

An International Comparison of Assisted Dying Regimes

Part 2—Safeguards for Requests and Assessments

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Introduction

How do the procedural safeguards for euthanasia and assisted suicide requests and assessments compare across jurisdictions? This research report, the second in a series of reports and briefs, compares the Canadian "medical assistance in dying" (MAiD) program to international jurisdictions in which some form of assisted dying is legal.

As discussed in more detail in part 1 of this series, "An International Comparison of Assisted Dying Regimes: Part 1—Eligibility Criteria," assisted dying refers to euthanasia and/or assisted suicide. "Medical assistance in dying," or MAiD, is the specific term used for both practices in Canada. The first paper also summarized the difference between euthanasia (clinician-administered death[1]) and assisted suicide (self-administered death), and the legal status of both practices across international jurisdictions, specifying which jurisdictions are and are not included in our comparison.[2] We have added in this second paper the US states of New York and Illinois, whose laws legalizing assisted suicide came into effect on August 5 and September 16, 2026, respectively.

Whereas part 1 of the series compared eligibility criteria, this second paper examines the procedural safeguards surrounding requests and assessments for assisted dying. We examine the nature of the safeguards in the following areas:

- initiating conversations about assisted dying with patients
- requesting assisted dying, including:
    - requirements for the request process
    - requirements for witnesses
- assessment of eligibility, including:
    - requirements for the number of assessors
    - requirements concerning who can serve as an assessor
    - requirements for residency
    - requirements for consultation with past/current health care providers and families

As in the first paper, this comparison is presented through a series of tables, accompanied by discussion. Government and scholarly sources were used to identify the legal parameters for each

1 Different jurisdictions have different rules surrounding which medical professionals can assess and/or administer assisted death. Canada, for instance, allows physicians or nurse practitioners to serve as assessors and providers of assisted deaths. Other jurisdictions may require assessors to be physicians—as we outline in this report—whereas providers could be nurse practitioners or nurses (we will explore restrictions surrounding which clinicians can administer assisted death in our third paper in this series).

2 Vachon and Beauregard, "An International Comparison of Assisted Dying Regimes: Part 1—Eligibility Criteria." Complete citations are provided for all sources at the end of this report.

jurisdiction. For more information on the sources consulted and the methodology used, please see part 1 in the series.

Because international legislation varies in the terminology used for those medical professionals authorized to assess assisted dying requests, here we use:

- "physician" to refer to those licensed to practice medicine (also referred to in various legislation as doctors, medical practitioners, health practitioners, etc.)
- "clinician" to refer to those medical professionals who are allowed, in a given jurisdiction, to assess assisted dying requests (i.e., in Canada, this would refer to both physicians and nurse practitioners)
- "assessor" to refer to those clinicians who actually conduct assisted dying assessments
- "registered healthcare professionals" to refer to a broader category of professions regulated under the given jurisdiction's healthcare professions act (nurses, midwives, physical therapists, etc., as well as physicians)

We find that, for the safeguards examined in this report, Canada's approach lies somewhere between that of Australia, New Zealand, and US states on the one hand (more restrictive), and that of Europe on the other (more permissive). For the province of Alberta specifically, recent legislation aligns more closely with that of Australia, New Zealand, and the US.

Safeguards should be also understood in the context of eligibility criteria, discussed in part 1 of the series.

Initiating Conversations About Assisted Dying

In some jurisdictions, patients must be the ones to initiate a discussion about assisted dying, and clinicians and sometimes other healthcare professionals or workers are prohibited from raising the issue unsolicited. The government of South Australia, for instance, states that this safeguard exists to "ensure that the request is completely voluntary and made without coercion."[3] While some critics argue that this safeguard serves as a barrier to an informed decision for patients who may be unaware of assisted dying as an option, other voices argue that the safeguard acknowledges the power dynamic in the relationship between medical professionals and their patients, and how the presentation of assisted dying as an option may encourage patients—even inadvertently—to choose a premature end to their lives.[4]

This safeguard was adopted in Australia by the state of Victoria and then by the state of South Australia and by New Zealand. A much looser version of the safeguard was adopted in the

3 Government of South Australia, SA Health, "Voluntary Assisted Dying in South Australia Explained."

4 For critics, see, for example, Willmott et al., "Restricting Conversations," and McDougall and Pratt, "Too Much Safety?" For supporting voices, see, for example, Grant, "Legislated Ableism," 310–11; Jones, "Slippery Slopes Down Under," 93; Pullman, "Slowing the Slide," 69.

Australian states of New South Wales, Queensland, Tasmania, and Western Australia (table 1). The Australian Capital Territory adopted slightly different wording in its law, but the safeguard appears to be similar in practice.

Although Victoria was the first to establish this safeguard, a 2025 bill amended the original law and will allow, as of April 2027, discussion about assisted dying to be initiated "in the course of discussion about end of life care," so long as "reasonable steps" are taken to inform the patient of treatment options and palliative care.[5] This diluted safeguard is about as strong as what exists in most other jurisdictions that require alternatives and palliative care to be raised/considered as part of informed consent. It may still provide residual protective elements, however, since it requires that treatments and palliative care be specifically discussed when *raising* MAiD, rather than merely at some point during the assessment and approval process.

Canada does not have this safeguard. Government guidance instead *encourages* clinicians to raise MAiD in some cases. Specifically, Health Canada's Model Practice Standard recommends that physicians raise MAiD as an option to patients who may be eligible, if the clinician considers MAiD to be "consistent with the person's values and goals of care." Health Canada's "Advice to the Profession" advises the same. Both were developed as documents "for use by regulatory bodies, public authorities, and health professional organisations and [are] intended to support a consistent approach to MAID practice across Canada." They do not constitute binding law and are not applied consistently across the country.[6] As explored in a previous Cardus report, survey results indicate that a significant proportion of the Canadian population is concerned that Canadian clinicians raising MAiD unsolicited may create pressure on patients to choose MAiD.[7]

The province of Alberta recently legislated this safeguard, among others, and will prohibit all regulated health professionals from providing unsolicited information about MAiD during their provision of health services. The province's legislation also took the step of prohibiting information on MAiD from being displayed "in a public manner within a health care facility."[8]

5 Victoria State Government, *Voluntary Assisted Dying Amendment Act 2025*, at §7.

6 Health Canada, "Model Practice Standard," 2, 6–7; Health Canada, "Advice to the Profession," 13–14; Close et al., "Medical Assistance in Dying in Canada."

7 Vachon, "Disability and MAiD," 23–24.

8 "Regulated health professionals," according to Alberta's legislation, are all those regulated under the *Health Professions Act* and therefore a broader category than physicians and nurses only. Government of Alberta, Bill 18, *Safeguards for Last Resort Termination of Life Act*, at §1 (1)(p). Regarding the display of MAiD information, see Government of Alberta, Bill 18, *Safeguards for Last Resort Termination of Life Act*, at §10.

Table 1. Safeguards for Initiating Conversations About Assisted Dying with Patients

Jurisdiction	Are medical professionals prohibited from initiating discussion of assisted dying?	If prohibition is conditional, what conditions apply?	
		For clinicians	For other registered healthcare professionals
Austria	No	-	-
Australia[1]			
Australian Capital Territory	Yes, unless conditions are met.	Possess "necessary expertise" Believe the patient has a condition that may be eligible Inform the patient of treatment options and palliative care	Believe the patient may be eligible Inform the patient of treatment options and palliative care Inform the patient that they should discuss this with their physician
New South Wales	Yes, unless conditions are met.	Inform the patient of treatment options and palliative care	Inform the patient of treatment options and palliative care Inform the patient that they should discuss this with their physician
Queensland Western Australia	Yes, unless conditions are met.	Inform the patient of treatment options and palliative care	Prohibited
South Australia	Yes	-	-
Tasmania	Yes, unless conditions are met.	Inform the patient of treatment options and palliative care	Inform the patient that a physician is the most appropriate person for this discussion
Victoria	Yes, from 2019–27. Yes, unless conditions are met, starting in April 2027.	Starting in April 2027: Must be a physician, nurse practitioner, registered nurse, registered psychologist, or registered Aboriginal and Torres Strait Islander health practitioner (other registered healthcare practitioners are prohibited)	
Belgium	No	-	-
Canada			
Canada (federal laws)	No	-	-
Alberta	Yes, pending implementation of 2026 legislation	-	-

(*continued*)

Table 1. (*continued*)

Jurisdiction	Are medical professionals prohibited from initiating discussion of assisted dying?	If prohibition is conditional, what conditions apply?	
		For clinicians	For other registered healthcare professionals
Luxembourg	No	-	-
Netherlands	No		
New Zealand	Yes	-	-
Spain	No	-	-
Uruguay	No	-	-
United States (relevant states)	No	-	-

Sources: See reference list at the end of this report.
[1] There is variance in the Australian states about prohibitions pertaining to non-registered healthcare workers. See Waller et al., "Voluntary Assisted Dying in Australia," 1437.

Request Process and Witnesses

Request Process

The request process varies in formality across jurisdictions. Australian states, most US states, and New Zealand provide more specificity in their laws as to the conditions surrounding requests for assisted dying. The Australian and US models typically have a three-request process. Researcher Russell Tolentino notes that requiring more requests can provide "additional avenues for reflection" for patients as well as greater scope for medical assessments, particularly when there are specific waiting periods between requests.[9] For example, California requires a two-day waiting period between the first and the second oral requests, while the District of Columbia and Delaware require at least fifteen days.

