



Boudewijn Chabot MD PhD (1941) is a Dutch psychiatrist. Long before the Dutch euthanasia law of 2002, he assisted in the self-chosen death of a woman who had no physical illness. The Dutch Supreme Court passed judgement in 1994: “guilty without punishment”. Since then Chabot has devoted his professional life to non-doctor assisted dying that is self-chosen and dignified. His book *Taking Control of your Death by Stopping Eating and Drinking* is based on his nationwide research that has been published in *Social Science and Medicine*.

This book will stimulate communication between very ill or very old persons and their relatives and friends. It may give peace of mind to all involved in the difficult decision how to die with dignity. Thanks to this *Guide* any layperson can take control of such an intimate process as his own death. It provides detailed information on the medication method and the use of inert gases for a self-chosen and dignified death.

Though the Dutch legislation on physician-assisted dying is the most liberal in the world, it does not fulfill the wishes of those who strive for more autonomy in dying. Dr. Chabot’s position is that physician-assisted dying and dignified self-help routes to death are complementary approaches, rather than mutually exclusive alternatives. Only together can they provide an answer to the demand that a dignified, self-directed death be accessible for those who want it at a time of their choosing.

One obstacle to productive discussion among right-to-die experts is that there is no consensus on what most people regard as ‘dying well’. Dr. Chabot discusses shared opinions about ‘good’ or ‘bad’ death that have emerged from sociological studies in a wide variety of societies. This provides the empirical base for Chabot’s seven SESARID criteria that apply to what most people would consider an ideal autonomous method: dying asleep at home in one’s intimate circle rather than dying a lonely death for fear of risks to those present.

Chabot’s books and films can be ordered from  
[www.dignifieddying.com](http://www.dignifieddying.com)

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Boudewijn Chabot

Dignified Dying – A Guide

Death at Your Bidding

Boudewijn Chabot MD PhD

# Dignified Dying

## A Guide

## Death at Your Bidding

# Dignified Dying

## A Guide

This book is dedicated to:

PIETER ADMIRAAL (1929-2013)

Dutch anesthesiologist and right-to-die pioneer

Royal decoration: *Officer Oranje Nassau*

Janet Good Memorial Award from the Hemlock Society

Honorary member of Right-to-Die NL and

Deutsche Gemeinschaft für humanes Sterben

# Dignified Dying

a Guide

*Death at Your Bidding*

Boudewijn Chabot MD PhD

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#### Disclaimer

It is the author's conviction that information about how to achieve a self-chosen, humane death in the presence of one's loved ones should be available to people who have a well-considered and lasting wish to die. In this book, he provides this information based on his experience, on expert pharmacological and toxicological advice, and on reports from relatives who were present.

The author of this book does not in any way wish to encourage forms of suicide that are chosen by depressed people and that are impulsive, lonely and violent. Before undertaking a self-chosen death, someone near the end of life with a well-considered and persistent wish to die should receive professional therapy, palliative care, spiritual comfort if desired, and other help to make life bearable.

There are three methods to hasten death in a well-considered and responsible way: by medication, by helium gas and by voluntarily stopping eating and drinking. These are not suicide methods, but an exercise of the individual's right to die in connection with his or her loved ones. From this book, it will become clear that a humane, self-chosen death requires many time-consuming preparatory steps, which are not compatible with acting on impulse or in a violent way.

It remains the reader's responsibility to comply with all the laws of his or her country and/or state regarding the topics covered here and other end-of-life decisions. The author is not responsible for failure or any unfortunate outcome.



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## Foreword by Faye Girsh

Past president of the World Federation of Right to Die Societies.\*

### HELPFUL ADDITION TO THE END-OF-LIFE GENRE

As someone who's been in the right to die field for many years I still find it confusing about what to advise people about the best way to have a peaceful death when help from a doctor is unobtainable, as it is for most people around the world.

Chobot's new book I found to be a further clarification of the major methods with more scientific evidence, clarification of some of the more dubious methods that people talk about, and a clear description of what is needed. He explores what the criteria are for deciding on which method is workable and compares information from several sources.

