Medically-Assisted or Induced Death Around the World: An Overview of Law, Policy, Ethics, and Practices

Scott Kim, MD, PhD

Department of Bioethics

Clinical Center | National Institutes of Health

scottkimbioethics.org

Please note

- The views, information or content, and conclusions presented do not necessarily represent the official position or policy of, nor should any official endorsement be inferred on the part of, the Clinical Center, the National Institutes of Health, or the Department of Health and Human Services.

Many terms!

- Physician-assisted suicide (PAS)
- Euthanasia
- Medical aid in Dying (MAID)
- Physician-aid in Dying or Physician assisted death (PAD)
- Death with Dignity (DWD)
- End of Life Option (EOLO)
- The list goes on…
- Some quick thoughts on the battle over terminology: https://scottkimblog.wordpress.com/2016/01/29/battles-of-terminology-in-bioethics/

For the purposes of this talk

- Will use various terms, but mostly…

- 'EAS' = "euthanasia **and/or** physician assisted suicide"
  - Legal term in places where most cases take place; also widely used in research literature
  - Covers **both** euthanasia **and/or** assisted suicide
  - Covers nurses, doctors, and lay volunteers

Goal of this talk

- To give you a **big picture perspective and the overall 'structure'** of the assisted dying debate.

- To complicate the way we usually think about it, for both sides of the debate.

- To make the discussion of EAS less polarized, more evidence based, and policy-oriented.

Outline

- Intro to relationship between ethics/morality and law
- Brief overview of EAS laws and practices around the world
- Exposition and analysis of 3 main types of EAS laws—with focus on how these relate to one another

WAYS OF DEBATING EAS: ETHICS AND LAW

Breakout discussion question 1

"If it can be shown that in some situations EAS is ethically/morally acceptable, then it should be legally allowed."

Agree or disagree?

Why or why not?

Morality, legality, and rights

- Many assume that somehow answering the ethics question by itself determines the legal question.

- Although (obviously) EAS raises profound ethical questions, legalization is still a separate and distinct question that goes beyond the ethics question.

Consider (for example) one key ethical question

- Is the value of human life…
  - inherent to the concept of a human being; regardless of age, gender, SES, race, ethnicity… intrinsically and equally valuable.
  - conditioned upon how well it goes?
  - Both? Then what to do when they conflict?

- This talk assumes:
  - People have different views about such questions
  - Decision about EAS law probably won't result from eventual unanimity

- **Q: How do you resolve the legal question in a pluralistic democracy when ethical views differ?**

OVERVIEW OF EAS REGIMES

Regimes that permit EAS

- All EAS laws require some kind of informed consent (competent, informed, voluntary, etc.)*

- I will focus on what *differentiates* the various regimes

*The Netherlands allows by law or prosecutorial agreement certain practices (e.g., neonates; advance requests; etc). Also, well documented extra-legal practices exist in some other countries (like Belgium)

WORLD HAPPINESS INDEX

		Score	GDP per capita	Social support	Healthy life expectancy	Freedom to make life choices	Generosity	Perceptions of corruption
1	Finland	7.632	1.305	1.592	0.874	0.681	0.192	0.393
2	Norway	7.594	1.456	1.582	0.861	0.686	0.286	0.340
3	Denmark	7.555	1.351	1.590	0.868	0.683	0.284	0.408
4	Iceland	7.495	1.343	1.644	0.914	0.677	0.353	0.138
5	Switzerland	7.487	1.420	1.549	0.927	0.660	0.256	0.357
6	Netherlands	7.441	1.361	1.488	0.878	0.638	0.333	0.295
7	Canada	7.328	1.330	1.532	0.896	0.653	0.321	0.291
8	New Zealand	7.324	1.268	1.601	0.876	0.669	0.365	0.389
9	Sweden	7.314	1.355	1.501	0.913	0.659	0.285	0.383
10	Australia	7.272	1.340	1.573	0.910	0.647	0.361	0.302
11	Israel	7.190	1.244	1.433	0.888	0.464	0.262	0.082
12	Austria	7.139	1.341	1.504	0.891	0.617	0.242	0.224
13	Costa Rica	7.072	1.010	1.459	0.817	0.632	0.143	0.101
14	Ireland	6.977	1.448	1.583	0.876	0.614	0.307	0.306
15	Germany	6.965	1.340	1.474	0.861	0.586	0.273	0.280
16	Belgium	6.927	1.324	1.483	0.894	0.583	0.188	0.240
17	Luxembourg	6.910	1.576	1.520	0.896	0.632	0.196	0.321
18	United States	6.886	1.398	1.471	0.819	0.547	0.291	0.133
19	United Kingdom	6.814	1.301	1.559	0.883	0.533	0.354	0.272
20	United Arab Emirates	6.774	2.096	0.776	0.670	0.284	0.186	*N/A*
21	Czech Republic	6.711	1.233	1.489	0.854	0.543	0.064	0.034

