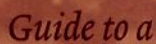

Guide to a

Humane Self-Chosen Death

WOZZ Foundation

Guide to a Humane Self-Chosen Death

WOZZ Foundation

This guide was made possible through the many reports from witnesses to successful and failed attempts at a humane self-chosen death. The authors thank those who have contributed to the knowledge in this book.

We hope to improve that knowledge with the help of others who will send us eyewitness reports of self-chosen deaths (see Appendix 2). If a carefully prepared self-chosen death by one of the methods discussed in this guide is unsuccessful, that report will be important for a revised edition of this guide, so that others can avoid mistakes.

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Guide to a

Humane Self-Chosen Death

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Contents

Warnings to the reader 6

1. Introduction 7
   - 1.1 What this guide is about 7
   - 1.2 About the authors 9
   - 1.3 For whom this guide is intended 11
   - 1.4 Why this guide fills a gap 13
   - 1.5 Summary of contents 14

2. Basic information concerning the lethal drugs discussed in Chapters 3-7 18
   - 2.1 Few drugs are both effective and humane 18
   - 2.2 The preparation phase: What to know and what to do 20
   - 2.3 The final phase: What to know and what to do 31
   - 2.4 Notes about collecting lethal drugs 35
   - 2.5 The report form: a strategy to increase knowledge 39
   - 2.6 Overview of Chapters 3-7 40

3. Barbiturates and glutethimide 41

4. Opiates 48

5. Chloroquine 55

6. Tricyclic antidepressants 60

7. Orphenadrine 63

8. Helium gas: a non-drug method 65

9. How doctors do it: physician-assisted suicide in Switzerland, the Netherlands and Oregon 74
9.1 Physician-assisted suicide by a lethal dose of barbiturates taken orally 75
9.2 Euthanasia by two consecutive injections 79

10. Well-known methods that are ineffective or dangerous to others 82
10.1 Plastic bag with sedatives method 82
10.2 Carbon monoxide 85
10.3 Debreather 87

11. Judicial risks for relatives and trained lay persons in five countries 88
11.1 Introduction 88
11.2 Canada 90
11.3 USA 92
11.4 Switzerland 94
11.5 Germany 95
11.6 The Netherlands 96
11.7 Conclusion 100

Literature References
Appendix 1: Addresses of organizations concerned with humane self-chosen death 103
Appendix 2: Report form for an eyewitness of a humane self-chosen death 106
Appendix 3: How to order this book 109

Literature on medicines 111

Drug Table: see fold out in back cover
Generic names and brand names of drugs in eleven countries 112

Warnings to the reader

The Board of the WOZZ and the authors of this guide do not in any way wish to encourage suicide. Someone with a wish to die should receive spiritual comfort, adequate palliative care, professional therapy or other help to make life bearable.

It is of the utmost importance that no person with an impulsive wish to die should have access to the information in this book. For this reason the WOZZ has decided not to publish this guide through a publishing house, bookstores, or on the Internet. It will sell this book exclusively to right to die societies in various countries. Right to die societies can develop their own policies for distribution of this guide, in a manner that is consistent with the practices and laws of their own countries.

It will become clear from this book that a humane self-chosen death requires many time-consuming preparatory steps, which are not compatible with acting on an impulse.

This book offers scientifically based information on how to achieve a humane self-chosen death. A Dutch edition was written in 2003 and has been sold only to physicians, pharmacists and professionals who have been trained to care for dying people. Severely ill people whose death may be a matter of weeks or months and who want to consider the option of a humane self-chosen death should be allowed access to the information in this book.

It remains the reader's responsibility to comply with all the laws regarding topics covered in this book. When someone is present at a humane self-chosen death to offer moral support, this person must not give instructions that may lead to death nor act to cause the ill person's death.

This edition has corrected and expanded on the Dutch edition. It is particularly important that one not deviate from the steps outlined in this book if one hopes to achieve a humane death. Even so, neither its authors nor the WOZZ Foundation can guarantee that death will be achieved.

CHAPTER 1

Introduction

1.1. What this guide is about

This guide presents the practical steps involved in a self-chosen death, realised without conscious suffering and caused by oneself. The standard phrase for this, 'dying with dignity', has acquired so many ideological overtones that we prefer the term 'humane self-chosen death'. The authors of this book consider a death *humane* when someone dies in the presence of others (relatives, friends or health care workers) without conscious experience of pain or serious discomfort. In most cultures dying in a circle of loved ones is regarded as a 'good death', while dying alone and dying in pain is considered to be a 'bad death'.

We consider a good death as *self-chosen* if a competent person prefers to die rather than to live on in irreparable physical and mental pain. This decision should be based on adequate information about possible viable alternatives for death (e.g. spiritual comfort, adequate palliative care or professional therapy). To avoid the mistakes of a shortsighted and preoccupied mind, that decision needs to be discussed with a loved one and with a compassionate professional.

We consider a humane death as *self-executed* if the series of acts that together cause death are all performed by the person himself. Unfortunately, at present no reliable, precise and comprehensive information is available on how to do just that.

No one should be forced to an aggressive suicide by violent means because of a lack of adequate information on humane methods to end one's life. This is one of the reasons we provide detailed information, which is impossible to find in medical or pharmacological textbooks.

Only methods that facilitate a humane death are discussed in this guide. These methods share six characteristics:

1. At first they induce a phase of deep sleep or coma.
2. After some time, death occurs while unconscious through cardiac or respiratory arrest.
3. All life-terminating acts can be executed by the person himself without substantial help by other persons. In case of terminal or crippling illnesses or in case of frailty by old age some help in the preparatory phase may well be of importance (see below).
4. Death occurs in a non-violent way, there is no mutilation of the body.

