientiously objects is obliged by law to refer their patient to an organization favourable towards euthanasia. Upon legalization, euthanasia was to be considered an exception to the criminal offence of murder; but a 'right to euthanasia' is now considered among the patient's basic rights.

Although the Dutch euthanasia law has not been formally amended, proposals have been put forward to extend euthanasia and assisted suicide to minors below the age of twelve, and the guidelines issued by the Dutch Euthanasia Commission are illustrative of an increasingly permissive approach towards euthanasia and assisted suicide.

The existence of a 'Euthanasia Expertise Centre' in the Netherlands, formerly known as the 'End-of-Life Clinic', shows that, twenty years after its legalization, euthanasia is offered as an ordinary medical service with a provider specialized in (euphemistically called) 'euthanasia care', thus

further trivializing the fact that euthanasia is the intentional ending of a life.

Prof. Theo Boer, a Dutch ethicist, and a nine-year-member of a Netherlands regional euthanasia review committee writes that:

under the name 'End-of-Life Clinic' the Dutch Right to Die Society NVVE founded a network of travelling euthanizing doctors. Whereas the law presupposes (but does not require) an established doctor-patient relationship, in which death might be the end of a period of treatment and interaction, doctors of the End-of-Life Clinic have only two options: administer life-ending drugs or send the patient away. On average, these physicians see a patient three times before administering drugs to end their life.¹⁴⁰

When it comes to Canada, as illustrated in the previous section, recent amendments entailed a significant enlargement of the 2016 law, less than five years after the legalization of euthanasia and assisted suicide.

B. Ineffective 'safeguards' and control mechanisms

Furthermore, in all jurisdictions in which euthanasia or assisted suicide, or both, have been legalized, regulations were put in place to prevent abuse. These measures have included, among others, explicit consent by the person requesting euthanasia, mandatory reporting of all cases, administration only by physicians, and consultation by a second or third physician.

As previously highlighted, there is evidence¹⁴¹ to show that these laws, setting forth so-called strict conditions and safeguards, are regularly ignored and transgressed, and that transgressions are not followed with prosecutions, as it has also been confirmed by former members of the Belgian and Dutch euthanasia commissions.

Prof. Boer was a member of a regional euthanasia review committee in the Netherlands from 2005 until 2014. In 2007, he wrote

‘there does not need to be a slippery slope when it comes to euthanasia’, further indicating that ‘a good euthanasia law, in combination with the euthanasia review procedure, provides the warrants for a stable and relatively low number of euthanasia’.

In 2014 however, based on his first-hand experience as a member of the regional review committee, and after having reviewed thousands of euthanasia cases, he changed his position. He wrote a public appeal to the British House of Lords, warning: ‘We were wrong, terribly wrong’. He mentioned the escalation in numbers of euthanasia demands, the development of End-of-Life Clinics, the shift in patients who receive euthanasia (i.e. more cases of loneliness, depression, and bereavement), and the development from an exception in law to public opinion considering euthanasia a ‘right’, with corresponding duties on doctors to act.

In 2017, Dr Ludo Vanopdenbosch, a neurologist, palliative physician, and visiting university professor, although being in favour of euthanasia, resigned from his position as a substitute member of the Belgian Control Commission. In a letter¹⁴² sent to the President of the Belgian Parliament, he provided the following reasons for his resignation:

(...) The Federal Control and Evaluation Commission is indeed not independent nor objective. Whenever declarations are [found] not to be in conformity with the law, they are not, as the law prescribes, transferred to the Prosecutor for investigation, but [the Commission] plays the role of judge.

The most striking example of this took place on 5 September 2017, in a case under review at the request of the family of a patient severely affected by dementia and Parkinson’s disease. The incompetent general practitioner who performed the euthanasia was ignorant of palliation, and had an intent to kill the patient, who did not request the euthanasia. The means used to relieve pain were disproportionate, and the advice given by the other physician was most likely not independent,

and retroactively given. None of the legal conditions, except for the euthanasia to be [afterwards] declared, were met.

The commission held a recorded hearing with the physician. Video footage of the patient's situation was submitted prior to the hearing, and hours of debate ensued culminating with a vote. However, the two thirds majority required to transfer the case to the Prosecutor for investigation was narrowly missed.

The motivations of those that did not want to transfer the case to the Prosecutor are fundamentally of a political nature: defending euthanasia in whatever circumstances, there is now fear that in Wallonia [red. French speaking part of Belgium], euthanasia cases will decrease again, [and] a desire to [allow] euthanasia for persons with dementia. (...) The Control Commission does not enlarge the scope of the law: it violates the law.