9 Tolentino, "Strengthening Safeguards," 3.

In most US states in which assisted dying is legal, the first two requests are oral, with a waiting period between the two, and the third request must be written. In Australia, the three-request model in most states is as follows:

1. The patient makes an oral or written request, or otherwise communicates it, to a medical practitioner. The request triggers an assessment process to determine the patient's eligibility (see next section of this report).
2. If found eligible, the patient makes a second, written request in the presence of two witnesses.
3. The patient makes a final oral or written request or otherwise communicates it.[10]

Jurisdictions that require a written request also typically specify that if a patient cannot sign their written request for some reason, a third party may do so on their behalf. The third party is typically required to be an adult, not receive a benefit from the patient's death, and sign in the presence of the patient and sometimes also the assessor.

In other jurisdictions, such as Belgium, Luxembourg, and the Netherlands, the law does not specify the request process but merely requires the clinician to be, as articulated in the Netherlands' law, "satisfied that the patient's request is voluntary and well considered."[11] Similar wording is found in the Belgian and Luxembourg laws; these two countries both require a request to be made in writing.[12] In the Netherlands, uniquely, a written request is not required, but clinicians "must be satisfied that the request is unequivocal and consistent" prior to administering euthanasia.[13]

Canada's approach is close to that of Belgium and Luxembourg, requiring a written request after a finding of eligibility (resulting in, functionally, a two-request process—one that initiates the assessment processes, and one that constitutes the formal written request),[14] but does not delineate in law a highly specific series and sequence of requests as in Australia.

Witnesses

Some jurisdictions that require a written request also require that the request be witnessed by one or two persons. This requirement is understood to "bolster the integrity of the process" by helping to ensure that the request is voluntary.[15] The Australian state of Victoria, for instance,

10 In Tasmania, the second request (in writing) occurs after the primary assessor finds the patient eligible (first assessment), which then triggers the referral to a second assessor (second assessment). Following this, the third request must also be made in writing. *Tasmanian Government, End-of-Life Choices (Voluntary Assisted Dying) Act 2021*, at §53.

11 Government of the Netherlands, *Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding,* at §2(a).

12 Government of Belgium, *Loi relative à l'euthanasie, 2002*, at §1, 4; Government of the Grand Duchy of Luxembourg. *Loi du 16 mars 2009* at §Art. 2, 1(2)(4).

13 Regional Euthanasia Review Committees, Government of the Netherlands, *Euthanasia Code*, 12–13.

14 Health Canada, "Model Practice Standard," 13–14.

15 Tolentino, "Strengthening Safeguards," 3.

specifies that the witnesses must certify that the patient appears to "freely and voluntarily sign the declaration," "have decision-making capacity," and "understand the nature and effect of making the declaration."[16]

The Australian and US states require two witnesses to the written request. In Australia, witnesses must be adults and cannot be the assessors for the patient's request. In the US, the primary assessor is barred from being a witness; some US states also block the second (consulting) assessor from being a witness. In all Australian and US states but two, one or both of the witnesses cannot receive a benefit from the patient's death. That is, some states require that neither witness be a beneficiary of the patient's estate or receive other financial or material benefit from the death, and other states require that at least one of the two witnesses not be a beneficiary.

Of the other jurisdictions that require a written request (Belgium, Luxembourg, New Zealand, Spain, and Uruguay), no witnesses are required. Austria does not specifically require a written request but does require the request to be registered by an official public notary or legally qualified member of the *Patientenvertretung* (body of patient representatives).[17]

Canadian law was initially more aligned with that of the Australian and US states on requirements for witnesses. It required two independent witnesses for the written request and had similar restrictions on who these witnesses could be. This safeguard was loosened significantly in 2021 to require only one witness, and now allows paid professional caregivers or healthcare workers to serve as witnesses (previously, this was prohibited).[18] Canadian law has never prohibited family members from serving as witnesses.

In Quebec, the requirement for an independent witness is not specifically mentioned in legislation but is mentioned on the government website and on the form used for the written request. Thus Quebec's practice appears to align with the federal law. The provincial law does specify witness requirements for advance requests.[19]

16 Victoria State Government, *Voluntary Assisted Dying Act 2017*, at §36(1).

17 Khakzadeh, "Assisted Suicide in Austria," 141.

18 Bill C-14 at §3(c), 5; Bill C-7 at §(4), (8); Nicol and Tiedemann, "Legislative Summary of Bill C-7," 12.

19 For more on advance requests, see Vachon, "The Risks of Advance Requests."

Table 2. Legislative Requirements for Assisted Dying Requests

Jurisdiction	Number of requests required	Are written requests required and, if so, how many?	Number of witnesses to the written request required	Witness independence requirements
Austria	One[1]	Not specified, but the request must be registered by a qualified professional	One: the registrar	Must be a public notary or legally qualified member of the *Patientenvertretung* (patient representatives)
Australia				
Australian Capital Territory and Queensland	Three	Yes, one	Two witnesses to the signing of the written declaration	Adult Not receiving financial or material benefit from the patient's death[2] Not an owner/responsible for a facility where the patient resides Not either of the assessors
New South Wales	Three	Yes, one	Two witnesses to the signing of the written declaration	Adult Not receiving financial or material benefit from the patient's death Must be related to the patient Not either of the assessors Not a family member or employee of either of the assessors
Tasmania	Three	Yes, two	Two witnesses to the signing required or witnessed by a "commissioner for declarations"	Adult Not either of the assessors One of the witnesses must not: Receive a financial benefit from the patient's death (other than "reasonable fees for the provision of services") Be a residential care provider/ employee/agent to the patient, or a resident of a facility owned/ operated by the patient's residential care provider Be related to the patient

(*continued*)

Table 2. (*continued*)

Jurisdiction	Number of requests required	Are written requests required and, if so, how many?	Number of witnesses to the written request required	Witness independence requirements
Australia				
Victoria South Australia Western Australia	Three	Yes, two	Two witnesses to the signing of the written declaration	Adult Cannot receive financial or material benefit from the patient's death Cannot be an owner / responsible for a facility where the patient resides Cannot directly provide health care or professional care services to the patient One of the witnesses cannot be related to the patient
Belgium	One[1]	Yes, two	None, except for advance requests[3]	-
Canada				
Canada (federal laws)	One[1]	Yes, one	One	Adult Cannot receive financial or material benefit from the patient's death Cannot be an unpaid caregiver to the patient but can be a paid professional personal or healthcare worker providing services to the patient Cannot be an owner or operator of the healthcare facility where the patient lives/receives care "Must understand what it means to request medical assistance in dying."
Quebec	One[1]	Yes (no number specified), for both contemporaneous requests and advance requests.[3]	One, for the request form Must be signed in the presence of a health or social services professional	Adult Cannot receive financial or material benefit from the patient's death Must understand the nature of the request for MAiD

(*continued*)

Table 2. (*continued*)

Jurisdiction	Number of requests required	Are written requests required and, if so, how many?	Number of witnesses to the written request required	Witness independence requirements
Luxembourg	One[1]	Yes (no number specified)	None	-
Netherlands	One[1]	No, unless an advance request is used[3]	-	-
New Zealand	Three	Yes (no number specified)	None[4]	-
Spain	Two, plus confirmation by commission	Yes, two, either written "or by another means to be recorded"	None	-
Uruguay	Two	Yes, two	Two, for the signing of the second written request	Adults Cannot receive financial benefit from the patient's death
United States				
California Colorado Delaware District of Columbia Hawaii Illinois Maine New Jersey	Three	Yes, one	Two, for the signing of the written request	See table 3 for a breakdown of the differences between states, but in general: Cannot be the primary assessor for the patient One of the two cannot be: Related to the patient A beneficiary of the patient's estate Owner, operator, or employee of a healthcare facility where the patient is treated or resident

(*continued*)

Table 2. (*continued*)

Jurisdiction	Number of requests required	Are written requests required and, if so, how many?	Number of witnesses to the written request required	Witness independence requirements
United States				
New Mexico	Two	Yes, one	Two, for the signing of the written request	Cannot be a healthcare provider for the patient One of the two cannot be: Related to the patient Owner, operator, or employee of a healthcare facility where the patient is treated or resident
New York	Two	Yes, one	Two, for the signing of the written request	Adult Cannot be: Related to the patient or their domestic partner A healthcare proxy or power of attorney for the patient A beneficiary of the patient's estate Owner, operator, employee, or independent contractor of a healthcare facility where the patient is treated or resident Either of the patient's assessors, nor their mental health assessor (if one was required)

Sources: See reference list at the end of this report.

[1] Although the laws of these jurisdictions specify only the requirement of a written request, they also require the written request be made after the patient has been found eligible. Functionally, then, the process involves two requests: The first request (which can be oral) triggers the assessment, and the written request follows.

[2] The law in Australian Capital Territory specifies that witnesses may receive no benefits other than "reasonable fees for the provision of services as a witness."

[3] Provisions relating to advance requests will be detailed in a subsequent paper in this series.

[4] The attending medical practitioner (i.e., primary assessor and provider of an assisted death) must be present for the signing of the written request.

Table 3. Witness Independence Requirements for US States with Legalized Assisted Dying

US State		CA	CO	DE	DC	HI	IL	ME
Adult		Yes	-	Yes	-	-	-	-
Not primary assessor		Yes	Yes	Yes	Yes	Yes	Yes	Yes
Not consulting assessor		Yes	Yes	-	-	-	-	-
Not mental health assessor (if one was required)		Yes	-	-	-	-	-	-
Not power of attorney		-	Yes	-	-	-	-	-
How many of the two witnesses can be:	**Related to the patient**	One	One	One	One	One	One	One
	Beneficiary of the estate	One	One	One	One	One	One	One
	Owner, operator, or employee of the facility at which the patient is treated/ resides	One	One	One	One	One	One	One
Designated by the long-term care facility at which the patient resides		-	-	-	Yes	-	-	Yes
Other		-	-	-	-	-	Cannot be the patient's interpreter, if one was needed	-

(*continued*)

Table 3. (*continued*)

US State		NJ	NM	NY	OR	VT	WA
Adult		-	-	Yes	-	Yes	-
Not primary assessor		Yes	Cannot be a "health care provider" of the patient	Yes	Yes	Cannot be the "patient's physician"	Yes
Not consulting assessor		-		Yes	-	-	-
Not mental health assessor (if one was required)		-	-	Yes	-	-	-
Not power of attorney		-	-	Yes	-	-	-
How many of the two witnesses can be:	**Related to the patient**	One	One	Zero	One	Zero	One
	Beneficiary of the estate	One	-	Zero	One	Zero	One
	Owner, operator, or employee of the facility at which the patient is treated/ resides	One (Other than at a long-term care facility)	One	Zero (Nor an independent contractor at the facility)	One	Zero	One
Designated by the long-term care facility at which the patient resides		-	-	-	Yes	-	-
Other		-	-	-	-	-	-

Sources: See reference list at the end of this report.