5. Relatives and friends can be present without any risk for their health.
6. If all precautions are met these methods result almost always in death.

8 These six characteristics of a humane self-chosen death should make it clear why many life-terminating methods are *not* discussed in this book. We do not want to give information on:

1. Methods that necessitate the active assistance of someone else in causing death (for example by putting a plastic bag over someone's head).
2. Methods that cause physical danger to those present (e.g. inhalation of carbon monoxide).
3. Methods that cause pain or choking *before* losing one's consciousness (as is the case with poisons from plants, with cyanide or some drugs).
4. Methods that mutilate the body (e.g hanging and other methods that compress the carotid arteries in the neck).
5. Methods that have a high failure rate even when all precautions are met (e.g. the plastic bag method, see Chapter 10).

We fully realise that the methods discussed in this book are not sufficient for a good death. That involves other important aspects such as being at peace with one's loved ones. Neither are the methods discussed here necessary for a good death, which, after all, usually comes without any express intervention. But for some people under certain unfortunate conditions in which death will arrive soon anyway, the methods discussed in this book provide just that piece of information that brings a humane self-chosen death within reach. For those individuals this book has been written.

In case of terminal or crippling illnesses some help in *the preparatory phase* may well be of importance. For instance, help by a compassionate physician who is prepared to prescribe some medicines step by step, in order to make a humane death possible in the near future. In other cases relatives or friends may have to provide some assistance in the preparatory phase by buying medicines abroad or by doing some practical plumber's work required by the helium method. However, the authors of this book cannot emphasize strongly enough that in *the final phase* of a self-chosen death, the series of acts that together induce a

humane death should all be performed by the individual himself.

To this fundamental rule there is one exeption: if an illness is so debilitating that the final phase cannot be executed without help (e.g. in case of Lou Gehrig disease), we feel that assistance by a compassionate doctor is indispensable in the final phase as well. Therefore, in Chapter 9 we include the technicalities of a self-chosen death with the assistance by a physician in those countries where under strict conditionsthat assistance is permitted within the limits of the law: Switzerland, the Netherlands, Oregon and Belgium. In Switzerland, members of Swiss right to die organisations who are trained in providing assistance in dying play a very important role which remains completely within Swiss penal law (see Chapter 11).

Nevertheless, this book is focused on methods that – in the final phase – can be executed by the person who wants to die. As far as someone is physically able to take responsibility for the series of final acts that lead to a self-chosen death, he or she should take that responsibility and not leave it to others.

1.2. About the authors

In 2000, a group of researchers in the Netherlands brought their specialist knowledge together in the foundation for Research into a Humane Self-chosen Death, RHSD in English and WOZZ in Dutch. We use the Dutch abbreviation in this book which is easier to remember.[1]

The central aim of the WOZZ is:
The promotion of scientific research into a humane self-chosen death, planned and carried out in a careful manner by the individual without substantial help from others.

Information on effective methods for a humane and self-chosen death is at present scattered over professionals from widely different specialties. The WOZZ has joined forces between those specialties as can be seen below from the list of five authors with different expertise.

---

1. In Dutch WOZZ stands for Wetenschappelijk (= Scientific) Onderzoek (Research) naar (into) Zorgvuldige (carefully executed, Humane) Zelfdoding (Self-chosen Death).

In 2001, WOZZ established a research committee with this task:
Draw up a concise overview of drugs suitable for humane self-chosen death and describe the necessary steps to ensure a humane death with these drugs. This information must be scientifically based and make full use of the present state of toxicological and pharmaceutical knowledge. This information is primarily intended (1) for physicians and (2) for professional helpers or volunteers of right to die societies who are consulted by people wishing to end their lives in a humane and careful way.

This resulted in the publication of a book in Dutch on humane methods to end one's life in a dignified way.[2] That Dutch guide was sold exclusively to physicians, pharmacists, staff members and volunteers of Dutch right to die organisations, and to researchers in the field of humane self-chosen death including ethicists and lawyers. It was not sold to lay people.

Soon the WOZZ received requests from professionals in other countries to share that information with them. Therefore in 2004 the WOZZ established a research committee for an expanded English edition based on the Dutch Guide. The research committee gathered expert knowledge from five specialties:

Pieter V. Admiraal M.D., Ph.D retired anesthesiologist and member of the Committee for Euthanatics of the Royal Dutch Pharmaceutical Society.
Boudewijn E. Chabot M.D., psychiatrist and researcher in medical sociology.
Russel D. Ogden, criminologist and researcher in new technology in self-deliverance.
Aad Rietveld Ph.D (a pen-name), biochemist and medical toxicologist.
Jan Glerum Ph.D, retired professor of clinical pharmacy and hospital pharmacist.

We also received technical advice from two professors in hospital pharmacy who critically reviewed and improved chapters 2-7. Last but not least the writers received suggestions for improvement from the Advisory Board of the WOZZ (for their names and professions see below).

In each Chapter reported cases will be discussed which confirm the efficacy of the method in causing a humane death.

---

2. Title: *Informatie(=information) over (on) Humane Zelfdoding (Humane Self-chosen death)*, WOZZ Foundation, Delft 2003

1.3. For whom this guide is intended

The Board of the WOZZ and the authors of this guide do not in any way wish to encourage suicide. Moreover, it is considered to be of the utmost importance that no person with an impulsive wish to die should have access to the information in this book. Someone with a wish to die should receive spiritual comfort, adequate palliative care, professional therapy, or other ways to make life bearable. Improved quality of life can be facilitated by a physician or by trained health care professionals. Unfortunately, this is not always possible.