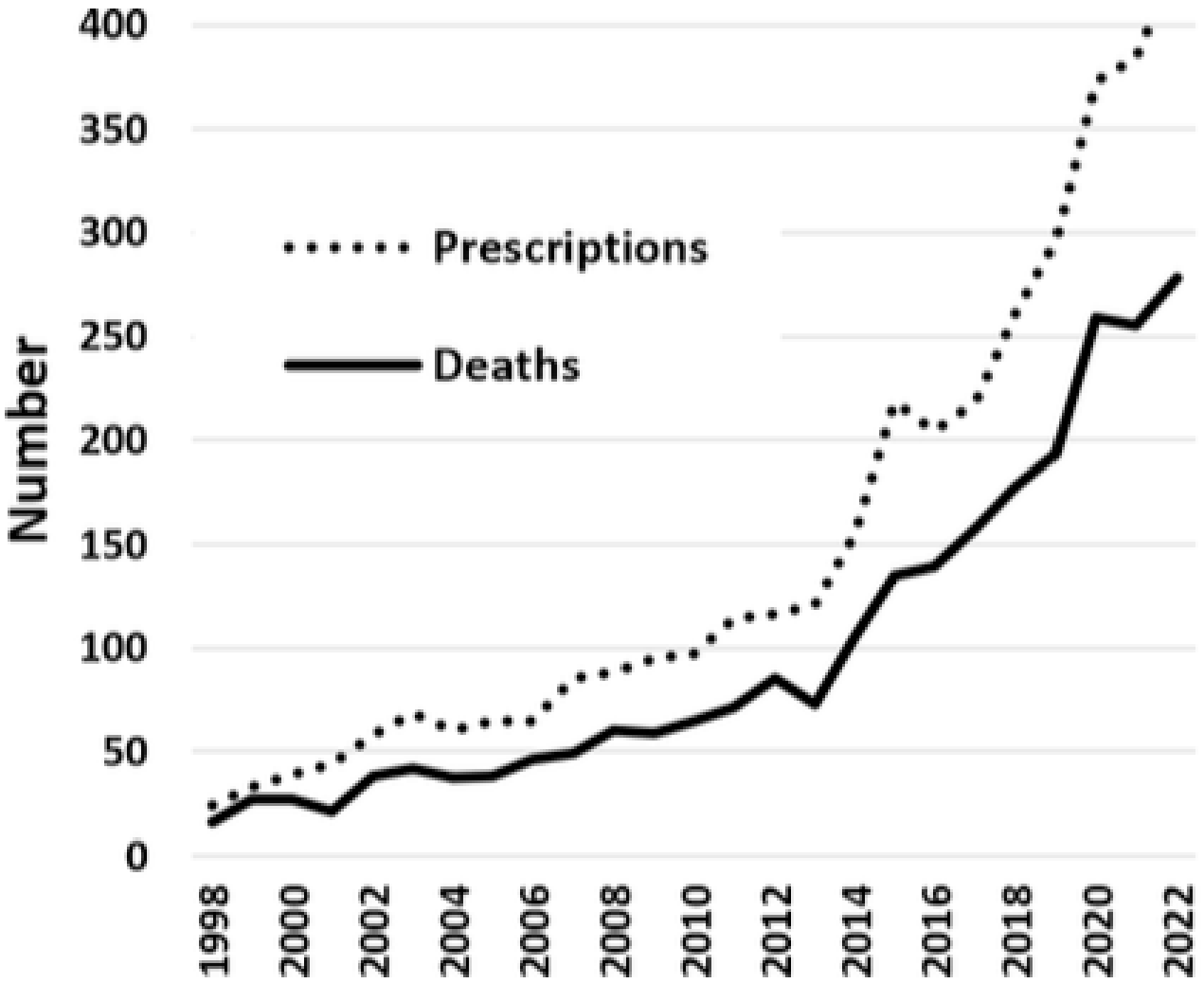
US States with annual EAS reports

(9 of 11 states; source: DWD 2022)