I do not want to be part of a commission that deliberately violates the law and tries to hide it. The lawyers that were present indicated that it is not up to the Commission to interpret the law. After the meeting, members of the Commission were instructed not to communicate about this debate and this decision. This is unacceptable (...).

A third element that I noticed (...) is that I, being a neurologist, expressed concerns about the particularly vulnerable group of persons, the late-stage neurological patients, such as those affected by multiple sclerosis. One cannot lightly consider euthanasia in such cases. Following this I have been silenced by a [Commission] member of a 'right to die in dignity'-organization. The Commission's president and vice-president did not intervene to guarantee my right to freely speak out. I do not want to be a member of such a commission.

Fourthly, the Commission does not possess the ability to verify the factual accuracy of the declared data. I, as a practitioner,

now know how to fill in a euthanasia registration form in such a way that it will be without any doubt approved by the Commission, without any control of the facts. Numerous euthanasia [procedures] are performed by the members of the Commission themselves; they know that they can always protect each other. This impunity is frightening. (...)

This letter, despite its particularly clear warnings, was not followed by any political or judicial action, and was given very little attention in the public sphere.

In a documentary¹⁴³ broadcast by a Belgian public television channel in September 2020, Dr Robert Rubben, a former member of the Belgian Control Commission, expressed similar concerns:

The Commission never decides that something wrong was done. The Commission merely has to determine whether the rules were observed and whether there are no reasons to doubt. My fundamental dissatisfaction with this was that even in case of doubt, it was nevertheless always approved by the Commission. And secondly, and this is a statistical reality, that out of the first 10,000 evaluated cases, not one was referred for further investigation.

In that same documentary, Prof. Sigrid Sterckx, a Belgian professor of ethics and political philosophy, also highlighted that following the research she conducted for over fifteen years on the matter, one out of three euthanasia cases are never officially declared to the Control Commission in the Dutch-speaking part of Belgium.¹⁴⁴ Prof. Sterckx posited, 'Some physicians are very open about this. Have they ever been challenged by the judiciary? No'.

For instance, in a 2014 interview with a Belgian newspaper, Dr Marc Cosyns, a general practitioner, admitted he generally does not declare his cases, despite having a legal obligation to do so, because he considers euthanasia to be a 'normal medical procedure'.¹⁴⁵ Even though such statements constitute public confessions of unequivocal, deliberate

violations of the euthanasia law, they are not followed by any judicial action.

In the twenty years since the legalization of euthanasia in both Belgium and the Netherlands, there has not been a single case of a physician being found guilty of performing unlawful euthanasia.

C. Constant increase in numbers

The number of cases of euthanasia and assisted suicide have seen a consistent increase in Belgium and the Netherlands since its legalization. Given those official numbers only account for declared cases, it is likely that the real numbers are significantly higher than the official numbers. There is little reason to think a similar trend would not be observed in Canada in the forthcoming years.

Looking at those developments, it seems inevitable that the availability of legalized euthanasia stirs demand, and euthanasia and assisted suicide thus tend to become less 'exceptional' as time passes. The demand for euthanasia, originally limited to cases of extreme physical suffering, quickly expanded to non-extreme physical suffering, mental and psychological suffering, and even to cases of physically healthy people with symptoms of old age.

With such developments, it seems justifiable to ask whether the availability of on request euthanasia and suicide does eventually not turn into a duty not to be a burden on society, the family and the health care system in case of illness, suffering and ongoing medical care.

The amendments broadening euthanasia legislations, the ineffectiveness of safeguards and control mechanisms, as well as the constant increase in numbers illustrate that a slippery slope, leading to a broader acceptance of euthanasia and assisted suicide, can indeed be observed in every country that has pursued legalization. The slippery slope is therefore not just a hypothetical concern but a plainly demonstrable reality.

7) Refuting the Main Arguments for Legalizing Euthanasia

A. The right to 'Die with Dignity'

The compassionate argument for a 'good death' is one whereby supporters of euthanasia believe that respect for human dignity demands an end to the suffering of a particular person, even if this means the intentional ending of his or her life. It is argued that the option of choosing euthanasia is required to respect the 'dignity' of suffering people.

However, dignity is intrinsic to the human person not dependent on the person's circumstances. The 1948 Universal Declaration of Human Rights enshrined this principle in its preamble: 'recognition of the *inherent* dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world'.

The vulnerable are becoming victims of a 'euthanasia culture'. Legalizing euthanasia leads directly to the creation of a 'duty to die' when one's life becomes a burden on society. This is a form of direct harm to patients and a violation of their inherent dignity.