Chobot presents an excellent analysis of the need for information for those who want a self-chosen, humane death (a good term he employs) outside the law when a doctor will not help or when the person wants to retain control. He looks into the future when the number of old people and patients with long-term chronic disease and impending dementia will engulf the medical profession with their needs to die peacefully.

Taking it out of the hands of already reluctant doctors and empowering individuals, families, and professional end-of-life counselors with this information is the wave of the future, as Derek Humphry did with his pioneering, *Final Exit*. Chobot's book, though quite accessible to the lay reader, offers more scientific data and embeds the information in an historical and somewhat philosophical context. That there is a flurry of these do-it-yourself guides indicates people's hunger for a choice of workable methods for self-empowerment. It is too bad that so many of these techniques still require underground, often illegal, access.

\* Five star review on Amazon, September 21, 2014 to the previous, second edition of this book.



## Foreword by Libby Wilson MD

Past convenor of the Scottish Friends At The End (FATE)\*

Chabot sets out clearly and compassionately those methods of ending one's life effectively and with the least possible distress. This book also has chapters on methods to be avoided because they are not always successful and can be associated with unpleasant side effects before death supervenes.

The use of drug overdosage and of inert gasses like helium or nitrogen are described in detail which can be understood by any reasonably intelligent adult.

Voluntary refusal of food and fluid is also a recommended possibility for the elderly or terminally people which Chabot described in *Taking Control of Your Death by Stopping Eating and Drinking*.

Chabot has the advantage of practicing in The Netherlands which is known for its liberal law on Physician Assisted Suicide, but there is still a demand for knowledge about methods which do not demand medical intervention. In countries like the UK where suicide is legal but 'assisting' is not, this book makes an important contribution which should be available to all those who wish to know how to end a life whose suffering has become intolerable.

\* Review to the previous, second edition of this book in FATE Newsletter August 20, 2014.

## Foreword by Gerrit Kimsma MD MPh

Dutch family physician and philosopher\*

How can you die a self-chosen, dignified death if you face unbearable suffering and, together with your loved ones, you can no longer see a way out? For over 20 years, Dr Chabot has been carrying out research into how people have actually been doing this in the Netherlands over the years, by stopping eating and drinking and by taking lethal drugs. To everyone's surprise, both methods are used much more often than had been thought.

What he discovered is special for two reasons. First, doctors frequently remain out of the picture in such cases, because the act takes place outside the medical domain; and second, because a great deal of consultation and coordination is needed in order to make this a positive experience together with family and friends, in spite of the grief and the other feelings surrounding a farewell. In many countries, including the Netherlands, criminal law constitutes a barrier by criminalizing the act of taking control over one's death in consultation with one's family.

Twelve years after the Dutch Act of 2002, it is clear that physician-assisted dying is failing to meet the desire within society to be able to take control of ending one's life. This book is a powerful plea for do-it-yourself methods to have a place alongside physician-assisted dying. These methods are of particular importance for chronic psychiatric patients, elderly people who wish to forestall their deterioration through Alzheimer's, and elderly people who consider their lives to be 'complete'. These are significant groups in society, and this book makes it very clear to them how they can achieve a dignified end, together with their loved-ones. This book may prove to be of support to them.

- \*— a past member (1998-2010) of the Review Committee where cases of physician-assisted dying are reported;
- a consultant since 1997 for doctors who plan to perform physician-assisted dying and trainer of other consultants;
- physician-philosopher at the Department of Bioethics, Radboud University Nijmegen.



## Preface

### *Two personal experiences*

My interest in methods for ending one's life surrounded by loved ones is rooted in two experiences, both of which drew me to the subject fifty years ago. The first was the death of my father, who had a heart condition and who had reached an impasse in his work and love relationship. Before giving me a chance to understand his wish to die, he let himself be taken by a heart attack. 'A quick death', was the cardiologist's verdict; but I knew that it was a hidden suicide. They never appear in the statistics, all those people who silently find a way to bring an end to their mortal suffering 'by accident'.