WOZZ cannot effectively establish whether this guide is ordered by someone with an impulsive wish to die who should not have access to this information. Therefore, WOZZ has decided not to publish this guide through a publishing house, bookstores, or on the Internet. It will sell this book exclusively to associations of physicians or pharmacists and to to right-to-die societies in various countries. These societies and associations can develop their own policies for distribution of this guide, in a manner that is consistent with the practices and laws of their own countries. The Board of the WOZZ and the authors are of the opinion that this guide should preferably be sold to physicians, pharmacists and professionals who have been trained to guide dying people (ministers, psychologists, nurses, social workers and others). Ethicists, *lawyers and researchers in the field of a humane self-chosen death are* included in the intended circle of readers.

Moreover, severely ill people whose death may be a matter of weeks or months away and who want to consider the option of a humane self-chosen death should be allowed access to the information in this book. Especially so, if no physician or trained helper is in a position to offer information on how to achieve a humane self-chosen death. These professionals are not always available or sometimes prefer not to become involved. Therefore this guide is written in plain English that can be understood by someone who has rationally decided to end his or her life in a humane way and who is in need of reliable and detailed information on how to realise that goal.

It remains the reader's responsibility to comply with all the laws regarding topics covered in this book.

It is unfortunate that all over the world physicians and other health care professionals lack the expertise to advise on how to realise a humane self-chosen death by the person himself without assistance by a doctor. Nowhere is this taught in the medical curriculum.

The central motive for the publication of this guide is to enable both medical and other professionals who have been trained to guide dying people, to give well-informed advice to individuals with a persistent and rational wish to die. Psychologically or spiritually trained professionals may sometimes also need the down to earth information in this guide to comfort dying individuals who want to prepare themselves for a self-chosen death. Readers do not need a medical background to understand the content of this book.

In many countries physicians and lay people are not allowed to directly assist in a humane self-chosen death. Nevertheless, a physician or a health care professional may well be prepared to help someone to understand the practical how-to-do-it advice that is detailed in this book. Providing information is quite different from direct assistance in hastening death, both emotionally and from a judicial point of view.

In case health care professionals don't want to give that information, right to die societies can either distribute this information through their own volunteers (we would prefer trained helpers), or sell this book directly to those individuals each society considers eligible to receive this information. It will become clear from this book that a humane self-chosen death requires many time-consuming preparatory steps, which are not compatible with acting on an impulse.

The Board of the WOZZ and the authors realize that the contents of this guide will sooner or later become more widely known. Given the difficult legal position of many doctors to assist in a humane self-chosen death, it is to be expected that a number of gravely ill patients will want to find out for themselves what to do in order to achieve a good and humane death. Society will have to learn to cope with ever more precise and more effective information for lay people on this topic. Every nation will have to find its own way through this process of cultural change around death and dying.

1.4. Why this guide fills a gap

This guide fills a gap because it provides evidence-based information about methods of self-chosen death with a high success rate when all the steps in Chapters 2-8 are followed.

The first guides were published in 1980 in the Netherlands and Scotland: Dr. Admiraal's *Responsible Euthanasia. A guide for doctors* (in Dutch) and Dr. Mair's *How to Die with Dignity*. Since then, several other books have attempted to describe how to humanely end one's life without the help of a doctor. Well-known books include Derek Humphry's (1991) *Final Exit* (USA), Docker and Smith's (1993) *Departing Drugs* (Scotland), *De milde dood* (The Gentle Death) by the Belgian chemist Verzele (1994) and Last Rights Publications' (1998/2000) *The Art & Science of Suicide* (Canada).

After a detailed analysis of these books by specialists in the field of clinical pharmacy and clinical toxicology we have concluded that, with the exception of Dr. Admiraal's book, the information they offer falls short with regard to toxicology and pharmacology. We were lucky to have expert knowledge on these topics in our group. The books that have been published so far are imprecise in their discussion of the steps how to realise a humane death. In particular they have paid insufficient attention to the essential facilitating role of benzodiazepines (a group of sedative drugs that are not deadly in themselves, see Chapter 2). Most important, these sources of information all lack a critical appraisal of reliable eyewitness reports on both successful and failed attempts at a humane self chosen death. These areas of weakness can result in a failed planned death or possibly in an unnecessarily difficult and even painful death.[3]

The Internet also provides information but with even greater shortcomings. Numerous substances are known to be potentially lethal for humans, but by no means is the advised dose always successful and humane. A carefully planned and humane death requires a high degree of certainty that death will take place in a state of deep sleep and without endangering those loved ones who are present.

3. Stephen Jamison comments on 'how-to-books' such as Final Exit: "It is obvious that the public still lacks accurate knowledge of what works and what doesn't." Unfortunately, ten years later this observation is still essentially correct. See Jamison S. (1996). When Drugs Fail: Assisted Deaths and Not-So-Lethal drugs. In: Battin, M. P. & Lipman, A. G. (eds). *Drug use in Assisted Suicide and Euthanasia* (pp. 223-243). New York: The Pharmaceutical Products Press.

In North America, a method of humane self-chosen death has recently been developed which, rather than using medicinal drugs, uses helium. The helium method leads to a quick death with no pain or discomfort. Chapter 8 describes this method in detail and gives empirical data based on eyewitness reports.

With some drugs the number of cases that have been reported to the authors by eyewitnesses is quite small. These drugs have only been included in this guide because there is independent toxicological evidence on their efficacy, when used in the suggested dose with all the precautions met.

1.5 Summary of contents

Chapter 2 is not about a specific method but explains the many conditions that have to be met for medicines to cause a humane self-chosen death. The reader will find here the background knowledge he needs, from simple aspects such as the relation between body weight and drug dose to complex aspects like drug tolerance. To help the reader a detailed index of content comes with Chapter 2 as well as a summary of the most important steps in both the preparatory and the final phase.