Assessment of Eligibility

Number of Assessors

The assessment process requires patients to be found eligible by two assessors, or sometimes three.[20] In cases where eligibility or competence may be in question, additional consultation may be required, as discussed below.

Along with the two assessors required, Spain has a Regional Guarantee and Evaluation Commission, which appoints two of its members—a physician and a jurist—to verify the requirements and conditions for each approved request *before* the patient receives an assisted death. In this verification, these two members review documentation and the patient's medical history and, if they deem it necessary, interview the physician, health team, and/or patient.[21]

Concurring and Dissenting Opinions

The Netherlands sets a much lower bar than other jurisdictions do, in that agreement between two assessors is not needed. The primary assessor/provider need only seriously consider the consulting (or second) assessor's position but, as expressed in the *Euthanasia Code*, "if there is a difference of opinion between the two, the physician can nevertheless decide to grant the patient's request, but will have to be able to provide adequate grounds [to the Regional Euthanasia Review Committee] for this decision, reflecting explicitly on the views expressed by the independent physician."[22]

In other jurisdictions, a disagreement between two assessors requires that a third clinician provide an assessment. As the Canadian case shows, however, when patients have been found ineligible, they may continue applying until they receive two affirmative findings of eligibility.[23] Although we lack data on the prevalence of such "assessor shopping" in Canada, instances have come to light, such as that of Kiano Vafaeian, a twenty-six-year-old resident of Ontario. Vafaeian was repeatedly found ineligible for MAiD locally and subsequently travelled to BC and received MAiD on December 30, 2025, from well-known MAiD provider and advocate Ellen Wiebe. This prompted criticism from his family, who argue that he should not have received a MAiD death and that "the system failed him."[24]

20 Belgian law requires a third assessor (or a "second consulted physician") in cases where the requester is not expected to die reasonably soon; in such cases, this consulted physician must be either a psychiatrist or have expertise in the patient's condition. A third assessor—specifically a child or adolescent psychiatrist or psychologist—is also required for evaluating requests from non-emancipated minors. Raus et al. "Euthanasia in Belgium," 90–91. For more information about euthanasia for minors, see also Vachon and Beauregard, "An International Comparison of Assisted Dying Regimes: Part 1—Eligibility Criteria."

21 Martínez-León et al., "Medico Legal Study," 168; Velasco Sanz et al., "Spanish Regulation of Euthanasia," 2.

22 Regional Euthanasia Review Committees, Government of the Netherlands, *Euthanasia Code*, 20.

23 Lyon, "Canada's Medical Assistance in Dying System," 83–85.

24 Canadian Press, "One of Canada's Most Prominent MAID Providers Reflects"; Prasad and Judd, "Ontario Family Calls for Changes."

Investigative journalist Alexander Raikin has written about a similar case that was discussed during a Canadian Association of MAiD Assessors and Providers (CAMAP) seminar. In this case, a man who was found ineligible for MAiD subsequently connected with Wiebe through Dying with Dignity Canada. As described by Raikin, Wiebe "found him [the patient] eligible, and found a second assessor to agree," subsequently picking up the patient from the airport and, as Wiebe put it, "brought him to my clinic and provided [euthanasia] for him." Raikin also reports that law professor Jocelyn Downie has stated in CAMAP seminars that if a second assessor does not agree that a patient is eligible, "you can ask as many clinicians as you want or need," and "disagreement doesn't mean you must stop [asking for another assessment that concurs]."[25]

In Tasmania, by contrast, if two consulting clinicians (i.e., a second and then a third assessor) decide that the patient is ineligible, the process ends and the patient would need to restart with a new first request. The former primary assessor cannot accept a new first request from that patient for twelve months.[26] In Uruguay, if there is a disagreement between the first and second assessors, a final opinion is elicited from a medical board at the healthcare facility where the procedure would occur.[27]

Who Can Serve as Assessor

Most jurisdictions require both assessors to be physicians. The exceptions are Canada, the Australian Capital Territory, and a few US states. Canada allows nurse practitioners to be one or both assessors. The Australian Capital Territory requires one of the assessors to be a physician, but the other can be a nurse practitioner.[28] Until recently, all US states with legalized assisted dying required the assessors to be physicians, but three states now allow nurse practitioners ("advanced practice registered nurses" in the language of the US laws) to assess and prescribe, and two other states allow nurse practitioners and physician assistants to be assessors and providers.

Assessor independence is also required. As in the Canadian law, assessors may not be connected to each other as a mentor/mentee or supervisor/supervisee, nor be connected to the patient by benefiting in a material or financial way from their death—"other than standard compensation for their services relating to the request"—nor be connected to the clinician or patient "in any other way that would affect their objectivity."[29]

Expertise and Experience Required of Assessors

Requirements relating to assessor expertise and experience vary by jurisdiction (table 4). Tolentino discusses the importance of such requirements, noting that "medical practitioners without specialised training in end-of-life care, mental health, or complex capacity assessments

25 Raikin, "No Other Options."

26 Tasmanian Government, End-of-Life Choices *(Voluntary Assisted Dying) Act 2021*, at §48.

27 This board would include a psychiatrist, a physician with specialization in the patient's condition, and another physician (internist or palliative care specialist). Government of Uruguay, *Reglamentacion de la ley 20.431*, at §6.

28 Australian Capital Territory Government, *Voluntary Assisted Dying Act 2024*, at §97(3).

29 Government of Canada, Consolidated Federal Laws of Canada, *Criminal Code*, at §241.2(6).

may not possess the requisite expertise needed to navigate the nuanced clinical, psychological, and ethical dimensions of decisions surrounding assisted dying." He also describes how requiring psychological assessments may be beneficial to ascertain the full voluntariness of the request, since "coercion, whether overt or subtle, can prove difficult to detect without comprehensive psychological and social assessments."[30]

Some jurisdictions require one or both assessors to have expertise or experience in treating the patient's condition, whereas others require a consultation or referral to a specialist only if eligibility is undetermined or if decision-making incapacity or mental illness is suspected. Hawaii requires a higher standard for mental-health screening: Requesters must receive counselling from a licensed mental-health professional prior to a request being approved. This assessment is for the purpose of determining "that the patient is capable, and does not appear to be suffering from undertreatment or nontreatment of depression or other conditions which may interfere with the patient's ability to make an informed decision."[31]

Health Canada's Model Practice Standard indicates that, "Where appropriate, assessors and providers should consult with clinicians with expertise in the assessment of decision-making capacity,"[32] but expertise or referrals to those with expertise in psychiatry or mental health are not specifically required in Canadian law, although some provincial regulators do require a psychiatric referral if capacity is in question.[33] As such, the determination that any such consultation is needed would be left up to assessors' discretion.

In jurisdictions where eligibility is not limited solely to those with terminal illness,[34] the importance of an assessor having expertise or referring the patient to a specialist with expertise in the patient's condition is heightened. Belgium, for instance, requires that the second assessor be "competent" to evaluate the patient's condition, and if the patient's natural death is not expected in the near future, a third assessor must be a psychiatrist or a specialist in the patient's condition.[35]

Canadian law does not require assessments to involve specialists in the patient's condition. For cases of Track 2 MAiD, in which death is not "reasonably foreseeable," one of the assessors must have expertise in the condition causing the suffering, or if neither assessor has this expertise, another clinician with such expertise must be consulted. "Expertise" is not defined, however, and thus may result in significant variations in interpretation. As Close et al. have noted, some regulators have "clarified that this 'expertise' can be gained through experience, training, or

30 Tolentino, "Strengthening Safeguards," 2, 3.

31 Hawaii Revised Statutes, *Our Care, Our Choice Act*, at §6.

32 Health Canada, "Model Practice Standard," 10.

33 Close et al., "Medical Assistance in Dying in Canada," 15.

34 For more information, see Vachon and Beauregard, "An International Comparison of Assisted Dying Regimes: Part 1—Eligibility Criteria."

35 Government of Belgium, *Loi relative à l'euthanasie*, at §§2(3) and 3(1). As explained by bioethicists Raus et al., however, Belgium's Federal Control and Evaluation Commission for Euthanasia considers general practitioners as specialists in cases of polypathology, which comprise nearly half of non-terminal euthanasia cases, a latitude that could significantly limit the efficacy of this safeguard. Raus et al., "Euthanasia in Belgium," 90–91.

education,"[36] and thus the practitioner does not need to have a regulated specialty to qualify as having the requisite "expertise."[37]

Table 4. Legal Requirements for Assessments and Consultations for Assisted Dying

Jurisdiction	Who can be an assessor	Number of assessors required	Must include an expert in the medical condition?	Must include psychiatric/mental health expertise?
Austria	Physician	Two	No expertise in the condition of the patient required, only in palliative care.	If the doctor suspects the patient has a mental disorder.
Australia				
Australian Capital Territory	Physician or nurse practitioner[1]	Two	If eligibility of the condition is undetermined.	No
New South Wales	Physician	Two	If eligibility of the condition of the patient is undetermined.	If capacity is undetermined, or voluntariness is under question.
Queensland	Physician	Two	If eligibility of the condition of the patient is undetermined.	If capacity is undetermined.
South Australia	Physician	Two	At least one of the assessors must have expertise and experience in the terminal condition of the patient. If eligibility of the condition of the patient is undetermined, or if the condition is neurodegenerative and will cause death within six to twelve months.	If capacity is undetermined.
Tasmania	Physician	Two	Both assessors require relevant experience in treating or managing the condition.	No, but records or information may be sought, if needed.