Second, when I was studying medicine, I was always fascinated by the question: 'Why do people resign themselves to the power of doctors? As a doctor, will I leave people in ignorance and continue to treat them with chemo- or radiation therapy? Even when I know death will probably come in one or two months and the quality of this last stretch of their life will be badly affected by the treatment?' I felt a growing desire to tell people that they had the option of refusing further treatment in order to protect their quality of life when the end was in sight, whether due to illness or to very old age.

A turning point in my life came in 1991 when, for the first and last time, I assisted a woman in a suicide with 9 gram of secobarbital and reported this to the police. This 50 year old woman who did not suffer from any somatic disease had lost her two sons under dramatic circumstances. The Dutch Supreme Court found me guilty without imposing any punishment.<sup>1\*</sup> The notorious Chabot case sparked a heated public debate. Some argued that I had been seduced to death while others concluded that this woman had suffered the slings and arrows of outrageous misfortune.<sup>2</sup> For this woman, living on without her sons would have meant the loss of integrity that is the hallmark of suffering.<sup>3</sup> Since then my life has become focused on researching non-doctor as-

\* From here on, note indicators in the text refer to the notes on p. 117

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sisted dignified dying by medication or by voluntary stopping eating and drinking in the Dutch population. The surprising results of this survey study were published in the professional literature.<sup>4</sup> Since then I have elaborated the findings into practical steps that are understandable and workable for laypersons in different countries.<sup>5</sup>

This guide to dignified dying is certainly not meant as a substitute for physician-assisted dying. However, even in tolerant societies like Belgium or The Netherlands doctors cannot fulfill all demands for a gentle death. The doctor-centered and autonomy-centered routes to a humane death should not be seen as mutually exclusive alternatives, but rather as complementary ones. Only together can they provide an answer to the demand that a gentle death in the presence of family or friends will become accessible for those individuals who consider this to be of the utmost importance.

*A grim subject?*

This book deals with what many consider to be a grim subject: preparing for your own death, or that of your loved ones. Talking about it, arranging how it will be done, and perhaps actually doing it: these remain awkward issues. However, there is a growing desire on the part of people nearing the end of their lives to take control of their own death. I am convinced this desire is pervasive.

In most countries the medical and legal professions have joined forces to make it almost impossible to die a gentle death at the time of one's choosing. Notable exceptions in Europe are Belgium, The Netherlands and Switzerland. In Canada the law passed in Quebec (2014) that allows for physician-assisted dying has drawn worldwide attention. In the United States there are famous exceptions starting with Oregon (1997) followed by a number of other Federal States where physician-assisted dying has become a lawful option. Recently their number is increasing almost every year.

However, in countries and states that still oppose physician-assisted dying in 'terminal patients', as they are often referred to, the dominant political view is that life is precious and should be cherished, not ended in a careless fashion. True as this may be, increasing numbers of citizens all around the world feel that the time of one's death is ultimately

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a private affair. Not only in the immediate circle of one's family and friends but also in relation to one's own spiritual beliefs.<sup>6</sup>

This topic may well remain controversial for decades to come. Therefore this book is not aimed at medical or other professionals, but at lay people who are interested in knowing which dignified options are available in end-of-life situations due to incurable disease causing unbearable physical and psychological suffering that cannot be eased under conditions they deem tolerable. My aim is to show people that as long as they make the necessary preparations well enough in advance, the instruments for choosing a gentle death will be theirs.

*What does this book add to existing publications?*

Three high-profile books have already discussed ways of choosing one's own death: *Final Exit* by Derek Humphry, *The Peaceful Pill Handbook* by Philip Nitschke & Fiona Stewart, and *Five Last Acts – The Exit Path* by Chris Docker. My book offers a different perspective on several points.