Chapters 3 and 4 (on barbiturates and opiates) discuss drugs that are known as narcotics, and which are listed as controlled substances. Barbiturates and opiates are difficult to obtain for most people. Nevertheless they must be discussed, because many right to die organisations concerned with self-chosen death have most of their experience with these two families of drugs. Many doctors all over the world are willing to prescribe them in small quantities for a competent adult in the terminal stage of cancer who has a persistent and rational wish to die.

In Chapter 5, 6 and 7 (on chloroquine, some antidepressants and orphenadrine), drugs are discussed that are not controlled substances. They are not difficult to collect. Chloroquine can be obtained without a prescription in many countries. Although antidepressants require a prescription, it is usually not very difficult to obtain them if one presents the proper complaints over a period of time.

At present, there are not yet many well-documented experiences of planned deaths using the drugs mentioned in these Chapters. The research committee concludes on the basis of the toxicological litera-

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ture that ending one's life with these medicines is effective, provided all the precautions discussed in Chapter 2 are followed. The few well-documented cases known to the authors confirm this.

Chapter 8 describes in detail how inhaling helium gas is a non-drug method that leads to a humane death. Over the past few years this method has been increasingly used in North America with consistent results. There are several preparatory steps in assembly of the helium gas and balloon bag system, which may at first seem complex. Nevertheless for anyone with basic technical household skills, the preparation of an effective helium system is not difficult at all.

Chapter 9 is about physician-assisted dying using oral and intravenous routes. Some illnesses are so debilitating that the final phase of a self-chosen death cannot be executed without help from others. A brave and compassionate physician can offer assistance with relative ease, whereas health care workers or loved ones would encounter considerable technical difficulties. We rely heavily here on experiences in Switzerland, the Netherlands and Oregon.

Chapter 10 discusses some methods that we do not advise in this guide because reports by credible eyewitnesses have established beyond doubt that these techniques are either not usually effective or bring serious risks to those present or need assistance by someone else to cause death. For instance the combined use of the plastic bag and sleeping pills has a substantial rate of failure which has never before been discussed broadly. Our Chapter aims to dispel several myths about supposedly effective methods that in practice can do harm to the person with a death wish or to relatives and friends who are present.

Chapter 11 addresses the legal risks for relatives, friends and volunteers of right to die societies who are present at a humane self-chosen death. Attendance at a self-chosen death places one at serious risk of being subjected to police investigation and perhaps prosecution. This Chapter offers suggestions of how one can reduce this risk and stay within the boundaries of the law. This Chapter provides information drawn from Canada, the USA, Switzerland, Germany and the Netherlands.

Although the information in this guide has been checked by various experts, improvements will be possible with wider sharing of knowl-

edge and experience. No guarantee for a 100% certain death can ever be given. The wozz welcomes information from toxicologists and pharmacologists, and from individuals who have witnessed a humane self-chosen death. Improved knowledge in this area must overcome the secrecy of the past. Therefore we include a report form in Appendix 2 which can be completed and anonymously sent to the address given in the Appendix. Reporting may well increase our knowledge on humane self-chosen death and might result in a revised edition of this book.

Delft, the Netherlands, June 2006

The Board of the wozz consists of:

Pieter Admiraal M. D., Chairman, retired anaesthesiologist, member of the committee for euthanatics of the Royal Dutch Pharmaceutical Society
Jaap Brienen M. D., secretary, general practitioner
Jan Huls, M. D., treasurer, general practitoner
Boudewijn E. Chabot M. D., psychiatrist and researcher in medical sociology.

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Contents of Chapter 2

The information in this Chapter is comprehensive. A table of contents is provided so that particular subjects can be easily located. To ensure clarity, summaries are provided for the preparation phase (2.2.10) and for the final phase (2.3.3).

2.1 Few drugs are both effective and humane 18

2.2 The preparation phase: what to know and what to do 20
2.2.1 Generic names and trade names of drugs 20
2.2.2 Drug storage life 21
2.2.3 Body weight and drug dose 21
2.2.4 Discussions about the intention to end one's life 21
2.2.5 Refusal of life-saving treatment 22
2.2.6 Drug tolerance and withdrawal 23
2.2.7 Benzodiazepines: the need to combine them with most lethal drugs 25
2.2.8 Anti-emetics to prevent nausea and vomiting 27
2.2.9 Alcohol: drink in moderation 29
2.2.10 The preparation phase: a summary 30

2.3 The final phase: what to know and what to do 31
2.3.1 The final phase: how to take the drugs 31
2.3.2 The final phase: position to adopt when taking the drugs 32
2.3.3 The final phase: a summary 33

2.4 Notes about collecting lethal drugs 35
2.4.1 Collecting drugs: what courses have been followed? 35
2.4.2 Legal collection of lethal drugs 36
2.4.3 Collecting drugs through the Internet 37
2.4.4 Customs controls and importing from other countries 38

2.5 The report form: A strategy to increase knowledge 39

2.6 Overview of Chapters 3 to 7 40

Warning to the reader
This book has been put together with the greatest possible care. Even so, neither its authors nor the WOZZ Foundation can guarantee that death will be achieved. It is particularly important that one not deviate from the instructions given in this book if one hopes to achieve a humane death.

CHAPTER 2

Basic information concerning the lethal drugs discussed in Chapters 3-7

2.1. Few drugs are both effective and humane

It is essential that the greatest of care be taken in the preparation and carrying out of a humane hastened death. All steps must be followed diligently. This applies to collecting of the right combinations of drugs, preparing the stomach with proper anti-emetics, taking the drugs properly, and ensuring that life-saving interventions do not take place. A chain is only as strong as its weakest link and the humane ending of one's life will have the greatest chance of success if every link is prepared with equal care. Impulsive acts and deviations from the recommended steps will often lead to the failure of a humane planned death.