(*continued*)

36 Close et al., "Medical Assistance in Dying in Canada," 15–16. The authors also note that the College of Physicians and Surgeons of Newfoundland and Labrador require referral if both assessors lack expertise for those whose death is not reasonably foreseeable.

37 Lyon, "Canada's Medical Assistance in Dying System," 68, 89.

Table 4. (*continued*)

Jurisdiction	Who can be an assessor	Number of assessors required	Must include an expert in the medical condition?	Must include psychiatric/mental health expertise?
Australia				
Victoria	Physician	Two	Yes, either the first or second assessor must have "relevant expertise and experience in the disease, illness or medical condition expected to cause the person's death." Also, if the second assessor cannot determine whether the patient is eligible, the patient must be referred to a specialist with relevant skills and training.	If capacity is undetermined. [Repealed as of April 2027:] If the practitioner finds that the patient has a neurodegenerative condition that will cause death between six to twelve months, they must refer to a specialist with expertise in neurodegenerative conditions.
Western Australia	Physician	Two	If eligibility of the condition of the patient is undetermined.	If capacity is undetermined.
Belgium	Physician	Two or three	The second physician consulted must be "competent" on the condition of the patient. If the patient is expected not to die in the near future, a third physician must be consulted, who must be a psychiatrist or a specialist in the patient's condition. A third physician, specializing in child/adolescent psychiatry or psychology, is also required for non-emancipated minor requests for euthanasia.	Psychiatric consultation required for minors only.
Canada (federal laws)	Physician or nurse practitioner	Two	For Track 2 MAiD only (when death is not reasonably foreseeable): Yes, if neither of the two assessors has expertise in the condition causing suffering, one of the assessors must consult with someone with expertise. Does not require the consulting expert to assess the patient directly.	Not specified in the law but recommended by government guidance "where appropriate

(*continued*)

Table 4. (*continued*)

Jurisdiction	Who can be an assessor	Number of assessors required	Must include an expert in the medical condition?	Must include psychiatric/mental health expertise?
Luxembourg	Physician	Two	The second physician must be "competent" on the condition of the patient.	No
Netherlands	Physician	Two, but the second need not concur with the first	No	If capacity is undetermined. For psychiatric assisted death requests, psychiatric expertise should be sought.
New Zealand	Physician	Two	No	A third opinion by a psychiatrist is required if competence is not established by one or both assessing practitioners.
Spain	Physician	Two, plus verification by a commission	The second physician must have training relevant to the patient's condition.	No
Uruguay	Physician	Two	Yes. The second physician must be an internist or specialist in the patient's condition.	No
United States				
California District of Columbia Illinois Maine New Jersey New York Oregon	Physician	Two	Second assessor must be "qualified by specialty or experience" to provide a diagnosis and prognosis for the patient's terminal illness.	Only if the assessor suspects impaired decision-making capacity.
Colorado Delaware	Physician or advanced practice registered nurse	Two	Second assessor must be "qualified by specialty or experience" to provide a diagnosis and prognosis for the patient's terminal illness.	Only if the assessor suspects impaired decision-making capacity.

(*continued*)

Table 4. (*continued*)

Jurisdiction	Who can be an assessor	Number of assessors required	Must include an expert in the medical condition?	Must include psychiatric/mental health expertise?
United States				
Hawaii	Physician or advanced practice registered nurse	Two	Second assessor must be "qualified by specialty or experience" to provide a diagnosis and prognosis for the patient's terminal illness.	Psychological counselling required for all patients before request is accepted.
New Mexico	Physician or advanced practice registered nurse or physician assistant	Two	Second assessor needs to have "experience" with the underlying condition.	Only if the assessor suspects the patient has a mental disorder, or if the patient has a recent history of mental health issues or a mental disability.
Vermont	Physician	Two	No	If an assessment for impaired judgement is needed.
Washington	Physician or advanced practice registered nurse or physician assistant	Two	Second assessor must be "qualified by specialty or experience" to provide a diagnosis and prognosis for the patient's terminal illness.	Only if the assessor suspects impaired decision-making capacity.

Sources: See reference list at the end of this report.
[1] One of the assessors must be a physician, however.

Residency Requirements

Some, but not all, jurisdictions require a residency determination during the assessment process. Requiring that the patient be a resident of the jurisdiction can serve multiple purposes. Practically speaking, many healthcare systems are already strained, and policymakers may wish to avoid a situation whereby an "influx [of non-residents requesting assisted dying] may overwhelm the healthcare system and divert resources from domestic patients."[38] Additionally, it may be legally, ethically, and practically difficult to accommodate non-resident requests if the requester's medical records, medical team, and family are not easily accessible for consultation.

Another factor is "jurisdiction shopping," whereby requesters from jurisdictions where assisted dying is not legal, or legal but more difficult to access or to be found eligible, may travel to a more permissive jurisdiction to receive an assisted death. Switzerland is well known as one such jurisdiction. As discussed in the first brief in this series, assisted suicide there is decriminalized and not subject to residency requirements, resulting in "suicide tourism," with the country becoming "a destination for people internationally who wish to die by suicide."[39] A Swiss study examining death records from 1985 to 2014 found that 54 percent of those who died by assisted suicide were Swiss residents, and the remaining 46 percent were non-residents who travelled there for the purpose.[40]

A lack of residency requirements may encourage "jurisdiction shopping," thus "undermining the integrity of both domestic and international regulations" on assisted dying and allowing those with the means and finances to travel to receive an assisted death that would not otherwise be allowed in their home jurisdiction.[41]

As summarized in table 5, most jurisdictions have residency requirements. The Benelux countries are the exception. The Dutch government notes, however, that providing euthanasia to non-residents "almost never happens," because of the due-care criteria that clinicians apply, the time that assessments can take, and administrative issues.[42]

In jurisdictions that require or formerly required residency, some erosion in this safeguard has occurred. For instance, all US states with legal assisted suicide had a residency requirement at one point, but both Oregon and Vermont removed this requirement in 2023 in response to legal challenges.[43] Efforts, both legislatively and in courts, have been ongoing in other states to achieve the same change.[44]

38 Tolentino, "Strengthening Safeguards," 3.

39 Bartsch et al., "Assisted Suicide in Switzerland," 545; Gauthier et al., "Suicide Tourism."

40 Bartsch et al., "Assisted Suicide in Switzerland," 547.

41 Tolentino, "Strengthening Safeguards," 3.

42 Administrative issues include the fact that costs are not covered if a patient lacks Dutch health insurance, and that access to some services, such as the Dutch Euthanasia Expertise Centre, requires residency, Dutch health insurance, and registration with a physician in the Netherlands. Government of the Netherlands, "Is Euthanasia Legal in the Netherlands?"

43 Oregon Health Authority, *Oregon Death with Dignity Act: 2023 Data Summary,* 4–5; Vermont General Assembly, *An act relating to removing the residency requirement*. See also Dresser, "Residency Requirements."

44 Pope, "Top Ten New and Needed Expansions," 89.

In Australia, states that have legalized assisted dying more recently have been less restrictive about residency. Requesters can apply for an exemption to residency requirements in the Australian Capital Territory, New South Wales, Queensland, and, starting in April 2027, Victoria. Exemptions may be granted based on a substantial connection to the state (living nearby, working in the state, receiving medical care in the state, etc.) and, in some jurisdictions, on compassionate grounds.

New South Wales, Queensland, and Tasmania are overall less restrictive on residency, in that they allow persons to request assisted dying if they can demonstrate residency in Australia for a minimum of three years continuously—creating a pathway for those who are neither Australian citizens nor permanent residents.[45] The Australian Capital Territory, which is the most recent jurisdiction in Australia to legalize assisted dying, goes further, requiring the person to have lived in the jurisdiction only for the prior twelve months (or receive an exemption).[46]

Canada does not require residency specifically, but eligibility for MAiD is contingent on eligibility for funded health services.[47] In other words, the law does not require MAiD recipients to be Canadian citizens or residents so long as they qualify for funded health services, but practically speaking, this largely prevents international assisted death "tourism." As discussed in the previous section, however, some patients who are found ineligible in their own province or locality do travel to other Canadian provinces to receive MAiD from more permissive providers, leading to similar problems of circumventing safeguards.