First, the empirical basis: I spent ten years undertaking a survey in the Dutch population to assess the frequency of “dying a gentle death” accompanied by relatives or friends. How do people manage to do it? Everyone knows it happens, but not how often it occurs. By now, two studies conducted in the Netherlands (population about 16 million) have demonstrated that every year there are at least 600 self-chosen deaths by stopping eating and drinking and 300 by medication attended by relatives.<sup>7</sup> No epidemiological data on these two methods for a dignified self-chosen death are available for any other country in the world.

Second, I had the good fortune to find two leading Dutch pharmacists Paul Lebbink (Pharm.D), Annemieke Horikx (Pharm.D), and biochemist-toxicologist Ed Pennings (Ph.D) willing to share their expertise with me in ongoing discussions. They fully endorsed my attempt to provide information on the options for the medication method with lethal doses. This allowed me to incorporate in chapters 2 and 3 their expertise on the appropriate combinations and dosages for a humane self-chosen death. Their contributions were also indispensable in analyzing attempts to find other autonomous methods (chapter 4).

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Third, I take a moral stand. It should be obvious that people who choose to die alone are fully entitled to do so and no one should moralize about their choice. It is equally obvious that very old or very ill persons should not be forced to die alone for fear of the legal consequences to those who are present. This last point has been insufficiently dealt with in right-to-die publications. In the last section of the introduction I will return to this sensitive topic: how can you pass away in your intimate circle while taking precautions that may appease the authorities after your death?



## P R E F A C E

**Textbox: changes in the third edition**

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*Dignified Dying – A Guide* ([www.dignifieddying.com](http://www.dignifieddying.com)) is a thoroughly revised and retitled third edition of *A Way to Die* that was published in September 2014 at the Chicago World Federation Congress of Right-to-Die Societies.

THE INTRODUCTION has been expanded to include recent jurisprudence of the *European Court of Human Rights*. The ECHR has stated that a fundamental right to privacy and a family life includes the right to decide when and how one chooses to die. From cases in Switzerland, Germany, The Netherlands and Ireland, lessons can be drawn that might protect relatives and close friends who have assisted in a self-chosen death.

CHAPTER 1 on basic information regarding lethal drugs has remained unchanged.

NUTECH MEETING SAN FRANCISCO, June 6-7 2015. Methods for a self-chosen death have been discussed by experts from around the world.

The insights I gained from them have been assimilated in this book.

CHAPTER 2 on the medication method discusses effective methods that have been witnessed many times. I have removed morphine, phenobarbital and tricyclic antidepressants from chapter 2 to chapter 4 because observational reports from different professionals are scarce.

CHAPTER 3 has been expanded to include nitrogen gas.

CHAPTER 4 has been expanded to include a discussion of other lethal gases and of mechanical and medication methods that are still lacking in observational reports by experts.

The previous edition had a concluding chapter 5 on physician-assisted dying in the Netherlands. Developments around self-chosen death in that country are ‘confusing’ to put it mildly. I have decided to drop this topic from the present edition and wait whether the fog will clear up when in 2016 the Dutch Supreme Court has passed judgment in the case of Abert Heringa.

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## Introduction

### Good or bad death in death-denying societies

#### *Is that how I want to end my life?*

As they get older, many people are troubled by visions of what it might be like to linger on for years, needing constant help, with their friends vanishing one by one, the future shrinking, and tiredness making every visit seem too long. What goes through your mind if you find yourself in a nursing home where even your bedtime is decided for you? What might it be like to suffer from all the woes of old age or a crippling disease and to feel your vitality ebbing away, facing the prospect of having to stay in bed 24/7? Is the overriding feeling then a fear of death, or a desire for death?

Elderly people sometimes wonder whether they might be able to die a gentle death. They think, ‘Will I really have to spend years being dependent on other people’s care before I’m allowed to die? Will I have to spend days waiting for a visit when I can’t read or watch TV? How can I take control of my own death?’

Many people feel strongly that they don’t want to end their lives in a nursing home. But neither do they want to put their loved ones through the ordeal of finding them dead by their own hand, in some violent or horrible way. Some manage to find their own path to what they consider to be a “good death”: passing away peacefully in their own bed, surrounded by those who are dear to them.