Furthermore, the availability of euthanasia is likely to lead to less, instead of more and better, training of doctors in pain management.¹⁴⁶ The goal of palliative care is to ease suffering and improve the patient's quality of life. While 98% of the pain can medically be controlled today, more than 65% of cancer patients still die in pain, because doctors lack the necessary training.¹⁴⁷

Studies show that patients who receive palliative care report improvement in pain, improved communication with patients' healthcare providers and family members, as well as improved emotional support, among other benefits.¹⁴⁸ To uphold the inherent dignity of each human life, we need to further invest into palliative care.

B. Respect for Individual Autonomy

In medical ethics and medical law, patient autonomy is a central concept. Patients generally have the right to refuse treatment even if this refusal leads to their death. It is therefore argued that people should also have the right to determine the moment of their death if they are in a situation which is unbearable, and without prospect of improvement.¹⁴⁹

This is troubling for a number of reasons. Firstly, the 'choice' of euthanasia is never autonomous. It always involves a counterpart—the doctor or nurse—who needs to assist or carry it out; the autonomy of the patient frequently clashes with the autonomy of the doctor who refuses to intentionally kill.

Secondly, there is a notable increase in euthanasia requests coming from patients who have been diagnosed with dementia.¹⁵⁰ Some of them were diagnosed with the illness but had not yet suffered fully from the symptoms. Nevertheless, an increasing number of such patients asked for their life to be ended out of fear of future suffering and loss of autonomy.¹⁵¹ It is questionable whether one can really speak of an autonomous choice when a person is in a situation of fear, vulnerability, and the onset of a serious mental health condition.

In a similar manner to suicide, the choice of euthanasia has deep implications on others around the person concerned including family, friends, and colleagues. According to the UK charity *Survivors of Bereavement by Suicide*,¹⁵² a suicide can even affect people who did not know the person who died.

Finally, the existence of consent does not necessarily mean that human dignity is thereby respected. For instance, although a trite example, in the French case of *Commune de Morsang-sur-Orge*, the Conseil d'Etat ruled that the 'sport' of 'dwarf throwing' was in breach of respect for human dignity and banned it, even though the persons of short stature involved consented.¹⁵³ In the name of humanity, a society needs to protect the vulnerable.¹⁵⁴

C. Euthanasia does not harm others

This argument says that euthanasia is a private, individual choice. It does not infringe the rights or freedoms of someone else, and therefore doesn't negatively impact on anyone else or society.

However, such an argument ignores the harm inflicted upon family members, friends, the medical staff, and society at large (as discussed above). The foundational societal value of respect for human life is damaged. In the words of American philosopher, Daniel Callahan: 'Euthanasia is an act that requires two people to make it possible and a complicit society to make it acceptable.'¹⁵⁵

D. Euthanasia is properly regulated

This public policy argument says that euthanasia can be safely regulated by government legislation. This is covered in more detail in sections 4 and 5, above.

Yet, looking at the developments in Belgium and the Netherlands, it is clear that the availability of legalized euthanasia stirs the demand. As discussed in sections 4 and 5, the examples of legalized euthanasia show that legal restrictions and safeguards do not prevent abuse.

In the words of Dutch ethicist Prof. Theo Boer, 'whereas assisted dying in the beginning was the odd exception, accepted by many — including myself — as a last resort... [P]ublic opinion has shifted dramatically toward considering assisted dying a patient's right and a physician's duty'.¹⁵⁶ He insists that not even the Dutch Review Committees, despite trying to keep euthanasia within the limits of the law, have been able to halt these developments. Once legalized, there is no logical stopping point to euthanasia.

E. Economic pressure

It is undeniable that there are huge economic implications at stake. A study by the Canadian Medical Association Journal from January 2017¹⁵⁷ shows that if euthanasia became more widely available, it would considerably unburden the public health care budget, potentially reducing the annual health care spending across Canada by between \$34.7 million and \$138.8 million, significantly exceeding the \$1.5–\$14.8 million in direct costs associated with its implementation.¹⁵⁸

Concerns over a link between economic pressure and the legalization of euthanasia is shared by disability groups. For example, the UK-based association 'Not Dead Yet' warns:

[d]isabled and terminally ill people fear that calls to legalize assisted suicide and euthanasia are likely to intensify. Our concerns are heightened by the current economic climate and calls from politicians from all parties for cuts in public services. We, and our families, rely upon such services to live with dignity.... We face a bleak situation as calls for assisted suicide to be lawful are renewed, whilst vital services are being withdrawn or denied.¹⁵⁹

8) Conclusion

Without exception, the experience of legalized euthanasia shows that a slippery slope is unavoidable. No matter how apparently strict the law is designed to be, it is bound to fail to protect the vulnerable members of society as well as medical practitioners and society at large. The abovementioned examples show the inherent dynamic of a growing demand for euthanasia, once legalized. Furthermore, laws and safeguards are regularly ignored and transgressed in all the jurisdictions where euthanasia has been legalized, and those transgressions are rarely prosecuted even when they come to light. The mere existence of such a law is an invitation to see assisted suicide and euthanasia treated as a normal part of healthcare. It is therefore essential to oppose any pressure for legalization of euthanasia based both on principled and pragmatic considerations.