Table 5. Residency Requirements for Assisted Dying

Jurisdiction	Is residency required?	Details	Is an exemption possible?
Austria	Yes	Must be an Austrian citizen or have a habitual residence in Austria. No specified time required for residency.	No
Australia			
Australian Capital Territory	Yes	Must have lived in the territory for at least twelve months.	Yes
New South Wales	Yes	Must be Australian citizen or permanent resident or resident in Australia for at least three years. Must be ordinarily resident in the state for at least twelve months.	Yes
Queensland	Yes	Must be Australian citizen or permanent resident or ordinarily resident in Australia for at least three years, or have an Australian residency exemption. Must be ordinarily resident in Queensland for at least twelve months.	Yes

(*continued*)

45 Jones, "Slippery Slopes Down Under," 93; Okninski, "Voluntary Assisted Dying in Australia," 14.

46 Australian Capital Territory Government, *Voluntary Assisted Dying Act 2024*, at §11(1)(f), 154.

47 Government of Canada, Consolidated Federal Laws of Canada, *Criminal Code*, at §242.2(1)(a).

Table 5. (*continued*)

Jurisdiction	Is residency required?	Details	Is an exemption possible?
Australia			
South Australia Western Australia	Yes	Must be Australian citizen or permanent resident and ordinarily resident in the state for at least twelve months.	No
Tasmania	Yes	Must be Australian citizen or permanent resident or resident in Australia for at least three continuous years. Must be ordinarily resident in Tasmania.	No
Victoria	Yes	Must be Australian citizen or permanent resident and ordinarily resident in Victoria for at least twelve months. As of 2027, those who have been ordinarily resident in Australia for at least three years and ordinarily resident in Victoria will also be allowed.	Yes, starting April 2027
Belgium	No	-	-
Canada	No, but must be eligible for funded health service.	Established through eligibility for funded health services in Canada.	No
Luxembourg	No	-	-
Netherlands	No	-	-
New Zealand	Yes	Must be citizen or permanent resident.	No
Spain	Yes	Must have Spanish nationality, legal residence, or reside in the country for at least twelve months if not a legal resident.	No
Uruguay	Yes	Must be a citizen or provide proof of habitual residence. Required residence length not specified.	No
United States			
California Colorado Delaware Hawaii New Jersey Illinois Maine	Yes	Must be a resident of the state. Residency can be proved through the following: owning a state ID being registered to vote owning property in the state having filed a tax return for the most recent year Illinois and Maine also list other document options and will accept "any other objective facts tending to indicate a person's place of residence." New Jersey accepts any other government record that demonstrates current residency.	No

(*continued*)

Table 5. (*continued*)

Jurisdiction	Is residency required?	Details	Is an exemption possible?
United States			
District of Columbia New Mexico New York	Yes	DC, New Mexico, and New York do not specify proofs in the law but require residency. Other DC Health publications list documents that can be used to establish residency; the patient must submit two of the sixteen document options.	
Washington	Yes	Residency can be proved through, but is not limited to, the following: owning a state ID being registered to vote owning property in the state	
Oregon Vermont	No	-	-

Sources: See reference list at the end of this report.

Consultation with Health Care Providers and Family

Jurisdictions differ in the degree to which assessors are obligated to consult with a patient's current or past medical providers and/or with the patient's family. Such consultations could provide important information about a patient's medical history and state of mind, but this safeguard is usually not required.

In many jurisdictions, the law simply requires the assessor to *encourage* the patient to inform their other care provider(s) of their assisted dying request. Belgium, New Zealand, and Spain are the exception here, requiring assessors to have contact with the previous or regular healthcare teams. In New Zealand, the consultation appears to be related more to ensuring that the request is free from external pressure than to gathering information about the patient's medical history per se.[48]

Most jurisdictions have no requirement to consult or even notify the patient's family. Some jurisdictions, such as the Australian states, do indicate that providers should take "reasonable steps" to inform a patient's family about clinical guidelines and processes for an assisted death, but only if the patient consents. Even this contact, however, is for the purpose of arranging the death, not for assessing eligibility. New Zealand has a slightly higher bar, in that the assessors must confer with family members "approved" by the patient.[49]

48 Government of New Zealand, *End of Life Choice Act 2019*, at §11(2)(h).

49 Government of New Zealand, *End of Life Choice Act 2019*, at §11(2)(h).

Some jurisdictions note that family contact can be useful for collecting information, but this contact is optional rather than required. For example, in cases in the Netherlands in which the assessor cannot communicate with the patient (due to loss of verbal faculties), the *Euthanasia Code* indicates that the physician "must provide an assessment based on all other available and relevant facts and circumstances. It can be useful to obtain further information from the physician and any family members of the patient or other healthcare professionals involved in the patient's care."[50]

Canadian federal law is silent on consulting with previous healthcare providers or families. Health Canada guidance indicates, however, that "forming an opinion about MAID eligibility may require the provider or assessor to undertake certain actions," including gathering "information known to the current or previous treating team and/or family members and/or significant contacts." Such contact requires consent of the patient, and if consent is denied, "then the assessors and providers must explain that without such information, the assessment cannot be completed and therefore the person cannot be found to be eligible."[51] However, given that the recommendation is not law, and given a general lack of comprehensive monitoring and compliance programs in Canada, we do not know the extent to which this recommendation is followed in practice.

Local Canadian authorities may introduce particular stipulations for their regions or institutions regarding collecting information on the patient's history from previous care providers or families.[52] This variation by locality can result in varied approaches to assessment. Likewise, individual assessors may have higher or lower standards for the information that they decide to collect and review. While some assessors may take a thorough approach, others may be less thorough, given that some MAiD provisions in Canada occur on the same day as or the day after the assessment.[53]

Quebec and Alberta have enshrined higher standards in law. Quebec requires the assessment of eligibility through, among other actions, "discussing the patient's request with any members of the care team who are in regular contact with the patient."[54] Alberta's recent legislation goes further, requiring the assessor to make reasonable efforts to review a patient's medical history and personal information, including contacting each primary healthcare provider who treated the patient in the twelve-month period preceding the request. Alberta does not require that family members be contacted during assessments but does require that they be notified at some point before the death, due to the new requirement that a family member be a witness to the *provision* of MAiD (so long as there is a family member available and willing).[55]

50 Regional Euthanasia Review Committees, Government of the Netherlands, *Euthanasia Code*, 22, 28–31.

51 Health Canada, "Model Practice Standard," 16.

52 Thomas et al., "Medical Assistance in Dying."

53 Troubling cases that were found within the practice of same day / next day assessments and provisions are also detailed in Ministry of the Solicitor General, Office of the Chief Coroner of Ontario, *MDRC Report 2024–4*.

54 Government of Quebec, *Act Respecting End-of-Life Care*, at §29(1)(d)(e).

55 Government of Alberta, Bill 18, *Safeguards for Last Resort Termination of Life Act*, at §§5(2), 4(1), (2)(e), (3), (4).

Table 6. Communication Requirements with Other Healthcare Providers and/or Family Members for Assisted Dying Assessment Process

Jurisdiction	Communication requirements for assessment process	
	Other healthcare providers	**Patients' families**
Austria	No requirement in the law.	No requirement in the law.
Australia		
Australian Capital Territory	Unclear. Assessors "may take . . . into account . . . any relevant information about the individual that has been prepared by another person who, in the opinion of the coordinating practitioner, has the appropriate skills and training to provide the information." In clinical guidelines, clinicians are instructed to inform the patient that the patient could inform other regular medical clinicians of their request.	No requirement in the law.
New South Wales South Australia Victoria Western Australia	The patient is encouraged to inform their other regular clinicians of their request. (In Western Australia, with consent, the assessor may engage with other healthcare team members of the patient.)	Not for assessment. If consented to by the patient, the clinician must take "reasonable steps" to communicate clinical guidelines and plans to a person nominated by the patient.
Queensland	The patient must be informed that they could consider informing other regular clinicians of their request.	Nothing specified in the law.
Tasmania	Not specifically required. The clinician who accepts the patient's request for assisted dying is directed to do "any one or more of the following" to determine the first and second requests of the patient, which can include—among other options—requesting records from other practitioners. If consented to, the clinician who accepted the first request can provide the usual care provider with information about the request.	If consented to by the patient, the clinician must provide information to the family, including the patient's plan for accessing assisted dying.
Belgium	Yes. Consult with "a healthcare team that maintains regular contact with the patient," if there is one.	Consult with relatives designated by the patient, if desired by the patient.

(*continued*)

Table 6. (*continued*)

Jurisdiction	Communication requirements for assessment process	
	Other healthcare providers	**Patients' families**
Canada		
Canada (federal laws)	Not required in the law, but government guidance indicates that assessing eligibility may include collecting information from current/previous treating teams.	Not required in the law but described in the Health Canada guidance as part of gathering collateral information needed for a MAiD assessment. However, it also specifies that disclosure of a request/ receipt of MAiD requires the patient's consent.
Alberta	Added requirement to make reasonable efforts to review a patient's medical history and personal information, including contacting all past primary health care providers (within the twelve-month period before the request for MAiD).	Not for the assessment process, but a family member must be a witness for the provision of MAiD (so long as there is a family member available and willing).
Quebec	Specifies that the clinician must determine the patient's eligibility by, among other things, discussions with the regular care team for the patient.	As part of the eligibility assessment, the clinician must, "if the patient so wishes, [discuss] the request with the patient's close relations or with any other person the patient identifies."
Luxembourg	Consult with "a healthcare team that maintains regular contact with the patient, unless the patient refuses."	Consult the trusted person designated by the patient, unless the patient refuses.
Netherlands	Other than considering the report from the consulting assessor, nothing is specified, except for advance requests where family consultation can be used to complete the assessment.	
New Zealand	In the request process, clinicians must "do their best to ensure that the person expresses their wish free from pressure from any other person," which includes conferring with the other regular healthcare practitioners of the patient.	As part of ensuring freedom from pressure, the act requires clinicians to confer with family members approved by the patient.
Spain	Consult with the healthcare team, "especially nursing professionals."	Only if the patient requests it.
United States		
California Colorado District of Columbia Delaware Hawaii Illinois	No requirement in the law.	Clinicians must suggest that the patient notify their family, but the patient can decide not to.

(*continued*)

Table 6. (*continued*)

Jurisdiction	Communication requirements for assessment process	
	Other healthcare providers	Patients' families
United States		
Maine New Jersey New York Oregon Washington	No requirement in the law.	Clinicians must suggest that the patient notify their family, but the patient can decide not to.
New Mexico Vermont	No requirement in the law.	No requirement in the law.
Uruguay	No requirement in the law.	No requirement in the law.

Sources: See reference list at the end of this report.

Conclusion

In this second part of the "International Comparison of Assisted Dying Regimes" series, we compared the request and assessment processes for assisted dying across jurisdictions where it is legal.