	CA	CO	HI	ME	NJ	OR	VT	WA	DC
Since…	2016	2017	2018	2019	2019	1998	2013	2009	2017
# years legal	6	5	4	3	3	24	6	12	2
Total Rx#	3287	774	145	118	95	3259	115	2286	4
Total Deaths	2148	--	71	77	--	2109	74	1687	2

OREGON

- 0.46% of all deaths in OR
- 90% in hospice
- Most 65 years or older (79.2%), and most hac cancer (62.5%)
- 97% white [cf 85%], 1.2% Asian [cf 4.1%],
- 55% with post-HS degree



Regnard et al 2023

Top reasons for request in Oregon

(As reported by doctors)

- “Loss of autonomy” (91.7%)
- “Decreasing ability to participate in activities that made life enjoyable” (90.5%)
- “Loss of dignity” (66.7%)

These have been stable over the years, across jurisdictions also.

- However, being concerned about being a burden/finances, etc… has steadily increased as a reason.(Regnard 2023)

California End of Life Option Act, 2023 data
N=884 deaths (1281 rxs given)

- 93% over 60 y.o.
- Race and ethnicity:
  - 85.4% white [cf 35% of population]
  - 7.1% Asian [cf 15%]
  - 4.9% Hispanic [cf 39%]
  - 0.9% black [cf 5%]
- 77% with some college or beyond
- 49.9% female

Canadian MAID data 2019-2023

Year	Total MAID Cases	% Increase from Previous Year	% of All Deaths	Mean Age (Years)	Standard Dev	Track 1, EOL	Track 2, Not EOL	% by Nurses (NPs)	% Found Ineligible
2019	5,631	—	2.0%	75.2	11.8	100% (5,631)	0% (0)	7.8% (439)	2.2%
2020	7,595	**+34.9%**	2.5%	75.3	11.7	100% (7,595)	0% (0)	8.9% (676)	3.1%
2021	10,064	**+32.5%**	3.3%	76.3	11.6	99.5% (10,014)	0.5% (50)	10.2% (1,027)	2.7%
2022	13,241	**+31.6%**	4.1%	76.8	11.4	97.9% (12,964)	2.1% (277)	10.9% (1,442)	3.0%
2023	15,343	**+15.9%**	4.7%	77.6	11.2	97.5% (14,964)	2.5% (379)	11.3% (1,735)	2.8%

The Netherlands 2011-2023

Year	Total Cases	% Increase	% of All Deaths
2011	3,695	-	-
2012	4,188	+13.3%	-
2013	4,829	+15.3%	-
2014	5,306	+9.9%	-
2015	5,516	+4.0%	-
2016	6,091	+10.4%	4.1%
2017	6,585	+8.1%	4.4%
2018	6,126	-7.0%	4.3%
2019	6,361	+3.8%	4.2%
2020	6,938	+9.1%	4.5%
2021	7,666	+10.5%	4.9%
2022	8,720	+13.8%	5.1%
2023	9,050	+3.8%	5.3%

Varieties of Boundaries for EAS regimes

1. **'End of life'—i.e., some type of proximity to death criterion**
   - Terminal illness (e.g., death expected within 6 months)
   - 'End of life'
   - Reasonably foreseeable natural death

2. **'Irremediable medically based suffering'**
   - 'medical dimension' to the suffering required--two types (NL vs Canada)

Other boundaries?

3. Tired of living or 'completed life'.

- Rejected by Schnabel commission in the Netherlands in 2016 (bc current law deemed sufficient to cover such cases) but still active political issue
- I won't say anymore about this as it is not adopted anywhere…

4. Autonomy as the only justification (and eligibility condition)

- Germany as of 2020; ?Estonia as of May 7, 2025; Switzerland

Variations within each type…

- Combination of EOL and suffering boundaries [NZ/AUS]
- Euthanasia allowed only if PAS not possible (e.g., Portugal, some NZ/AUS states)
- EOL definition: 6mo to 12mo, or ‘reasonably foreseeable death’ [wide range of interpretation]
- Whether the state ensures it is last resort (e.g., palliative care guaranteed if pt wants it) or not. Cf Portuguese law vs Dutch vs Canada