#### *Moving into the driver’s seat*

These days, one often hears people standing up for the right to die ‘with dignity’. These people may feel that they are masters of their destiny. They believe in self-determination and autonomy, and feel these values should apply to the end of life as well. Many countries have constitutions in which these fundamental values are enshrined. But when it comes to dying, societies seem to be divided about whether these values should be applied.

What autonomy means in practice is closely linked to prevailing

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ideas of what makes a 'good death'. One person might say a good death means living as long as possible, while for someone else, it might mean dying while you are still able to think clearly, or to live independently. Enormous differences of opinion exist between those who see a good death as something that happens at a time of your own choosing, and those who believe it means waiting until God calls you to Him. There are other areas of disagreement: can a 'good death' take place at home, or is it only possible in an institution? How much care might your loved ones be able to organize and pay for? Are dependency and suffering meaningful experiences.

Some paint a dark picture of the notion that elderly persons should be able to plan their own deaths, emphasizing that autonomy can be manipulated. They point out that what we define as a personal decision, a free choice, is partly determined by our shared beliefs regarding the purpose of life. Don't we have obligations to our children? Wouldn't accepting the notion of a humane self-chosen death disrupt the delicate social fabric of caring for each other?

Certain changes in society may well lead to more acceptance of the idea that there is a 'time to die'. Take the fact that we are increasingly tending to confine the elderly to nursing homes. In such homes, people lose their former social roles. What's more, institutional care is becoming more and more expensive, and not everyone has the resources to afford the best possible care. In such conditions, ending one's life might come to be considered a reasonable alternative to the prospect of a harrowing illness such as Lou-Gehrig disease or the oblivion of Alzheimer's.

Ever since the days of Socrates and Seneca, public figures have acted out their concept of a dignified death. However, the difference today – a situation that is unprecedented in the history of mankind – is that millions of elderly people are slowly dying in institutions when they are already socially "dead"; that is, no longer able to live an ordinary meaningful life. It is not uncommon for patients to be restrained or sedated for the benefit of the staff. Suppose someone who faces the prospect of having to be admitted to such an institution chooses to end his or her life in a dignified fashion. This might be called an autonomous, or even rational, decision. But is it really a free choice? In

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the end, it comes down to opting for death as the lesser of two undesirable choices.

Can someone, in a self-directed way and without the help of a doctor, die a good death if life is no longer tolerable for them? Because doctors hold the keys to the medicine cabinet, you are dependent upon them – unless you know the way out. Some very old people wish to choose the time of their death when they have had enough of life. Sometimes people with terminal illnesses – people who have by no means had enough of life – do not want to wait to die as a result of their illness. Many strive for an end that is in harmony with the life that they have lived. The question is often asked: how can I remain in control? After all, isn't the manner in which I die a part of my life? Perhaps the most important part for me and for my loved-ones, who will live on with the example that I want to give them, that it is possible to die a good death. The choice should be in your own hands. The *Economist* has put it this way: 'Although most Western governments no longer try to dictate how consenting adults have sex, the state still stands in the way of their choices about death. An increasing number of people — and this newspaper — believe that is wrong'.<sup>1</sup>

*Shared opinions about good or bad death*

Anthropologists and historians have studied notions of what constitutes a good death in a wide variety of Western and non-Western societies.<sup>2</sup> They concluded that ideas regarding what constitutes a good death appear to be virtually universal. Three characteristics emerge.

**A good death** means:

- dying at the end of a long life,
- at home and surrounded by those dear to you,
- from illness or old age, without violence as in suicides by hanging or by firearms.

**A bad death**, on the other hand, is one that takes place prematurely or violently. It also means dying alone or surrounded by strangers, as often happens in a hospital or in a nursing home.

These values seem to be anchored in the human condition. They help us to make a distinction between suicides that devastate family and friends and ways of ending one's own life that can lead to a good death, a self-directed, dignified death.