Canada's safeguards around requests and assessments place it somewhere between the approach of Australia, New Zealand, and the US states (more restrictive) and that of European jurisdictions (more permissive). Overall, coupled with the generally stricter eligibility criteria found in Australia, New Zealand, and the US (see the brief "An International Comparison of Assisted Dying Regimes: Part 1—Eligibility Criteria"), these jurisdictions provide examples of stricter safeguard criteria that Canada could learn from. Unfortunately, however, erosion has occurred over time in those jurisdictions. Some states in Australia and the US have enacted less strict legislation or amended legislation to loosen safeguards, a worrying trend.[56]

The province of Alberta, by contrast, is a unique example of tightening, rather than loosening, safeguards. Its 2026 legislation prohibits MAiD from being raised unsolicited to patients or advertised in healthcare facilities, and specifically requires more in-depth medical reviews and consultations with patients' past healthcare providers. Whether other Canadian provinces or international jurisdictions follow suit remains to be seen.

56 Jones, "Slippery Slopes Down Under"; Jones, *Wrong Side of the World*.

References

References are listed by jurisdiction, in alphabetical order, and broken out by sub-national jurisdiction when relevant. References that discuss more than one jurisdiction are placed in a final section, titled "Other."

Further references consulted for this series overall, but not used specifically in this report, can also be found in the reference section of part 1 of the series.

Australia

Jones, D. "Slippery Slopes Down Under: The Progressive Loosening of Requirements for Voluntary Assisted Dying in Australia and New Zealand." *New Bioethics* 31, no. 2–4 (2025): 86–107. https://doi.org/10.1080/20502877.2025.2593200.

Jones, D. *Wrong Side of the World: The Misplaced Reliance on Australia in the UK Debate on "Assisted Dying."* Augustine Bioethics Network, 2026. https://abnethics.org/wrong-side-of-the-world-the-misplaced-reliance-on-australia-in-the-uk-debate-on-assisted-dying/.ß

Okninski, M.E. "Voluntary Assisted Dying in Australia—Key Similarities and Points of Difference Concerning Eligibility Criteria in the Individual State Legislation." *Journal of Bioethical Inquiry* 20 (2023): 13–16. https://doi.org/10.1007/s11673-023-10228-9.

Waller, K., K. Del Villar, L. Willmott, and B.P. White. "Voluntary Assisted Dying in Australia: A Comparative and Critical Analysis of State Laws." *UNSW Law Journal* 46, no. 4 (2023): 1421–70. https://www.unswlawjournal.unsw.edu.au/article/voluntary-assisted-dying-in-australia-a-comparative-and-critical-analysis-of-state-laws.

Australian Capital Territory

Australian Capital Territory Government. *ACT Voluntary Assisted Dying Clinical Guidelines*. August 2025. https://www.act.gov.au/__data/assets/pdf_file/0011/2911565/Voluntary-assisted-dying-clinical-guidelines.pdf.

Australian Capital Territory Government. "Becoming an Authorised Voluntary Assisted Dying Practitioner in the ACT." n.d. https://www.act.gov.au/__data/assets/pdf_file/0011/2868788/Becoming-an-authorised-VAD-practitioner-information-pack.pdf.

Australian Capital Territory Government. *Voluntary Assisted Dying Act 2024*. A2024-24 (2024). https://www.legislation.act.gov.au/View/a/2024-24/current/html/2024-24.html.

New South Wales

New South Wales Ministry of Health. *NSW Voluntary Assisted Dying Clinical Practice Handbook Version 2.0*. November 28, 2023. https://www.health.nsw.gov.au:443/voluntary-assisted-dying/Pages/practitioner-handbook.aspx.

New South Wales Government. *Voluntary Assisted Dying Act 2022 No 17*. 2023. https://legislation.nsw.gov.au/view/html/inforce/current/act-2022-017.

Queensland

Queensland Government, Queensland Health. "Legal Obligations for All Medical Practitioners." Last updated May 12, 2023. https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/voluntary-assisted-dying/information-for-healthcare-workers/obligations-medical-practitioners.

Queensland Government, Queensland Health. *Queensland Voluntary Assisted Dying Handbook Version 2.0*. October 2022. https://www.health.qld.gov.au/__data/assets/pdf_file/0027/1166184/qvad-handbook.pdf.

Queensland Government, Queensland Health. "Voluntary Assisted Dying in Queensland: The Process." https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/voluntary-assisted-dying/explained/process.

Queensland. *Voluntary Assisted Dying Act 2021*. https://www.legislation.qld.gov.au/view/html/asmade/act-2021-017.

South Australia

Government of South Australia, SA Health. "Preparing for Your Voluntary Assisted Dying Death." https://www.sahealth.sa.gov.au/wps/wcm/connect/f6f00c6a-8995-420a-b8da-592d4f752ebf/Preparing+for+your+voluntary+assisted+dying+death+PDF.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-f6f00c6a-8995-420a-b8da-592d4f752ebf-oW2a.jU.

Government of South Australia, SA Health. *Voluntary Assisted Dying Clinical Guideline for Health Practitioners, Version 2.3*. Clinical guideline no. CG005, version 2.3, August 13, 2025. https://www.sahealth.sa.gov.au/wps/wcm/connect/e148edcb-134b-449d-8e57-9c3f7ad21eb2/Voluntary+Assisted+Dying+Clinical+Guideline+for+Health+Practitioners+v2.3_Aug+2025+meta.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-e148edcb-134b-449d-8e57-9c3f7ad21eb2-pHX.KgA.

Government of South Australia, SA Health. "Voluntary Assisted Dying in South Australia Explained." https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/services/community+and+specialised+services/voluntary+assisted+dying/explained/voluntary+assisted+dying+in+south+australia+explained.

Government of South Australia. *Voluntary Assisted Dying Act 2021*. https://www.legislation.sa.gov.au/lz?path=%2FC%2FA%2FVOLUNTARY%20ASSISTED%20DYING%20ACT%202021.

Tasmania

Tasmanian Government, Department of Health. "Information for Health Professionals." https://www.health.tas.gov.au/health-topics/voluntary-assisted-dying-1/information-health-professionals.

Tasmanian Government, Department of Health. *Voluntary Assisted Dying: Clinical Practice Handbook*. https://www.health.tas.gov.au/sites/default/files/2024-07/voluntary_assisted_dying_clinical_practice_handbook.pdf.

Tasmanian Government, Department of Health. "Voluntary Assisted Dying in Tasmania—Fact Sheet: Making a First Request." 2022. https://www.health.tas.gov.au/sites/default/files/2022-10/making_a_first_request_fact_sheet.pdf.

Tasmanian Government, Department of Health. "Voluntary Assisted Dying in Tasmania: How to Complete Form 1—First Request Form." 2022. https://www.health.tas.gov.au/sites/default/files/2022-11/Form%201%20-%20First%20Request%20-%20Instructions.pdf.

Tasmanian Government. *End-of-Life Choices (Voluntary Assisted Dying) Act 2021.* No. 1 of 2021. https://www.legislation.tas.gov.au/view/html/asmade/act-2021-001.

Victoria

Victoria State Government. *Voluntary Assisted Dying Act 2017*. 61/2017, Version 006. https://www.legislation.vic.gov.au/in-force/acts/voluntary-assisted-dying-act-2017/006.

Victoria State Government. *Voluntary Assisted Dying Amendment Act 2025*. 50/2025. https://www.legislation.vic.gov.au/as-made/acts/voluntary-assisted-dying-amendment-act-2025.

Western Australia

Government of Western Australia, Department of Health. *Western Australian Voluntary Assisted Dying Guidelines*. 2024. https://www.health.wa.gov.au/~/media/Corp/Documents/Health-for/Voluntary-assisted-dying/VAD-guidelines.pdf.

Government of Western Australia. *Voluntary Assisted Dying Act 2019*. https://classic.austlii.edu.au/au/legis/wa/consol_act/vada2019302/

Austria

Government of Austria. *Sterbeverfügungsgesetz* [Death Decree Act]. Law no. 20011782. 2022. https://ris.bka.gv.at/eli/bgbl/i/2021/242/P1/NOR40240919.

Government of Austria. *Sterbeverfügungsgesetz sowie Änderung des Suchtmittelgesetzes und des Strafgesetzbuches* [Law on the disposition of deaths and amendments to the Narcotics Act and the Criminal Code]. 2021. https://www.ris.bka.gv.at/Dokumente/BgblAuth/BGBLA_2021_I_242/BGBLA_2021_I_242.html.

Khakzadeh, L. "Assisted Suicide in Austria—the New Legal Framework." *BioLaw Journal* 9, no. 1 (2022): 135–43. https://teseo.unitn.it/biolaw/article/view/2242/2221.

Masel, E. "Perspective: Legal, Ethical, and Medical Perspectives of the Landscape of Assisted Suicide in Austria." *Wiener klinische Wochenschrift* 136 (2024): 380–81. https://doi.org/10.1007/s00508-024-02344-2.

Belgium

Government of Belgium, *Loi relative à l'euthanasie*, *2002*. https://www.ejustice.just.fgov.be/eli/loi/2002/05/28/2002009590/justel.

Government of Belgium, Santé publique. "Euthanasie en Belgique" [Euthanasia in Belgium]. https://web.archive.org/web/20260818091524/https://www.health.belgium.be/fr/themes/sante/votre-sante/euthanasie/euthanasie-belgique.

Raus, K., B. Vanderhaegen, and S. Sterckx. "Euthanasia in Belgium: Shortcomings of the Law and Its Application and of the Monitoring of Practice." *Journal of Medicine and Philosophy* 46, no. 1 (2021): 80–107. https://doi.org/10.1093/jmp/jhaa031.

Canada

Bill C-7, *An Act to Amend the Criminal Code (Medical Assistance in Dying)*. 2nd Sess, 43rd Parl. 2021. https://www.parl.ca/LegisInfo/en/bill/43-2/c-7.