Country/jurisdiction	Euthanasia or Assisted Suicide	End of Life Requirement?	Suffering Requirement
US (OR, WA, CA, NJ, HI, CO, VT, DC, ME, NM, and MT)	AS	Yes	No
Canada	E and AS	No (as of 2021)	Yes
Colombia	E and AS (2022)	No (as of 2021)	Yes
The Netherlands	E and AS	No	Yes
Belgium	E (AS de facto)	No	Yes
Luxembourg	E and AS	No	Yes
Australia (WA, Vic, NSW, QL, Tasmania, SA)*	E and AS	Yes	Yes
Spain*	E and AS	No	Yes
New Zealand*	E and AS	Yes	Yes
Switzerland	AS	No	No
Germany*	AS	No	No
Austria*	AS	No	Yes, if non-terminal
Italy	AS	Requiring LST	Yes
Portugal	E and AS	No	Yes

Many types of assisted dying laws

	Prohibition	EOL	EOL + Medical Suffering	Medical Suffering-A	Medical Suffering-B	Autonomy is sufficient
Example jurisdictions	Most jurisdictions	US states	NZ and Australian states	Belgium, the NL	Canada	Germany, Estonia, ?Switzerland?
Psychiatric EAS?	NA	No	No	Yes	Yes/No*	Yes
Permitted **only** within medical/healthcare	NA	Yes	Yes	Yes	Yes	No
Type of legal justification	NA	Policy	Policy	Policy	Human right?	Basic right (Germany)
Who defines irremediability of medical suffering	NA	NA	EOL-doctor MS-Patient	Doctor with Patient	Patient	NA

EOL=end of life; AS=assistance (assisted suicide) in taking life; E = euthanasia or induced death; in Medical Suffering-A AD is last resort per ordinary medical practice; in Medical Suffering-B last resort is defined solely by requestor.

Breakout discussion question 2

Which of the following reasons seem strongest, as a basis for legal EAS:

- EOL: as an option for the already dying.
- Suffering, regardless of whether at EOL
- Autonomy only: need only a competent request, regardless of motivation.

NB: discussing this question doesn't imply you are endorsing any of these!

Summary of various regimes

- EAS is not one thing, but many.
- It's not just about EOL decisions, as most of the public assume.
- Even within types, there are variations.

- QUESTION: What are we to make of these variations?

Proximity to death as a boundary

Proximity to death boundary

- **Historical source**: EAS as part of end of life decision-making discussion
- General public's default understanding of EAS? [NB: even in jurisdictions that do not use this boundary, overwhelming majority of cases are EOL]
- Aim of controlling the manner of one's inevitable demise; a kind of time-circumscribed autonomy right.
- Implies medical context since it is about end-of-life medical decisions (but is it a medical treatment?)
- Notice no appeal to relief of suffering (e.g., US state laws do not mention)

Proximity to death boundary: questions

- How to define it and enforce that definition?
  - Why 6 mo, 12 mo? What does ‘reasonably foreseeable death’ mean?
  - If I have IDDM but either refuse insulin or cannot afford it, am I terminally ill? (Oregon and Canada appear to think so…)
- Also, is suffering an unstated justification?
- All this leads to the question: Not clear why the principles underlying it (autonomy, w/ or w/o suffering) should apply to only a certain segment of one’s life.

Terminal illness requirement as 'foot in the door'

"[Gardner] sees it as a first step. If he can sway Washington to embrace a restrictive law, then other states will follow. And gradually, he says, the nation's resistance will subside, the culture will shift and laws with more latitude will be passed…"

--Booth Gardner, former two term governor of Washington, reported by Borgner in **NYT Magazine**, Dec 2, 2007.

October 7, 2015

"**These restrictions might be necessary at this point in the history of aid in dying in this country**, according to Judith Schwarz of the advocacy group End of Life Choices New York.

Schwarz said that maybe, very far in the future, there might be some way to cover dementia…

A death with dignity bill [in Utah] tried to broaden the safeguards to include people with a wider range of illnesses."

The American Journal of Bioethics, 19(10): 29–39, 2019

ISSN: 1526-5161 print / 1536-0075 online
DOI: 10.1080/15265161.2019.1653397

Target Article

Check for updates

Physician Aid-in-Dying and Suicide Prevention in Psychiatry: A Moral Crisis?