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*Which methods are available for a good death?*

For a good death it is important that at least one person from the intimate circle can be present at the self-chosen deathbed. It remains to be seen whether being present at the death scene is legally safe. This depends on the law of the country or US State and, to a large extent, also on its enforcement by the authorities. My focus in this book will be on two methods for a self-chosen death that are effective in at least 90% of cases and physically safe for those present:

1. combinations of drugs, the medication method for short (ch. 1 and 2)
2. inert gases, of which nitrogen is the rising star and helium the waning one (ch. 3).

**Textbox. A warning**


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From April 2015 onward some helium balloon tanks have been diluted with 20% air, which contains about 4-5% oxygen. The dilution must be indicated on the tanks. When a 80 / 20 mixture of helium and air is inhaled death will probably take hours to come or not at all. As long as there are still tanks around with pure helium gas, one can use them for a self-chosen humane death. Philip Nitschke (PPH handbook online edition) has claimed that nitrogen gas is equally effective as helium. For more information on nitrogen gas see chapter 3

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This book would be incomplete without a discussion of the many and varied other methods for a self-chosen death some of which have been around for some time: poisons and other gases. All are usually executed alone, in secret and unexpected to those who loved the deceased. In chapter 4 I will discuss which ones may be effective. The evidence reported by independent observers is scanty. No rate of successes versus failures for these methods is known. Some of them, like e.g. carbon monoxide, are still in an experimental phase as they are risky for those present.

My decision not to discuss these lonely suicide methods in detail is not based on a moral judgment. Anyone who wants to die alone and take the risk of failure has the right to proceed on his own. However,

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very old or very ill persons prefer not to die alone but in the presence of someone dear and want to be reassured that the method is effective in almost all cases. Only some drugs and some inert gases will suit them.

*Stopping eating and drinking*

Completely different from all the methods just mentioned is Voluntarily Stopping Eating and Drinking (VSED) under palliative care. This can be a dignified death but the practical, legal and ethical differences compared to the other two are such that I have chosen to discuss this method in a separate book. Let me mention here a few points the reader should know to decide whether he wants to learn more about this oldest of all methods to hasten death.

Only for very ill or very old people, voluntary refusal of food and fluids may be a peaceful and natural way of dying.<sup>3</sup> The aim is to hasten, under palliative supervision, a death that would have come eventually after months or years. A competent person who is seriously ill, or weak because of old age, and who deliberately refuses to drink (apart from some water for mouth care), will become sleepy within a week and die some days later. Palliative care can make it possible for all those concerned to say their goodbyes with all the intensity of emotion that they feel.

My book about voluntary stopping eating and drinking to hasten death (VSED)<sup>4</sup> explains how and why this need not be a gruesome way out. In the polarized public debate some advocates of physician-assisted dying discredit this self-directed route to death: 'The only legal option is to starve oneself to death – a hideous course that many people take in desperation'.<sup>5</sup> Apparently those commentators are still unaware of the research among hospice nurses in Oregon that showed that almost all of the patients they had cared for who had chosen this route had a dignified death.<sup>6</sup> It is not only for hospice patients that thirst can be made bearable. According to the KNMG (2015), even for the elderly at home, clinical experience has shown that with good oral care and easily obtainable prescription drugs, this can be a dignified way out.<sup>7</sup>

Some doctors are unwilling to supervise the process as they fear that providing palliative care might be considered in religious circles as

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assistance in suicide. However, palliation by e.g. giving mouth care and preventing bed sores are not considered assistance in suicide by the authorities. These skills can be learned by any compassionate spouse, child, friend or other caring person. Detailed information on VSED that is available in my book and online<sup>8</sup> should be studied beforehand.