Bill C-14, *An Act to Amend the Criminal Code and to Make Related Amendments to Other Acts (Medical Assistance in Dying)*. 1st Sess, 42nd Parl. 2016. https://www.parl.ca/LegisInfo/en/bill/42-1/C-14.

Canadian Press. "One of Canada's Most Prominent MAID Providers Reflects on Divisive Decade." *CTV News.ca*. June 17, 2026. https://www.ctvnews.ca/vancouver/article/one-of-canadas-most-prominent-maid-providers-reflects-on-divisive-decade/.

Close, E., M. Gupta, J. Downie, and B.P. White. "Medical Assistance in Dying in Canada: A Review of Regulatory Practice Standards and Guidance Documents for Physicians." *Palliative Care and Social Practice* 19 (2025): 1–24. https://doi.org/10.1177/26323524251338859.

Government of Canada. Consolidated Federal Laws of Canada, *Criminal Code*, R.S.C., 1985, c. C-46 (2024). https://laws-lois.justice.gc.ca/eng/acts/C-46/section-241.2.html?txthl=consent+final.

Grant, I. "Legislated Ableism: Bill C-7 and the Rapid Expansion of Medical Assistance in Dying in Canada." *McGill Journal of Law and Health* 15, no. 2 (2024): 259–335. https://commons.allard.ubc.ca/fac_pubs/739/.

Health Canada. "Advice to the Profession: Medical Assistance in Dying (MAID)." March 27, 2023. https://www.canada.ca/en/health-canada/services/publications/health-system-services/advice-profession-medical-assistance-dying.html.

Health Canada. "Medical Assistance in Dying: Overview." https://www.canada.ca/en/health-canada/services/health-services-benefits/medical-assistance-dying.html.

Health Canada. "Model Practice Standard for Medical Assistance in Dying (MAID)." March 27, 2023. https://www.canada.ca/en/health-canada/services/publications/health-system-services/model-practice-standard-medical-assistance-dying.html.

Lyon, C. "Canada's Medical Assistance in Dying System Can Enable Healthcare Serial Killing." *HEC Forum* 37 (2025): 65–105. https://doi.org/10.1007/s10730-024-09528-3.

Ministry of the Solicitor General, Office of the Chief Coroner for Ontario. *MDRC Report 2024 – 4: Complex Same Day / Next Day Provisions*. 2024.

Nicol, J., and M. Tiedemann. "Legislative Summary of Bill C-7: An Act to Amend the Criminal Code (Medical Assistance in Dying)." Publication no. 43-2-C7-E (2020; rev. April 2021). https://lop.parl.ca/sites/PublicWebsite/default/en_CA/ResearchPublications/LegislativeSummaries/432C7E.

Prasad, T., and A. Judd. "Ontario Family Calls for Changes After Their 26-Year-Old Son Received MAID in B.C." *Global News*, January 29, 2026. https://globalnews.ca/news/11644100/ontario-family-changes-son-maid-bc/.

Raikin, A. "No Other Options." *New Atlantis* (Winter 2023): 3–24; pub. online December 16, 2022. https://www.thenewatlantis.com/publications/no-other-options.

Thomas, R., B. Pesut, G. Puurveen, S. Thorne, C. Tishelman, and B. Leimbigler. "Medical Assistance in Dying: A Review of Canadian Health Authority Policy Documents." *Global Qualitative Nursing Research* 10 (2023): 1–13. https://doi.org/10.1177/23333936231167309.

Vachon, R. "Disability and MAiD: A Discussion Paper of Public Opinion Polling." Cardus, 2026. https://www.cardus.ca/research/disability-and-maid/.

Vachon, R. "Policy Brief: The Risks of Advance Requests for Medical Assistance in Dying (MAiD)." Cardus, 2024. https://www.cardus.ca/research/health/policy-brief/policy-brief-the-risks-of-advance-requests-for-medical-assistance-in-dying-maid/.

Vachon, R., and Beauregard, É. "An International Comparison of Assisted Dying Regimes: Part 1—Eligibility Criteria." Cardus, 2026. https://www.cardus.ca/research/health/research-brief/an-international-comparison-of-assisted-dying-regimes/.

Alberta

Government of Alberta. Bill 18. *Safeguards for Last Resort Termination of Life Act*. 2026. [Awaiting proclamation.] https://docs.assembly.ab.ca/LADDAR_files/docs/bills/bill/legislature_31/session_2/20251023_bill-018.pdf.

Government of Alberta. "Bill 18: Safeguards for Last Resort Termination of Life Act." https://www.assembly.ab.ca/assembly-business/bills/bill?billinfoid=12110&from=bills.

Quebec

Government of Quebec. "Aide médicale à mourir" [Medical aid in dying]. https://www.quebec.ca/sante/systeme-et-services-de-sante/soins-de-fin-de-vie/aide-medicale-a-mourir.

Government of Quebec. "Démarche pour faire une demande d'aide médicale à mourir" [How to apply for medical aid in dying]. https://www.quebec.ca/sante/systeme-et-services-de-sante/soins-de-fin-de-vie/aide-medicale-a-mourir/demarche.

Government of Quebec. S-32.0001, *Act Respecting End-of-Life Care*. https://www.legisquebec.gouv.qc.ca/en/document/cs/s-32.0001.

Luxembourg

Government of the Grand Duchy of Luxembourg. *Loi du 16 mars 2009 sur l'euthanasie et l'assistance au suicide* [Law of 16 March 20009 on euthanasia and assisted suicide]. A46, 4909. https://legilux.public.lu/eli/etat/leg/loi/2009/03/16/n2/jo#intituleAct.

Netherlands

Government of the Netherlands. "Is Euthanasia Legal in the Netherlands?" Onderwerp. Ministerie van Algemene Zaken, November 21, 2013. https://www.government.nl/topics/euthanasia/is-euthanasia-allowed.

Government of the Netherlands. *Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding* [Termination of life on request and assisted suicide assessment act]. https://wetten.overheid.nl/BWBR0012410/2012-10-10.

Regional Euthanasia Review Committees, Government of the Netherlands. *Euthanasia Code: Review Procedures in Practice*. January 2026 version. https://www.euthanasiecommissie.nl/documenten/2026/01/01/euthanasiecode. English-language relevant statutory provisions from the 2001 law are found in the Annex of the Code.

New Zealand

Government of New Zealand. *End of Life Choice Act 2019*. 2019 no. 67, November 16, 2019. https://www.legislation.govt.nz/act/public/2019/0067/latest/whole.html.

Ministry of Health New Zealand–Manatū Hauora. "Assisted Dying Regulation and Reporting." https://www.health.govt.nz/regulation-legislation/assisted-dying/regulation-and-reporting.

Ministry of Health New Zealand—Manatū Hauora. *Responding When a Person Raises Assisted Dying: A Handbook for Registered Health Professionals*. 2021. https://static.info.content.health.nz/docs/health-pros/topics/death-dying/assisted-dying/Responding-when-a-person-raises-assisted-dying-a-handbook-for-registered-health-professionals-PDF-533-KB.pdf.

Spain

Arimany-Manso, J., and C. Martin-Fumadó. "Medicolegal Aspects of Euthanasia Regulation Law in Spain." *Spanish Journal of Legal Medicine* 47, no. 3 (2021): 89–91. https://doi.org/10.1016/j.remle.2021.04.001.

Government of Spain. *Ley Orgánica 3/2021, de 24 de marzo, de regulación de la eutanasia*. https://www.boe.es/eli/es/lo/2021/03/24/3/con. English translation of the law available at https://wfrtds.org/wp-content/uploads/2021/03/Spain-law-EN.pdf.

Martínez-León, M., J. Feijoo Velaz, D. Queipo Burón, and C. Martínez-León. "Medico Legal Study of the Organic Law of the Regulation of Euthanasia in Spain Compared to the Rest of the Countries That Regulate Euthanasia and / or Assisted Suicide." *Spanish Journal of Legal Medicine* 48, no. 4 (2022): 166–74. https://doi.org/10.1016/j.remle.2022.01.006.

Velasco Sanz, T.R., P. Pinto Pastor, B. Moreno-Milán, L.F. Mower Hanlon, and B. Herreros. "Spanish Regulation of Euthanasia and Physician-Assisted Suicide." *Journal of Medical Ethics* 49, no. 1 (2023): 49–55. https://doi.org/10.1136/medethics-2021-107523.

United States of America

Dresser, R. "Residency Requirements for Medical Aid in Dying." *Hastings Center Report* 54, no. 3 (2024): 3–5. https://doi.org/10.1002/hast.1570.

Pope, T.M. "Medical Aid in Dying: Key Variations Among U.S. State Laws." *Journal of Health and Life Sciences Law* 14, no. 1 (2020): 25–60. http://dx.doi.org/10.2139/ssrn.3743855.

Pope, T.M. "Top Ten New and Needed Expansions of U.S. Medical Aid in Dying Laws." *American Journal of Bioethics* 23, no. 11 (2023): 89–91. https://doi.org/10.1080/15265161.2023.2256244.

California

Government of California. *Health and Safety Code*. Part 1.85: *End of Life Option Act [443–443.22]*. https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=HSC&division=1.&title=&part=1.85.&chapter=&article=.

Colorado

Colorado Revised Statutes. Title 25, Art. 48. *End-of-Life Options [25-48-101–25-48-124]*. 2016. https://law.justia.com/codes/colorado/title-25/health-care/article-48/.

Delaware

Delaware House Bill no. 140. An Act to Amend Title 16 of the Delaware Code Related to End of Life Options. 2025. https://legis.delaware.gov/json/BillDetail/GenerateHtmlDocument?legislationId=79026&legislationTypeId=1&docTypeId=2&legislationName=HB140.

District of Columbia

DC Health. "Death with Dignity: Physician Education Module." 2018. https://dchealth.dc.gov/sites/default/files/dc/sites/doh/page_content/attachments/Death%20with%20Dignity%20-%20Education%20Modules.Physician.DC%20HEALTH%20Version.03.02.18.pdf.