Brent M. Kious, University of Utah
Margaret (Peggy) Battin, University of Utah

Involuntary psychiatric commitment for suicide prevention and physician aid-in-dying (PAD) in terminal illness combine to create a moral dilemma. If PAD in terminal illness is permissible, it should also be permissible for some who suffer from nonterminal psychiatric illness: suffering provides much of the justification for PAD, and the suffering in mental illness can be as severe as in physical illness. But involuntary psychiatric commitment to prevent suicide suggests that the suffering of persons with mental illness does not justify ending their own lives, ruling out PAD. Since both practices have compelling underlying justifications, the most reasonable accommodation might seem to be to allow PAD for persons with mental illness whose suffering is severe enough to justify self-killing, but prohibit PAD for persons whose suffering is less severe. This compromise, however, would require the articulation of standards by which persons' mental as well as physical suffering could be evaluated. Doing so would present a serious philosophical challenge.

"…the most reasonable accommodation might seem to be to allow PAD for persons with mental illness whose suffering is severe enough…"

Example: Canadian rejection of proximity to death boundary

- Bill C-14, June 2016
  - ‘reasonably foreseeable death’ criterion
- Truchon v Canada, Quebec Superior Ct, September 2019
  - Struck down the reasonably foreseeable death criterion
  - Bill C-14 was based on suffering as basis; court ruled non-dying suffer too.
- Bill C-7, track 1 for reasonably foreseeable death; track 2 for not.

Suffering as the boundary?

‘Irremediable suffering’ as basis for EAS?

- **Historical source**: Dutch EAS norms arose out of necessity defense--–i.e., in situation of conflicting duties of **physicians** (relief of suffering vs respect for life), exception to criminal law.

- Thus, suffering as a criterion is actually based on medical professional boundary concerns. Makes EAS a practice question for doctors.

- This set the trend (outside US at any rate): suffering is very much at center of eligibility criteria for many jurisdictions

The appeal to compassion is potent

Consider the following case:

> Person P has suffering due to condition D:
> --severe and excruciating pain that is constant
> --untreatable
> --will never get better

- Very few people in my experience say EAS would be ethically wrong in such a case.
- Note that “irremediable, unbearable suffering” captures above…

Question 1: Is 'irremediable, unbearable suffering' clear enough for policy and practice?

- What suffering is severe enough? By whose standards? Is it purely subjective?
- What type or source of suffering?
  - i.e., somatic, psychological, social, spiritual, existential…
  - How about: Loss of sense of control, loss of sense of dignity, fear of future suffering, or even fear of an undesired future state, or sense that life is not worth living?
- How certain must the prognosis be? How accurate must predictions for individual cases be?
- What does 'untreatable' mean? No cure? What if a rx helps people cope better?
- What if the person **declines** effective treatments, **or cannot afford them?**

Question 2: How to factor in impact on others in similar situations?

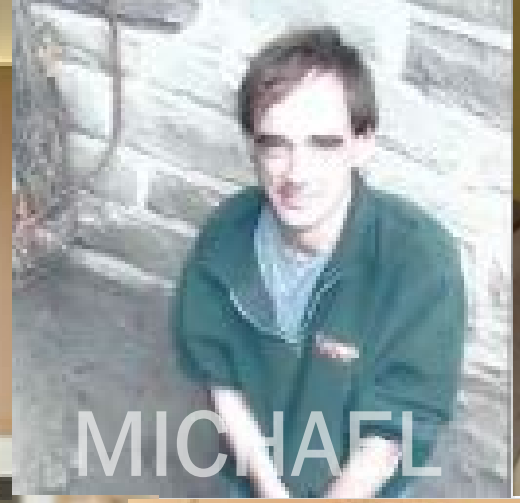
- Imagine a man P with D who wants EAS legalized; such a person is asking society to agree that his life is no longer worth living, and that a life *like* his is not worth living.

- Impact on others with similar suffering but who may not see his or her life as not worth living:
  - Suppose EAS for chronic depression becomes an accepted practice in a clinic. If a patient struggles with chronic depression, but wants to live, now feels he has to justify that decision.
  - Imagine a person with D who would rather live, but finances make it difficult to get basic resources to help with D.