ADF INTERNATIONAL

ADF International is a faith-based legal advocacy organization that protects fundamental freedoms and promotes the inherent dignity of all people. With headquarters in Vienna, and offices in Brussels, Geneva, Strasbourg, London, New York City, and Washington DC, we are at the forefront of defending religious freedom, the sanctity of life, and marriage and family worldwide.

Working on an international level, we have a full-time presence at all the institutions of strategic international importance. We are accredited by the UN Economic and Social Council (ECOSOC), the European Parliament and Commission, and the Organization of American States (OAS). Additionally, we enjoy participatory status with the EU's Agency for Fundamental Rights (FRA) and engage regularly with the Organization for Security and Co-operation in Europe (OSCE). On a national level, we work with local allies to provide training, funding, and legal advocacy.

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Notes

- 1 Merriam-Webster Dictionary, *verbo* 'Euthanasia', available on www.merriam-webster.com (accessed 9 January 2021).
- 2 With a view of briefly clarifying the most frequently encountered concepts in the field of the end-of-life, this section deliberately does not enter into nuances or controversies that could legitimately be expressed regarding the concepts and the related classifications or distinctions between them.
- 3 Unless otherwise mentioned, the definitions and considerations in the present section are either taken from or inspired by several sources, which can be consulted for a more comprehensive overview and more detailed insights in the terminology, i.a. University of Missouri – Center for Health and Ethics, *verbo* 'Euthanasia', available on <https://medicine.missouri.edu/centers-institutes-labs/health-ethics/faq> (accessed 9 January 2021) ; British Broadcasting Channel, 'Euthanasia and Physician assisted suicide', available on <http://www.bbc.co.uk/ethics/euthanasia> (accessed 9 January 2021) ; Debois, B., 'End-of-life: let's agree on semantics', *European Institute of Bioethics*, Teaching Card no. 12, 2016, available on www.ieb-eib.org (accessed 9 January 2021) ; Guerra, Y. M., 'Ley, Jurisprudencia y Eutanasia', *Revista Latinoamericana de Bioetica*, ed. July-December 2013, pp. 73-75, available on <https://www.redalyc.org/pdf/1270/127030498007.pdf> (accessed 9 January 2021) ; Montero, E., 'Repères éthiques pour accompagner la personne en fin de vie', *European Institute of Bioethics*, Dossier, 2010, available on www.ieb-eib.org (accessed 9 January 2021) ; Medical News Today, 'What are euthanasia and assisted suicide?', available on www.medicalnewstoday.com (accessed 9 January 2021) ; United Kingdom National Health Service, 'Euthanasia and assisted suicide', available on <https://www.nhs.uk/conditions/euthanasia-and-assisted-suicide> (accessed 9 January 2021).
- 4 Montero, E., *Rendez-vous avec la mort – Dix ans d'euthanasie légale en Belgique*, Anthemis, 2013, p. 13 (quote translated from French).
- 5 Merriam-Webster Dictionary, *verbo* 'Suicide', available on www.merriam-webster.com (accessed 9 January 2021).
- 6 On this topic, cf. in particular Dubus, C., 'La Sédation', *European Institute of Bioethics*, Teaching Card no. 13, 2019, available on www.ieb-eib.org (accessed 9 January 2021).
- 7 Montero, E., *Rendez-vous avec la mort – Dix ans d'euthanasie légale en Belgique*, Anthemis, 2013, p. 20-21 (quote translated from French).
- 8 Regarding the situation in Spain and Portugal, cf. *infra*, section D.
- 9 Dutch Act of 12 April 2001, *on the end-of-life on request and assisted suicide review*, available on <https://wetten.overheid.nl/BWBR0012410/2020-03-19> (accessed 21 December 2020).
- 10 Belgian Law of 28 May 2002, *on euthanasia*, available on <http://www.ejustice.just.fgov.be/eli/wet/2002/05/28/200200959d0/justel> (accessed 21 December 2020).
- 11 Luxembourg Act of 16 March 2009, *on euthanasia and assisted suicide*, available on <http://legilux.public.lu/eli/etat/leg/loi/2009/03/16/n2/jo> (accessed 21 December 2020).