Deviation from the advice given in this guide is strongly discouraged.
We have documented cases in which a doctor advised changes to the combinations of drugs recommended here, which resulted in failures to end life, or unpleasant and inhumane deaths. One instance is described below.

An illustration of how not to do it
A 75-year-old woman suffered from a disabling, non-terminal illness. She repeatedly asked her personal doctor for help in ending her life. The doctor was unwilling to give her direct assistance. The woman decided, in consultation with her doctor, that she would collect the lethal drugs described in Chapter 4 of this guide: dextropropoxyphene (an opiate) in combination with the sleep-inducing drugs flurazepam and oxazepam. The doctor discussed this combination with an internist friend. The internist strongly opposed the use of dextropropoxyphene because 'an overdose can lead to epileptic attacks', so he said. Instead of dextropropoxyphene he advised a calcium-antagonist, which is a medicine that slows down the stimulus conduction in the heart muscle. The internist believed that an overdose would lead to death by cardiac arrest. The woman and her daughter accepted this firm advice from a medical specialist. The elderly woman used the drug he recommended and twelve hours later she was still awake and showed no signs of being close to death. The attempt to end her life failed.

Analysis of this case

1. A high dose of a calcium antagonist may sometimes cause death by cardiac arrest. But by no means is even a very high dose of these medicines always lethal. There is a substantial chance of surviving the attempt. The internist's firm advice was based on an isolated experience and lacked an informed toxicological basis.
2. It is correct that heavy doses of dextropropoxyphene can induce an epileptic attack. But an epileptic attack is suppressed by a high dose of benzodiazepines taken simultaneously as is advised time and again in this guide. Even if an attack were to occur, the patient would be in such a deep coma that he or she would notice nothing though it is true that it can be upsetting for those present to witness an epileptic seizure.

There is 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. The death of Socrates from an extract of hemlock (Lat. Conium maculatum) was romanticized by Plato as a mild form of death. In fact, the poison in hemlock brings on paralysis while fully conscious, accompanied with diarrhea and (sometimes) convulsions. Eventually the paralysis reaches the respiratory muscles, causing a slow suffocation, a cruel death.

From the toxicological literature it appears that attempts at hastening death using natural poisons sometimes succeed but always with very unpleasant symptoms. More often they are ineffective and involve pain. Research into these naturally occurring poisons continues but despite great efforts there are no usable results for a humane self-chosen death.

The mass media are a third source of muddled thinking on humane and effective methods. Time and again they report on potentially lethal medicines such as insulin. Indeed, for elderly people in a frail condition heavy doses of insulin can be lethal. Nevertheless, we find in the toxicological literature evidence that even in extremely heavy doses the lethal effect of insulin on healthy persons is uncertain.

The research committee that wrote this book in a collaborative effort has unanimously decided not to include doubtful methods in this guide. Chapters 3 to 8 discuss only methods known to offer a very high probability of death without pain or serious discomfort, provided all the instructions are followed. Moreover, these methods cause no physical danger for relatives and friends present. The judicial risks for

those present vary from country to country and are discussed in a separate Chapter (Chapter 11).

With some lethal drugs there is an interval of more than 12 hours, sometimes even more than 24 hours, before death occurs. Given the scarcity of effective and humane lethal medicines, we decided to include drugs like phenobarbital (Chapter 3) or fentanyl (Chapter 4) though we are aware that it may take a long time for death to occur. The many hours of waiting can be difficult for those present.

Our first priority is that the person carrying out the planned death should be spared serious discomfort by the effects of the lethal drugs taken. This goal is attained by way of a deep sleep within an hour, sometimes even within minutes when it is induced by benzodiazepines. This phase of deep sleep or coma sooner or later merges into death. It is recommended that any persons who are present should be guided by an experienced person who can explain any unexpected events that may take place and reassure them in case death takes more than 24 hours.

2.2. The preparation phase: what to know and what to do

2.2.1. Generic names and trade or brand names of drugs

Every medicine has a generic name and often several trade or brand names. Because brand names vary from country to country, this guide exclusively uses the generic name for each drug. The reader can easily find the trade names of the medicines discussed in this book by searching the alphabetical Drug Table that is given as a fold out in the back cover.

In this alphabetical Drug Table of the *generic names* the reader will find *all the trade or brand names* in 11 countries: USA, Canada, Australia, New Zealand, UK, Germany, France, Italy, Spain, the Netherlands and Belgium. In other countries the reader has to search for the brand name, e.g. by asking his doctor or a pharmacist.

Most of the medicines mentioned in this guide are available only on prescription.

In this book we refer to 'lethal drugs' sometimes as 'lethal medicines' or alternatively to 'drugs' or 'medicines' for short.

2.2.2. Drug storage life

Pharmaceutical manufacturers always provide information on the package which specifies the date up to which the contents can be used. Manufacturers guarantee that the product will remain effective until the 'expiry date' under appropriate storage conditions. In the past, the storage life indicated by pharmacists varied from 1 to 10 years. At present, the maximum storage life is fixed at between 4 and 5 years and this assumes that the medicines will be stored in unfavorable conditions.

We recommend that lethal drugs be kept dry in airtight sealed bottles in a dark place. In these conditions the medicines discussed here can be stored for at least 10 years. It is unnecessary to add moisture-resistant granules. The storage life of lethal drugs is not prolonged through refrigeration. Moreover, a refrigerator is a poor storage-place because others may then have access to the drugs and may use them accidentally or for an impulsive suicide.

The research committee recommends the drugs be kept in a safe place out of the reach of others. A bank safety deposit box or a well concealed and securely locked safe are suggested.