Archie Rolland	**52M**	**2016**
Arleen Reinsborough	75F	2019
Sean Tagert	**41M**	**2019**
Anonymous (Madeline)	54F	2020
Chris Gladders	**35M**	**2021**
Rosina Kamis	**41F**	**2021**
Anonymous (Sophia)	**51F**	**2022**
Richard Ewald	M	2022
Alexis Wilson	42F	2022
Anonymous (Denise)	31F	2022
Rosie Ashcraft	37F	2022
Jennyfer Hatch	**37F**	**2022**
Anonymous (Gwen)	F	2022
Les Landry	65M	2022
Sathya Dhara Kovac	**44F**	**2022**
Joannie Cowie	52F	2022
Amir Farsoud	55M	2022
Michael Fraser	**55M**	**2022**
Jolene Van Alstine	F	2022
Jacquie Holyoak	59F	2022
Michal Kaliszan	39M	2023
Mary Sinclair	86F	2023
Rose Finlay	33F	2023
Andrew Robbins	51M	2023
Dav Langstroth	**69M**	**2023**
Dan Quayle	**52M**	**2023**
Samia Saikali	**67F**	**2023**
Normand Meunier	**66M**	**2024**
Jennifer Brady	46F	2024
Subash Bahl	69M	2022
Stephanie Lavoie	**30F**	**2024**
Tracey Thompson	50F	2022
Mitchell Tremblay	39M	2022
Isabella Gamk	F	2024
Raymond Bourbonnais	**79M**	**2019**
Sebastian Verret	44M	2024
Richard McLean	**M**	**2022**


DAN


RICHARD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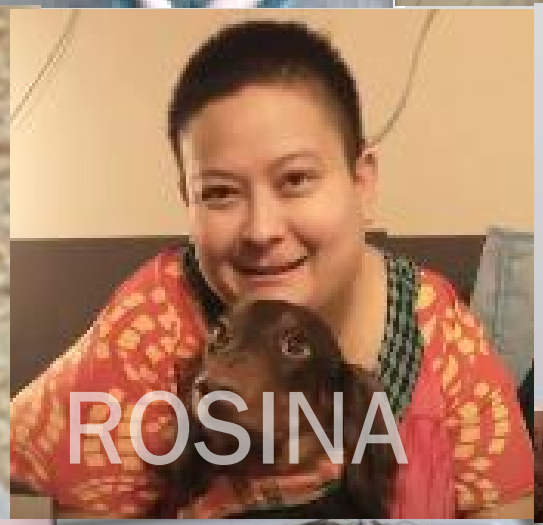
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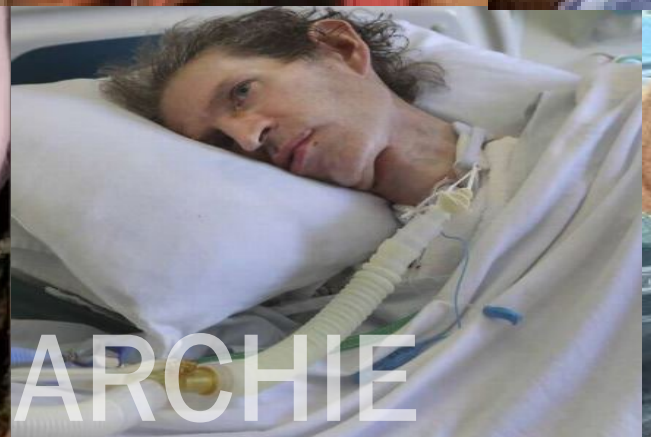
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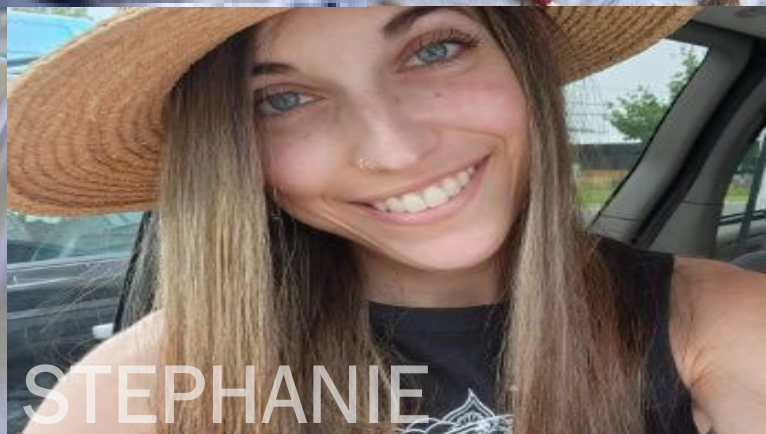
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Question 3: If suffering is key criterion, what about those who suffer but are not autonomous?

- Create pressure to allow non-voluntary EAS, if what justifies EAS is reduction of suffering.