- 12 On this particular question, cf. *infra*, section no. 5.
- 13 Italian Constitutional Court, 25 September 2019, available on <https://www.cortecostituzionale.it/actionSchedaPronuncia.do?anno=2019&numero=242> (accessed 21 December 2020).
- 14 British Broadcasting Channel, 'DJ Fabo ruling: Italy's top court backs assisted dying in extreme cases', 26 September 2019, available on <https://www.bbc.com/news/world-europe-49837610> (accessed 21 December 2020).
- 15 German Constitutional Court, 26 February 2020, available on https://www.bundesverfassungsgericht.de/SharedDocs/Entscheidungen/EN/2020/02/rs20200226_2bvr234715en.html;jsessionid=A9D657B025B92DF52822A7C72EA8B2A8.1_cid386 (accessed 21 December 2020) with official press release, available on <https://www.bundesverfassungsgericht.de/SharedDocs/Pressemitteilungen/EN/2020/bvg20-012.html> (accessed 21 December 2020).
- 16 Austrian Constitutional Court, 11 December 2020, available on <https://www.ris.bka.gv.at/Judikatur/> (accessed 19 January 2021).
- 17 Austrian Criminal Code, section 78, available on <https://www.ris.bka.gv.at/GeltendeFassung.wxe?Abfrage=Bundesnormen&Gesetzesnummer=10002296> (accessed 21 December 2020).
- 18 Swiss Criminal Code, article 115, available on <https://www.admin.ch/opc/fr/classified-compilation/19370083/index.html> (accessed 21 December 2020).
- 19 Swiss Academy of Arts and Sciences, *Management of Dying and Death*, pp. 22-24, available on https://www.samw.ch/dam/jcr:25f44f69-a679-45a0-9b34-5926b848924c/guidelines_sams_dying_and_death.pdf (accessed 21 December 2020).
- 20 Invoking a lack of clarity of the new guidelines, the Association of Helvetic Physicians however refused to adapt its own deontological guidelines. Cf. Swiss Info, 'La Fédération des médecins refuse d'adapter les directives', 26 October 2018, available on https://www.swissinfo.ch/fre/aide-au-suicide_la-f%C3%A9d%C3%A9ration-des-m%C3%A9decins-refuse-d'adapter-les-directives/44499986 (accessed 21 December 2020).
- 21 Swiss Academy of Arts and Sciences, op. cit., p. 25.
- 22 For a more detailed analysis of the situation of the United States, cf. World Youth Alliance, 'Assisted Suicide & Euthanasia – White Paper', 2019, pp. 48-65, available on <https://www.wya.net/press-release/wya-releases-new-white-paper-on-assisted-suicide-and-euthanasia/> (accessed 21 December 2020).
- 23 United States Supreme Court Decision, *Washington v. Glucksberg*, 26 June 1997, available on <https://www.supremecourt.gov/opinions/boundvolumes/521bv.pdf> (accessed 21 December 2020).
- 24 Colombian Act of 20 April 2015, *to render effective the right to die in dignity*, available on https://www.minsalud.gov.co/Normatividad_Nuevo/Resoluci%C3%B3n%201216%20de%202015.pdf (accessed 21 December 2020).
- 25 Colombian Constitutional Court, 2 October 1997, available on <https://www.corteconstitucional.gov.co/relatoria/1997/c-239-97.htm> (accessed 21 December 2020).
- 26 Canadian Supreme Court, *Carter v. Canada*, 6 February 2015, available on <https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/14637/index.do> (accessed 21 December 2020).
- 27 Canadian Act of 17 June 2016, *on medical assistance in dying*, available on <https://>