In summary, during the process of VSED a compassionate doctor is helpful but not indispensable. A nurse trained in palliative care who teaches some skills to those who want to care for you is more important. Elderly and terminally ill persons who yearn for a hastened death can stop eating first and then drinking to hasten the death they accept is approaching. Thanks to palliative care dying by VSED has become less difficult than it has been for the elderly and terminally ill persons in the past who did not get meticulous mouth care. It is important to realize that you do not have to express your intention to hasten death in words, except to someone you can trust (see appendix 2).

*The right to privacy and a family life*

For most elderly and ill people the medication and inert gas methods I have just mentioned are within their reach provided they get some help in the preparatory phase from relatives or close friends. Why would anyone take that risk? Close relatives and friends are bound to the person with a strong wish to die by many emotional threads. A good death for someone very old or very ill means to die connected with the people that care about him or her. This includes their being able to let you go, if and only if you can convince them that this is what you really, truly want.

If very old or very ill persons don't want to die alone how can they pass away within their intimate circle and at the same time try to protect those present against legal proceedings? Of course, there will never be any guarantee against harsh treatment by the police and sleepless nights in jail. But with some precautions an encounter with the law will become less likely, as has become evident in recent jurisprudence of the European Court for Human Rights (ECHR).

This important change came about in 2011 when the ECHR acknowledged in the case of Mr. Haas vs. Switzerland that Article 8 of the European Constitution on the fundamental right to "privacy and



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a family life”, includes the right to decide when and how one chooses to die. Two years later the European Court acknowledged the special position of relatives in a case of suicide in Germany.<sup>9</sup>

In 2015, Albert Heringa has been acquitted by a higher court in the Netherlands from assisting in the suicide of his 99 year old mother whom he had given a lethal cocktail of chloroquine and valium.<sup>10</sup> Giving someone medication for a suicide is forbidden by Dutch penal law but the court took his special position as a son into account as well as his video of some steps in the process that ended in her death.

Another acquittal of assisted suicide in a case of progressive MS attracted public attention in Ireland (see Appendix 3).<sup>11</sup> When a friend tried to arrange a travel for this patient to the Dignitas clinic in Switzerland a travel agent alerted the police to the plan. Shortly thereafter the patient was found dead in a wheelchair having taken a lethal dose of barbiturates from Mexico. The friend who was not present at the death was acquitted of the charge of assisting in a suicide.

In view of these legal developments regarding citizens from several European countries – Switzerland, Germany, the Netherlands and Ireland I want to discuss which lessons can be drawn from these cases that may protect relatives and close friends in the near future who want to be present at the self-chosen death of either a very old or very ill person. I am aware that at first sight my suggestions for relatives who live under more repressive jurisdictions may well sound utopian.

*How to protect those present at your death*

Lawyer William Simmons has suggested improvements  
to the Introduction and Chapter 4 that I have accepted with gratitude.

Assisting in a self-chosen and humane death is considered a crime in most European and English-speaking countries and in others. Diverging interests exist between the person who wants to die in the presence of loved ones, and the interests of society in protecting vulnerable citizens from being encouraged to die. The authorities want to establish, and rightly so, that no one else has helped to perform the very last acts that cause death. To my knowledge this topic has not received the attention it deserves in right-to-die publications.

## INTRODUCTION TO GOOD OR BAD DEATH

Assistance in the last acts that cause death is known to occur among experts in cases of dying by the helium method or with the “plastic bag with sedatives” method. I do not condemn this kind of help under the difficult circumstances that often occur at the end of life. However, every society has a legitimate stake in the safety of the elderly and terminally ill that should be acknowledged and respected.

The recent court cases in Europe give a clue how the tensions might be lessened between the right of the individual to determine time, place and method of his death on the one hand and the obligation of society to protect vulnerable individuals from being encouraged to die on the other. My advice is far from complete but a first start is better than none.

The authorities usually want to have some evidence, first that relatives and friends have not encouraged a very old or very ill person to proceed with a self-chosen death. Second, they want to be pretty sure that the last acts that caused death were performed by the dying person, not by those in attendance.