In case of doubt as to whether a particular drug is still effective, an expert can be consulted through one of the societies for dying with dignity listed in Appendix 1.

It is recommended by some to test the strength of tablets in a laboratory. Be aware that this is difficult and expensive.

2.2.3 Body weight and drug dose

The lethal dose indicated for each drug in this guide applies to persons with a body weight of between 60 and 100 kilograms (132 – 222 pounds). Anyone who weighs more than 100 kg (222 pounds) should increase the lethal dose by 10% for every 10 kg (22 pounds) of extra weight. The lethal dose can be reduced by 10% for every 10 kg (22 pounds) under 60 kg (132 pounds) of body weight.

2.2.4 Discussions about the intention to end one's life

When one has loved ones and close friends, it is of great importance to share with them the decision to end one's life. First, it is important to ensure that this decision is not a mistake and that other possibilities have not been overlooked. Second, support from at least one loved one is important in order to prevent unwanted attempts at life-saving rescue efforts (see 2.2.5). Third, the dialogue with one's loved ones can be

valuable for them to help them come to terms with your decision and their loss.

Sometimes there are no loved ones and no close acquaintances whom one trusts. In such situations, it is always possible to speak to an outsider with experience in giving guidance to people with a wish to die. Members of the organizations listed in Appendix 1 are experienced in conducting discussions about this. One's family doctor may also be open to such a discussion.

If after careful discussion the decision to end one's life humanely is taken, one must then choose from the drugs and methods discussed in this book. Practical considerations of availability (see Chapters 3 to 8) often play a decisive role. Concrete information about the availability of the preferred drug can be obtained from the organizations listed in Appendix 1 (see also Chapter 2.4).

2.2.5 Refusal of life-saving treatment

A risk factor in a humane self-chosen death is discovery before death occurred and attempts at unwanted life-saving interventions: pumping of the stomach, drip-feeding, antibiotics therapy, cardiac resuscitation and artificial respiration. A handwritten refusal of treatment which specifically names and forbids these interventions is legally valid. The patient's name must be clearly visible and the document must be carefully signed and dated.

In practice, however, a written refusal of life-saving treatment put in a clearly visible way, is easily overseen or ignored by ambulance workers and doctors finding someone who is not dead. They ignore such declarations because the saving of lives is their routine task and they may doubt whether the declaration has been drawn up by someone legally competent.

Unwanted life-saving treatment can be more effectively prevented by naming an authorized person who will ensure that the written refusal of treatment is observed. This authorized person must be informed of the time and place of taking the lethal drugs and must keep watch at or near that location.[1]

1. Other matters, such as the making of a will or the placing of papers that are of importance after death, fall outside the scope of this guide. This guide is exclusively concerned with matters directly related to the successful carrying out of a humane suicide.

2.2.6 Drug tolerance and withdrawal

After repeated exposure to a particular substance, the body learns to break it down more quickly. This is known as 'tolerance'. With alcohol, for example, an inexperienced drinker gets drunk more quickly than a regular drinker. The body of an experienced drinker learns to recognize alcohol and metabolizes it more quickly to render it less harmful. To achieve the same level of intoxication the regular drinker needs to increase the amount of alcohol consumed.

Similarly, with regular use of some lethal drugs the brain becomes less sensitive to them. Consequently, the effect of the drug in question is weakened.

For these two reasons – faster removal from the body and reduced sensitivity – tolerance to any drug means that increased doses are needed to achieve the same effect. In the case of regular users the body can sometimes render these lethal drugs harmless so quickly that death will not occur even after a double dose or more.

Not all medicines effective for ending life are subject to the effects of tolerance with regular use but some are. Especially subject to tolerance are opiates (painkillers, Chapter 4) and to a slightly lesser degree for barbiturates (sleeping pills, Chapter 3) and benzodiazepines (sleeping pills – tranquilizers, this Chapter).

Because of tolerance, those who use any benzodiazepines, opiates or barbiturates, and who wish to use them to end life must go through a withdrawal process and stop using them for some time. Stopping suddenly is dissuaded because of unpleasant reactions such as fear and anxiety. Suddenly stopping taking a benzodiazepine may even provoke an epileptic fit.

Other drugs used to end life, particularly chloroquine, anti-depressants and orphenadrine, do NOT lead to tolerance. Therefore, no withdrawal period from these drugs is necessary.

Withdrawal from the medicines just mentioned takes several weeks. First is a phase of gradual reduction which is followed by a phase during which one is 'clean' (no longer using the drug). As a rule, a period of 2 to 4 weeks is the recommended phase of gradual withdrawal. For the 'clean' phase at least 3 weeks and with some drugs 4 weeks are necessary. Only then can the plan to end one's life be carried out effectively.

The following is a standard recommendation for the minimum period for reduction and remaining 'clean' from opiates, barbiturates and benzodiazepines. There is no objection to taking longer to complete the reduction phase.

The standard recommendation is:

- *reduction phase:* over a period of at least two weeks gradually reduce use of the drug to zero;
- *'clean' period:* for at least 3 weeks before the planned death use of the drug must be entirely stopped;
- *total withdrawal period:* at least 2 weeks reduction plus 3 weeks 'clean'; which means at least 5 weeks are needed for total withdrawal.

Due to drug dependency, many regular users of opiates, barbiturates or benzodiazepines find it difficult to stop taking them. This is particularly true with opiates and it will sometimes be much too difficult to stop using them for at least three weeks before ending one's life.

Doctors prescribe several painkillers that may fall into the category of opiates. All four of the opiate painkillers suitable for humane self-chosen death (Chapter 4) lead to tolerance. Therefore, it is critical to know whether one is taking any opiate painkillers so that one can stop taking them and complete the process of withdrawal.