- laws-lois.justice.gc.ca/PDF/2016_3.pdf (accessed 21 December 2020).
- 28 Victoria State Act of 29 November 2017, *on voluntary assisted dying*, https://content.legislation.vic.gov.au/sites/default/files/68b6d184-e46e-38fb-b098-16b6e9768698_17-61aa001%20authorised.pdf (accessed 21 December 2020).
 - 29 New Zealand Act of 16 November 2019, *on the end-of-life choice*, available on <https://www.legislation.govt.nz/act/public/2019/0067/latest/DLM7285905.html> (accessed 21 December 2020).
 - 30 The referendum was held on 17 October 2020. The End-of-life Choice Act will enter into force on 7 November 2021, according to the official governmental website <https://www.health.govt.nz/our-work/regulation-health-and-disability-system/end-life-choice-act> (accessed 21 December 2020).
 - 31 French Act of 2 February 2016, *creating new rights in favor of ill persons and persons at the end of their life*, available on <https://www.legifrance.gouv.fr/jorf/id/JORFTEXT000031970253/> (accessed 21 December 2020).
 - 32 French Law Proposal of 17 October 2017 (Assemblée Nationale), *on the right to a free and chosen end-of-life*, available on https://www.assemblee-nationale.fr/dyn/15/textes/115b0288_proposition-loi (accessed 14 July 2021).
 - 33 French Law proposal of 17 November 2020 (Sénat), *aimed at creating the right to die in dignity*, available on <http://www.senat.fr/dossier-legislatif/ppl20-131.html> (accessed 21 December 2020).
 - 34 The Portugal News, 'Euthanasia law approved', 30 January 2021, available on <https://www.theportugalnews.com/news/2021-01-30/euthanasia-law-approved/58003> (accessed 14 July 2021).
 - 35 The Portugal News, 'Euthanasia: A door closes but a window opens', 19 March 2021, available on <https://www.theportugalnews.com/news/2021-03-19/euthanasia-a-door-closes-but-a-window-opens/58835> (accessed 14 July 2021).
 - 36 Spanish Law of 18 March 2021, *regulating euthanasia*, available on https://www.congreso.es/public_oficiales/L14/CONG/BOCG/B/BOCG-14-B-46-8.PDF (accessed 15 July 2021).
 - 37 Grupo Parlamentario Vox, Official website, 'Abascal presenta el recurso de inconstitucionalidad de VOX a la ley de eutanasia', available on https://www.voxespana.es/grupo_parlamentario/notas-de-prensa-grupo-parlamentario/recurso-inconstitucionalidad-vox-ley-eutanasia-texto-integro-20210616 (accessed 15 July 2021).
 - 38 Irish law proposal of 15 September 2020 (Irish National Assembly), *'to make provision for assistance in achieving a dignified and peaceful end of life to qualifying persons and related matter'*, available on www.oireachtas.ie/en/bills/bill/2020/24/ (accessed 28 January 2021).
 - 39 United Kingdom National Health Service, *Euthanasia and assisted suicide*, available on <https://www.nhs.uk/conditions/euthanasia-and-assisted-suicide> (accessed 9 January 2021).
 - 40 Sky News, 'Assisted dying could be legalized in the UK within four years, leading MP predicts', 24 August 2020, available on <https://news.sky.com/story/assisted-dying-could-be-legalised-in-the-uk-within-four-years-leading-mp-predicts-12055523> (accessed 9 January 2021).
 - 41 United Kingdom Law proposal of 26 May 2021 (House of Lords), *'to enable adults who are terminally ill to be provided at their request with specified assistance to end their own life ; and for connected purposes'*, available on <https://bills.parliament.uk/bills/2875> (accessed 15 July 2021).

- 42 The ICCPR was adopted by the United Nations General Assembly on 16 December 1966 and entered into force on 23 March 1976.
- 43 The CRC was adopted by the United Nations General Assembly on 20 November 1989 and entered into force on 2 September 1990.
- 44 The CRPD was adopted by the United Nations General Assembly on 13 December 2006 and entered into force on 3 May 2008.
- 45 Ninety-sixth session (CCPR/C/NLD/CO/42), 5 August 2009, at § 7.
- 46 Article 5 (2) TEU.
- 47 Article 168 (7) TFEU.
- 48 Recommendation 1418 (1999) § 9.
- 49 Resolution 1859 (2012) § 5.
- 50 WMA Declaration on Euthanasia, adopted by the 39th World Medical Assembly, Madrid, Spain, October 1987 and reaffirmed by the 170th WMA Council Session, Divonne-les-Bains, France, May 2005, and the 200th WMA Council Session, Oslo, Norway, April 2015.
- 51 WMA Statement on Physician-Assisted Suicide, adopted by the 44th World Medical Assembly, Marbella, Spain, September 1992 and editorially revised by the 170th WMA Council Session, Divonne-les-Bains, France, May 2005.
- 52 WMA Resolution on Euthanasia, reaffirmed with minor revision by the 194th WMA Council Session, Bali, Indonesia, April 2013.
- 53 WMA Declaration on Euthanasia and Physician-Assisted suicide, adopted by the 70th World Medical Assembly, Tblisi, Georgia, October 2019.
- 54 *Pretty v. the United Kingdom*, no. 2346/02, ECHR 2002 III.
- 55 Section 2(1) of the Suicide Act 1961.
- 56 *Pretty v. United Kingdom* (2002) 35 E.H.R.R. 1 §§ 39-40.
- 57 *Ibid.*, § 54.
- 58 *Ibid.*, § 67
- 59 *Ibid.*
- 60 *Haas v. Switzerland*, no. 31322/07, 20 January 2011, ECHR 2011.
- 61 *Ibid.*, § 51.
- 62 *Ibid.*, § 56.
- 63 *Lambert and Others v. France*, [GC] no. 46043/14, 5 June 2015.
- 64 French Conseil d'Etat Ruling, *Mme. Lambert*, June 24th, 2014.
- 65 *Mortier v. Belgium*, no. 78017/17.
- 66 For an overview of some other issues relating to this case and, more broadly, euthanasia in Belgium, cf. Clarke, R., '7 ways Belgium didn't even follow its own euthanasia law', Mercatornet, available on <https://mercatornet.com/7-ways-belgium-didnt-even-follow-its-own-euthanasia-law/67112/> (accessed 11 June 2021).
- 67 Belgian Law of 28 May 2002, *on euthanasia*, available on <http://www.ejustice.just.fgov.be/eli/wet/2002/05/28/200200959d0/justel> (accessed 21 December 2020).
- 68 Belgian Law on euthanasia, art. 2.
- 69 Belgian Law on euthanasia, art 3 (1).
- 70 Belgian Law on euthanasia, art 3.
- 71 Belgian Law on euthanasia, art. 5.
- 72 Belgian Law on euthanasia, art. 8.
- 73 With respect to this, for a particularly relevant analysis of the Belgian situation as from the legalization up to the year 2013, cf. Montero, E., *Rendez-vous avec la mort – Dix ans d'euthanasie légale en Belgique*, Anthemis, 2013.
- 74 Control Commission, *First report* (2004), p. 16, available on <https://>