DC Law 21-182. *Death with Dignity Act of 2016*. 2016. https://code.dccouncil.gov/us/dc/council/laws/21-182.

Hawaii

Hawaii Revised Statutes, Chapter 327L. *Our Care, Our Choice Act*. https://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0327L/HRS_0327L-.htm.

Illinois

Illinois Compiled Statues. 410 ILCS 22. *End-of-Life Options for Terminally Ill Patients Act*. 2025. https://www.ilga.gov/Legislation/ILCS/Articles?ActID=4646&ChapterID=35&Chapter=PUBLIC%20HEALTH&MajorTopic=HEALTH%20AND%20SAFETY&Print=True.

Illinois Health and Hospital Association. Memorandum on "End-of-Life Options for Terminally Ill Patients Act." November 7, 2025. https://team-iha.org/getmedia/5431d5c4-ad7e-4a2c-b6fe-cca41ea21fb0/Memo-Aid-In-Dying-SB-1950-11-6-25.pdf.

Office of the Governor J.B. Pritzker. "Governor Pritzker Signs Bill Expanding End-of-Life Options for Terminally Ill Patients." State of Illinois Newsroom, December 12, 2025. https://gov-pritzker-newsroom.prezly.com/governor-pritzker-signs-bill-expanding-end-of-life-options-for-terminally-ill-patients.

Maine

Maine Legislature. LD 1313, HP 948. *An Act to Enact the Maine Death with Dignity Act*. 2019. https://legislature.maine.gov/legis/bills/bills_129th/chapters/PUBLIC271.asp.

New Jersey

New Jersey. P.L.2019, C.59, S. 1-20. *Medical Aid in Dying for the Terminally Ill Act*. 2019. https://www.njconsumeraffairs.gov/Statutes/Medical-Aid-in-Dying-for-the-Terminally-Ill-Act.pdf.

New Mexico

New Mexico Legislature. HB 47. *Elizabeth Whitefield End-of-Life Options Act*. 2021. https://www.nmlegis.gov/Sessions/21%20Regular/final/HB0047.pdf.

New York

New York State Senate. Senate Bill S138. *Medical Aid in Dying Act*. 2025. https://www.nysenate.gov/legislation/bills/2025/S138.

New York State Senate. Senate Bill S8835. *Relates to requirements for the provision of medication for medical aid in dying*. 2026. https://www.nysenate.gov/legislation/bills/2025/S8835.

Office of Governor Kathy Hochul. "Governor Hochul Signs Medical Aid in Dying Act into New York State Law." February 6, 2026. https://www.governor.ny.gov/news/governor-hochul-signs-medical-aid-dying-act-new-york-state-law.

Oregon

Oregon Health Authority. *Oregon Death with Dignity Act: 2023 Data Summary*. 2024. https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/ar-index.aspx.

Oregon Legislature. Revised Statutes, Chapter 127. *Oregon Death with Dignity Act*. 2025 [1997]. https://www.oregonlegislature.gov/bills_laws/ors/ors127.html.

Vermont

Vermont General Assembly. Statutes, Title 18, Chapter 113. *Patient Choice at End of Life Law*. 2013. https://legislature.vermont.gov/statutes/fullchapter/18/113.

Vermont Legislature. *No. 10. An act relating to removing the residency requirement from Vermont's patient choice at end of life laws*. (H. 190) 2023. https://legislature.vermont.gov/D_ocuments/2024/Docs/ACTS/ACT010/ACT010%20As%20Enacted.pdf.

Washington

Washington State Legislature. *Revised Code of Washington*, Chapter 70.245. *Washington Death with Dignity Act*. 2008. https://app.leg.wa.gov/rcw/default.aspx?cite=70.245&full=true.

Uruguay

Government of Uruguay. Ley No. 20431, *Ley de Muerte Digna; Eutanasia* [Law No. 20431. *Law on Dignified Death; Euthanasia*] October 24, 2025. https://www.impo.com.uy/bases/leyes/20431-2025.

Government of Uruguay. *Reglamentacion de la ley 20.431 (Ley de muerte digna; eutanasia) relativa al derecho de las personas a transcurrir dignamente el proceso de morir. [Regulations of law 20.431(Law on dignified death; euthanasia) relating to the rights of persons to go through the dying process with dignity).]* April 20, 2025. https://www.impo.com.uy/bases/decretos/76-2026.

Other

Bartsch, C., K. Landolt, A. Ristic, T. Reisch, and V. Ajdacic-Gross. "Assisted Suicide in Switzerland." *Deutsches Ärzteblatt International* 116, no. 33–34 (2019): 545–52. https://doi.org/10.3238/arztebl.2019.0545.

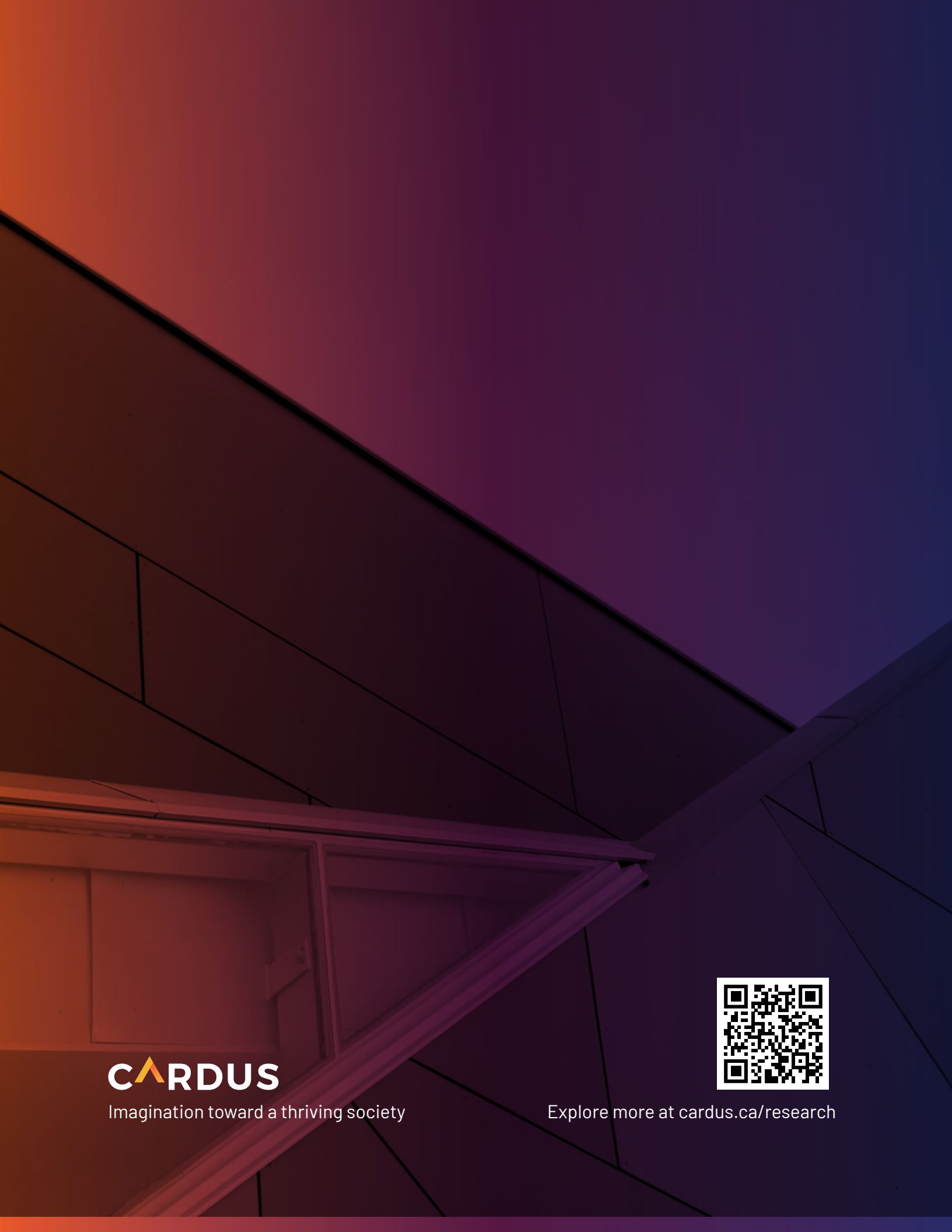
Gauthier, S., J. Mausbach, T. Reisch, and C. Bartsch. "Suicide Tourism: A Pilot Study on the Swiss Phenomenon." *Journal of Medical Ethics* 41, no. 8 (2015): 611–617. https://doi.org/10.1136/medethics-2014-102091.

McDougall, R., and B. Pratt, "Too Much Safety? Safeguards and Equal Access in the Context of Voluntary Assisted Dying Legislation." *BMC Medical Ethics* 21, no. 38 (2020): 1–10. https://doi.org/10.1186/s12910-020-00483-5.

Pullman, D. "Slowing the Slide Down the Slippery Slope of Medical Assistance in Dying: Mutual Learnings for Canada and the US." *American Journal of Bioethics* 23, no. 11 (2023): 64–72. https://doi.org/10.1080/15265161.2023.2201190.

Tolentino, R. "Strengthening Safeguards in the Assisted Dying Bill: A Comparative Review of Ethical, Legal, and Medical Considerations in End-of-Life Legislation." *Cureus* 17, no. 3 (2025): e80572. https://doi.org/10.7759/cureus.80572.

Willmott, L., B. White, D. Ko, J. Downar, and L. Deliens. "Restricting Conversations About Voluntary Assisted Dying: Implications for Clinical Practice." *BMJ Supportive & Palliative Care* 10, no. 1 (2020): 105–10. https://doi.org/10.1136/bmjspcare-2019-001887.



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