The necessary information about opiates can be obtained from one of the organizations listed in Appendix 1. A doctor or pharmacist can tell you if a painkiller is an opiate. The same information can be obtained from pharmaceutical books in public libraries.

To summarize: if one has been taking opiates, barbiturates or benzodiazepines and is unable to stop doing so for at least three weeks, there is a real chance that self-chosen death with these drugs will fail. If one is unable to stop taking these drugs another lethal substance must be chosen.

Opiates and barbiturates can be replaced by one of the lethal drugs that do not lead to tolerance (Chapters 5-7) but as explained below, benzodiazepines must be used in combination with all lethal drugs (except barbiturates). Therefore, to be certain that a humane ending of one's life will succeed, it is essential that one complete the withdrawal process from benzodiazepines.

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2.2.7 Benzodiazepines: the need to combine them with most lethal drugs

There are at least 20 different medicines included in the benzodiazepines class of drugs, commonly known as tranquillizers or sleeping pills. Some are prescribed for insomnia, others mainly relieve anxiety, and others are prescribed for both. Benzodiazepines are regarded as relatively safe because they are usually not lethal, even in heavy doses. It is explained below that it is critical to use most lethal drugs in combination with benzodiazepines. This does not apply to the barbiturates, which themselves provide a deep and lasting sleep (Chapter 3).

The lethal drugs discussed in Chapters 4 to 7 do not induce a long-lasting sleep. They must always be taken together with benzodiazepines for three reasons. First, lethal drugs often have unpleasant side-effects before death occurs, such as painful muscular contractions. Benzodiazepines suppress many side-effects, particularly muscular contractions and epileptic attacks. The second reason is that a high dose of benzodiazepines provides such a deep sleep that whatever unpleasant side-effects may take place, they will not be experienced in consciousness. Third, a high dose of benzodiazepines often reinforces the lethal effect of the drug that is being used to end life.

Although there are about twenty benzodiazepines on the market, only a few of these provide a sufficiently deep and long-lasting sleep. The working group recommends as first choice one of the long-acting benzodiazepines listed below. In the doses recommended, they will provide a deep sleep of at least 48 hours. After taking them, the patient generally falls asleep after 30 to 60 minutes. Variations from this are possible (faster with flunitrazepam, a little slower with flurazepam).

Recommended long-acting benzodiazepines:

- *flurazepam* (in USA: Dalmane,[2] see Drug Table): recommended 300 mg (20 tablets of 15 mg or 10 tablets of 30 mg);
- *diazepam:* recommended 300 mg (150 tablets of 2 mg, 60 tablets of 5 mg, or 30 tablets of 10 mg);
- *flunitrazepam*: recommended 20 mg (20 tablets of 1 mg or 10 tablets of 2 mg).

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2. Dalmane is a brand name. Brand names are always capitalized. Chemical names of substances, such as flurazepam or diazepam, are not capitalized. Patented brand names are marked with the symbol ®. This symbol is not used in this book.

Note on flunitrazepam: flunitrazepam is the most poisonous benzodiazepine, and is potentially lethal in combination with alcohol. Mr Verzele (1994, p. 118) reports that 100 mg flunitrazepam with 5 shot glasses of hard liquor is lethal provided the person is 'clean'.[3] The research committee has not encountered any reports of such cases. Therefore, we regard its lethal effect too uncertain to warrant recommending flunitrazepam as a drug that can be independently lethal. However, combined with other lethal drugs, flunitrazepam is the sleeping pill most recommended by us. It is difficult to obtain and in some countries it is illegal (e.g. USA and Canada).

As a second choice to flurazepam, diazepam and flunitrazepam, the research committee recommends oxazepam, a benzodiazepine that works for a somewhat shorter time:

– *oxazepam:* recommended 500 mg. (50 tablets of 10 mg or 10 tablets of 50 mg).

Note on oxazepam: We have reservations regarding oxazepam because it is effective for a shorter length of time than flurazepam, diazepam and flunitrazepam. We received reports in which a heavy dose (500 mg) of oxazepam induced a long-lasting and deep sleep. In Chapters 3-7 a few lethal drugs are discussed that may lead to death only after 24 hours (e.g. with phenobarbital). If one uses one of these slowly killing drugs the working group advises against using oxazepam without one of the three long-acting benzodiazepines.

All benzodiazepines can be taken at the same time as the lethal drug. It is quite acceptable to crush them into a powder so that they mix together with the lethal drug.

It is fairly easy to collect more than one benzodiazepine because they are often prescribed for sleeping disorders and for stress or anxiety. When two benzodiazepines are used, both in heavy doses, death generally occurs sooner. If it is possible to collect two, this is recommended though not necessary. What is essential is that one of the benzodiazepines is long-acting.

If chloroquine is chosen as the lethal drug (Chapter 5), it must be combined with both a long-acting benzodiazepine and a benzodiazepine that puts one to sleep quickly (within 30 minutes).[4] The reason for this is that an overdose of chloroquine can act quickly, after about an hour,

3. Verzele, M. (1994). *De Milde Dood* (The Gentle Death). Berchem: EPO

4. "Departing Drugs" (1993) advises against all benzodiazepines in cases of a ›

and cause painful muscular contractions or an epileptic attack. The concentration of the long-acting benzodiazepine is then sometimes still too low to suppress these side-effects. For this reason, the research committee advises that with chloroquine one of the four fast-acting benzodiazepines listed below should be used. The effects of these drugs wear off quickly so they must always be used in combination with a long-acting benzodiazepine.

After taking a fast-acting benzodiazepine, one generally falls asleep after 10 to 30 minutes. With midazolam this can even happen after 5 minutes.