- organesdeconcertation.sante.belgique.be/fr/organe-d%27avis-et-de-concertation/commission-federale-de-controle-et-devaluation-de-leuthanasie (accessed 5 January 2021).
- 75 Belgian Criminal Code, art. 397, available on http://www.ejustice.just.fgov.be/cgi_loi/change_lg_2.pl?language=fr&nm=1867060850&la=F (accessed 6 January 2021).
- 76 Ghent Assize Court, 31 January 2020, available on https://www.standaard.be/cnt/dmf20200131_04829478 (accessed 8 January 2021).
- 77 The Prosecutor of Leuven (Belgium) recently announced the investigation of several cases of alleged unlawful euthanasia (no further information being provided). Cf. De Standaard, 'Gerecht onderzoekt tiental euthanasie-cases', 21 November 2020, available on https://www.standaard.be/cnt/dmf20201120_98096902 (accessed 7 January 2021).
- 78 About the Control Commission, cf. also *infra*, section no. 5.
- 79 Quotes literally taken from Dr Distelmans'interview, in his capacity as president of the Control Commission, on the Belgian prime-time magazine 'De Afspraak' on 26 April 2019, hosted by the Official Public Belgian channel Vlaamse Radio- en Televisie (VRT), available on <https://www.vrt.be/vrtnws/nl/2019/04/26/arts-buiten-vervolging-gesteld-in-euthanasiedossier/> (accessed 4 January 2021 – quotes translated from Dutch).
- 80 *Ibid.*, emphasis added.
- 81 Belgian Law on euthanasia, art. 3 (4).
- 82 Control Commission, *First report* (2004), p. 16. Example drawn from Montero E., *op. cit.*, p. 47.
- 83 Cf. Montero E., *op. cit.*, p. 81, with references (2002-2012 period). Most recently, cf. Control Commission, *Ninth report* (2020), p. 25, as well as in particular pp. 29-30.
- 84 Mason B., Weitenberg C., 'Allow me to Die', SBS News Documentary, 24 November 2015, available on www.sbs.com.au/news/dateline/tvepisode/allow-me-to-die (accessed 22 January 2021).
- 85 Cf. Dr Distelmans'interview, in his capacity as president of the Control Commission, on the Belgian prime-time magazine 'De Afspraak' on 26 April 2019, hosted by the Official Public Belgian channel Vlaamse Radio- en Televisie (VRT), available on <https://www.vrt.be/vrtnws/nl/2019/04/26/arts-buiten-vervolging-gesteld-in-euthanasiedossier/> (accessed 4 January 2021).
- 86 De Morgen, 'Arts niet vervolgd wegens toedienen gifbeker: Geen illegale euthanasie, maar hulp bij zelfdoding', 26 April 2019, available on www.demorgen.be (accessed 15 January 2021) ; De Standaard, 'Arts niet vervolgd voor hulp bij zelfdoding', 26 April 2019, available on www.standaard.be (accessed 15 January 2019) ; Control Commission, *Ninth report* (2020), pp. 29-30.
- 87 Belgian Law on euthanasia, art. 9.
- 88 The reports of the Control Commission, some of which have been cited *supra*, can be consulted on its official website (<https://overlegorganen.gezondheid.belgie.be/nl/advies-en-overlegorgaan/commissies/federale-controle-en-evaluatiecommissie-euthanasie>). The number of euthanasia cases mentioned in this section are to be found in or deduced from the respective reports issued by the Control Commission.
- 89 Cf. also *infra*, section 6, b.
- 90 Control Commission, *Ninth report* (2020), p. 20.
- 91 *Ibid.*, p. 36. Emphasis added.
- 92 Control Commission, 'Euthanasia – Numbers of 2020', Press release, 2 March 2021, available on <https://overlegorganen.gezondheid.belgie.be/sites/default/files/>