Regarding the first precaution my advice is that relatives or close friends should provide evidence not only in writing but also on video that the person who wanted to die had seriously considered potential ways of making life more bearable. At least one such conversation about the reasons to proceed with the self-chosen death should be recorded on video or on a smart phone. This should be a real conversation, not a written statement read aloud. Such a recorded interaction will be more convincing for the authorities than a written statement. However, a written statement, such as in an advance health-care directive, can also be helpful, especially if repeated over a period of time.

In the preparatory phase, very old or very ill people need help from relatives or friends to obtain some of the medicines or some of the equipment for an inert gas method. However in some jurisdictions such purchases may be enough to bring a charge of assisting suicide. This is unfair as having pentobarbital in one’s bedside cabinet or inert gases in tanks does not cause death. With the medicine method, death is caused by drinking the liquid pentobarbital or by sprinkling the lethal powder in a cup of yogurt and eating it with a spoon. When

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using an inert gas it is the responsibility of the person who wants to die to turn the tap on the tanks and drawing the hood over their face. My second advice is that elderly or very ill people should do this themselves and that it should be recorded on video.

My hope is that elderly or terminally ill people will learn how they can take responsibility for their own death. They may be motivated to do this in time once they understand that by proving it on video they can protect their loved one's against legal proceedings.

In summary, to satisfy the authorities it is most essential that the dying person takes full responsibility for the acts that cause death. These can be recorded by video or smart phone. Together with the recorded conversations in the preparatory phase, this should be provided in the post-mortem as some evidence that no crime, particularly that of assisting suicide by pushing someone over the edge of the cliff, has been committed. This evidence may not be enough but it is a beginning that will be welcomed by impartial judges or by members of a jury.

I am aware that we have a long way to go to achieve a compromise between the conflicting interests of the individual and those of society. It will require the courage of conviction of many individuals in the face of possible prosecution before the authorities may come to understand and accept that a self-chosen death in the privacy of one's immediate circle is the fulfillment of a long-standing and deeply felt wish. The road of prosecution and harsh punishment is a dead end. It has driven self-chosen and self-performed dying assisted by relatives and friends underground. The Dutch authorities were surprised when my nationwide survey unearthed that a self-chosen death in the intimate circle occurred in a substantial number of deaths.<sup>12</sup> In other countries this has not been researched yet as has been done in the Netherlands. Most governments do not finance these nationwide survey studies. Perhaps, they do not like to find out what is going on in the twilight that surrounds dying at home.

## CHAPTER 1

**Lethal drugs: what one should know and do****1.1****Confusing information and legal precautions**

It is widely known that many suicide attempts fail. One reason for this is the confusing information in the literature on self-inflicted death. For instance, it is often thought that natural substances, such as poisonous plants, can be used in suicide. People cite the death of Socrates from an extract of hemlock (Lat. *Conium maculatum*). Indeed, Plato romanticized Socrates' death as a gentle death. In fact, the poison in hemlock brings on paralysis while the person is fully conscious, accompanied by diarrhea and sometimes even convulsions. Eventually the paralysis reaches the respiratory muscles, causing slow suffocation. Socrates died a slow death by suffocation.

This is by no means an exception. Attempts at hastening death by using natural poisons (from toadstools, snakes, spiders and others) may sometimes succeed, but will *always* be accompanied by excruciating pain or suffocation (see chapter 4).

The mass media are a source of confusion on humane and effective methods. Time and again, they report on the use of potentially lethal medicines, such as the insulin that was used by the physician Harold Shipman to kill elderly patients. Indeed, if the patient is in a frail condition, heavy doses of insulin can be lethal. Nevertheless, the toxicological literature provides evidence that even in extremely large doses, the lethal effect of insulin on healthy persons is uncertain.

Last but not least, medical specialists are a source of confusion. Information on lethal drugs is not part of their training. A death is considered dignified if one falls into a deep sleep first and only then, when unconscious, one dies from cardiac and/or respiratory arrest. Some doctors give authoritative advice what medication will cause death. They don't tell you that for some time you will be aware of very unpleasant symptoms like cardiac pain or suffocation.