- Already practiced to some degree
  - Especially in Belgium (cf. Cohen-Almagor's work) and some in NL
  - Neonates in the NL, special agreement w prosecutors
  - pediatric euthanasia (for young children)—recently legalized in the NL
  - Complex situations in advanced dementia with adv directives

nieuwsuur

NEWS HOUR · DOMESTIC · SAT SEPTEMBER 28, 7:15 PM

Pediatricians: euthanasia should also be possible for young children

A large majority of pediatricians who often deal with incurably ill children want euthanasia or active termination of life in young children. From research shows that 84 percent of specialist doctors is here. The investigation was submitted to the Lower House earlier this evening.

Now euthanasia is forbidden for children under the age of twelve because children up to that age are not willing, an essential condition for euthanasia.

The video below shows how doctors and parents are confronted with the situation in which a child suffers seriously, but in which euthanasia is not permitted.

Question 4: Why only medically based suffering?

- Often pointed out that EAS for psychiatric patients should be allowed since they suffer as much as or more than physically ill people do.
- Similar arguments for other non-terminally ill patients (eg., Canada), especially people with disabilities
- Recall also the ‘tired of living’ rationale—it can be stated as a form of social-existential suffering?
- “Non-disabled people with long life expectancies may also have suicidal desires grounded in conditions that are very unlikely to change, such as poverty, ugliness, menial and grueling jobs, lack of love.”(Ackerman 2020)

Autonomy only EAS as a response

- Perhaps the stigma problem and other equality problems can be addressed by making ‘irremediable suffering’ an entirely subjective notion?

- E.g., “enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable.” [wording from Canadian law]

- That is, make the suffering boundary similar to ‘autonomy only’ boundary?

Autonomy as the only eligibility condition

Swiss law

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

- NB: no legal restriction on requestor’s reasons. Self-regulated by voluntary organizations’ de facto rules, medical society guidelines.

- AS is legal by inference (illegal only if assisted with selfish motive, therefore legal otherwise).

German Federal Constitutional Court

(February 2020)

- "The right to a self-determined death is **not limited to** situations defined by external causes like **serious or incurable illnesses**, **nor** does it only apply in **certain stages of life or illness.** Rather, this right is **guaranteed in all stages of a person's existence**" (Federal Constitutional Court 2020).

- "**Restricting** [the right to assisted suicide] **to specific causes or motives** would essentially amount to a substantive evaluation, and thereby predetermination, of the motives of the person seeking to end their own life, which **is alien to the notion of freedom**" (Federal Constitutional Court 2020).

Some comments on German court decision

- Note that in autonomy only EAS, EAS is *not* inherently medical. Similar to Swiss situation, and also Estonian ruling.

- The German right to assisted suicide is:
  - A basic human right derived from dignity of autonomy, per their constitution
  - The Court asserts that any attempt to restrict AS can only be based on sectarian, non-neutral beliefs, and state neutrality demands protecting this right.

- However, other courts (e.g., US, South Africa, UK) have declined to establish a basic EAS right, deferring to democratic process (and appealing to same concern over court meddling in sectarian moral opinions)

Question 1: Does autonomy only EAS solve the problems raised for EOL or suffering-based regimes?

- Stigma/discrimination
  - May depend on how implemented; if integrated into health care system, effect will be same as for suffering based regime
  - Alternative? Independent ”death centers”? How to regulate?

- Justice concerns could remain
  - Unless society guarantees access to basic resources, similar situation as for suffering-based EAS
  - Unless basic resources are guaranteed, legal access to death could be much easier (especially if funded by the govt).

Question 2: How does autonomy only EAS fit with views of public?

- Most surveys show most would be against it (e.g., around 20% range, even in Canada where EAS support is quite high)
- Not surprising, given it reflects a philosophy (fairly extreme libertarian individualism) that is not shared by many
- Although it is believable that some cultures might adopt it, doubtful that it is a universal human right that can only be restricted by sectarian concerns.

Summary and Conclusion

- Morality of EAS is complex and important, touching on deeply held beliefs.
- Whether to legalize EAS requires additional considerations.
  - Where to draw the boundary and why.
  - Whether and how to involve health professions.
  - The pros and cons of each boundary as it would be implemented.
  - The pressure toward autonomy only EAS, which is not acceptable to most.
- Have I succeeded in making this topic more complicated and confusing? I hope so.

QUESTIONS?