- [documents/fcee-cijfers-2020_persbericht.pdf](#) (accessed 15 July 2021).
- 93 VRTNWS (Official Public Belgian channel Vlaamse Radio- en Televisie), '2.444 mensen kregen vorig jaar euthanasie, een opvallende daling: Door het euthanasieproces en de lockdown', 2 March 2021, available on <https://www.vrt.be/vrtnws/nl/2021/03/02/euthanasiecijfers-2020/> (accessed 15 July 2021 – quotes translated from Dutch ; emphasis added).
- 94 Cf. *supra*, section 4.A.(ii).
- 95 Belgian Law of 28 February 2014, *amending the Law of 28 May 2002 on euthanasia in order to extend it to minors*, available on http://www.ejustice.just.fgov.be/cgi_loi/change_lg.pl?language=fr&la=F&table_name=loi&cn=2014022803 (accessed 4 January 2021).
- 96 On this topic, cf. Van De Walle, J.P., 'Euthanasia of Minors in Belgium', *European Institute of Bioethics*, Dossier, 2015, available on www.ieb-eib.org (accessed 4 January 2021).
- 97 Belgian Law of 15 March 2020, *amending the law on euthanasia*, available on http://www.ejustice.just.fgov.be/cgi_loi/change_lg.pl?language=fr&la=F&table_name=loi&cn=2020031502 (accessed 4 January 2021). The constitutionality of the 2020 amendments is currently being challenged before the Belgian Constitutional Court, which will also have to assess their compatibility with fundamental human rights.
- 98 Belgian Law on euthanasia, art. 4.
- 99 Belgian Law on euthanasia, art. 14.
- 100 Belgian Law on euthanasia, art. 14. Cf. also the Preparatory Works to this amendment, no. 55K0523/012, available on www.dekamer.be/FLWB/PDF/55/0523/55K0523012.pdf (accessed 22 January 2021).
- 101 In practice, according to the preparatory works, only two associations are currently considered being 'specialized' in the 'right to euthanasia': 'LEIF' (www.leif.be – Life End Information Forum) and 'ADMD' (www.admd.be – Right to die with dignity society). Both associations are known for actively lobbying in favor of facilitating the application and further extension of the current euthanasia law. For instance, amongst other things, ADMD actively advocates for the recognition of a 'right to assisted suicide' in case of 'completed life'. LEIF in turn recently initiated a petition with a view of legalizing euthanasia of persons suffering from dementia.
- 102 Act of 12 April 2001, *on the Termination of Life on Request and Assisted Suicide (Review Procedures)*, <https://wetten.overheid.nl/BWBR0012410/2020-03-19> (accessed 21 December 2020).
- 103 Dutch Criminal Code, articles 293 and 294, https://wetten.overheid.nl/BWBR0001854/2020-07-25/#BoekTweede_TiteldeelXI_Artikel294 (accessed 8 January 2021).
- 104 Dutch Act on the Termination of Life on Request and Assisted Suicide (Review Procedures), article 2 (1).
- 105 *Ibid.*, article 2 (2), (3) and (4).
- 106 *Ibid.*, article 8.
- 107 Those reports can be consulted on the website of the Dutch Euthanasia Commission (<https://www.euthanasiecommissie.nl/de-toetsingscommissies/jaarverslagen>). The number of euthanasia cases mentioned in this section are to be found in or deduced from the respective yearly reports issued by this Commission.
- 108 Dutch Euthanasia Commission, *2019 report*, p. 12.
- 109 Expertisecentrum Euthanasie, News release, 3 September 2019, available on <https://expertisecentrum euthanasie.nl/actueel/> (accessed 8 January 2021). Cf. also *infra*,

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