Recommended fast-acting benzodiazepines:

- *midazolam:* recommended 150 mg (20 tablets of 7.5 mg or 10 tablets of 15 mg);
- *lorazepam:* recommended 25 mg (25 tablets of 1 mg or 10 tablets of 2.5 mg);
- *temazepam in soluble form:* recommended 400 mg (40 capsules of 10 mg or 20 capsules of 20 mg);
- *flunitrazepam:* recommended 20 mg (20 tablets of 1 mg or 10 tablets of 2 mg).

  Note on flunitrazepam: flunitrazepam is the only benzodiazepine that in an overdose both puts one to sleep quickly and provides a long-lasting sleep. However, it is difficult to obtain.

To avoid falling asleep while taking the lethal drugs, it is better to swallow the fast-acting benzodiazepines only after all lethal drugs have been taken. This is particularly true with the fast-acting midazolam, which can induce sleep in 5 minutes. When they are taken at the same time, one runs the risk of falling asleep before ingesting all of the lethal drugs.

2.2.8 Anti-emetics to prevent nausea and vomiting

The working group recommends three anti-emetics. These medicines work to prevent the emptying of the stomach. The first choice of anti-emetics is metoclopramide:

- *metoclopramide:* available only on prescription.

  Dose prior to self-chosen death: over a period of 36 hours, every 6 to 8 hours take one tablet of 10 mg or a suppository of 20 mg. This medicine is recommended as the most effective anti-emetic.

▸ self-chosen death with chloroquine. In Chapter 5 the authors of this guide explain why they consider this advice to be mistaken.

Second choice is:

– *domperidon:* available from pharmacies in tablet form without a prescription.
  Dose prior to self-chosen death: over a period of 36 hours, every 6 to 8 hours take one tablet of 10 mg or a suppository (on prescription) of 60 mg.

Metoclopramide (first choice)

	trade names
Australia	Anagraine; Maxolon; Metamide; Pramin
Belgium	Dibertil; Movistal; Primperan
Canada	Apo-Metoclop; Emex; Maxeran; Maxolon, Reglan
France	Anausin; Primperan
Germany	Cerucal; Duraclamid; duraMCP; Gastro-Tablinen; Gastro-Timelets; Gastronerton; Gastrosil; Gastrotem; Gastrotranquil; Gastrotrop; Hyrin; MCP; MCPham; Metoclamid; Paspertin; Reginerton
Italy	Ananda; Citroplus; Clopan; Cronauzan; Enterosil; Metocobil; Nadir; Plasil; Pramidin; Randum; Regastrol; Viscal
Netherl.	Primperan
New Z.	Maxolon; Metamide
Spain	Aeroflat; Ibsesal; Paidozim; Metagliz; Primperan
UK	Gastrese LA; Gastrobid Continus; Gastroflux; Gastromax; Maxolon; Metox; Metramid; Mygdalon; Parmid; Primperan
USA	Clopra; Intensol; Maxolon; Octamide; Reclomide; Reglan

Domperidon (second choice)

	trade names
Australia	Motilium
Belgium	Gastrocure; Motilium
Canada	Motilium;
France	Motilyo; Peridys
Germany	Motilium
Italy	Gastronorm; Motilium; Peridon
Netherl.	Motilium
New Z.	Motilium
Spain	Motilium
UK	Domperamol; Motilium; Vivadone
USA	Not available

One must be aware that about 10 % of people experience drowsiness or sleep as a side effect of metoclopramide. When drowsiness occurs after taking this anti-emetic, there is a risk that the proper procedure will not be followed. During the preparation phase it is a good idea to test one's reactions to metoclopramide. If it causes drowsiness, it is better to switch to domperidon or cisapride.

Some people recommend drugs designed to prevent motion sickness and car-sickness such as cinnarizine (Stugeron). These can be bought from many pharmacies and they work against nausea by dulling the organ of balance. But they are NOT effective against nausea caused by large quantities of drugs in the gastrointestinal tract. For this reason, we advise against the use of all medicines against travel-sickness. They offer insufficient protection against drug-induced vomiting. As another disadvantage, they *often* induce drowsiness which may compromise the proper carrying out of the self-chosen death.

It is important to begin using metoclopramide, domperidon or cisapride **at least** 36 hours before carrying out a humane ending of one's life. A tablet or suppository should be taken every 6 to 8 hours. The last tablet or suppository should be taken one hour before the planned ingesting of the pills.

One can continue to eat normally until 12 hours before taking lethal drugs. After that, it is important not to eat any more so that the stomach is empty when the lethal drugs are taken. This encourages the assimilation of these drugs into the body. One can continue to drink normally and can take a biscuit or cracker 30 minutes before the swallowing of the lethal combination of substances (see 2.3.3.)

2.2.9 Alcohol: drink in moderation

Many authors have recommend the use of alcohol in hastening death. It *is true that alcohol strengthens the effect of lethal drugs and of benzo*diazepines but unfortunately the dose at which this effect occurs is not known and is probably quite high. It is believed that the effect occurs only with a heavy dose (5 shot glasses of hard liquor or up to 250 ml.). The research committee sees at least three dangers in using this amount of alcohol. First, this is an amount that makes most people quite drunk and it can prevent the planned death from being carried out with the necessary carefulness. Second, as an even worse consequence, dying drunk is undignified, not a humane death. Finally, alcohol can cause vomiting when one is not used to it – even after taking anti-emetics. Our advice is to use only the amount of alcohol that one can easily take. Preferably, take the alcohol only when all lethal drugs have been taken.

2.2.10 The preparation phase: a summary

For complete clarity, the steps in the preparation phase are summarized more or less in chronological order. The figures between brackets refer to the Chapter headings or Chapters under which each point is discussed.

1. *Reaching a decision in consultation:* the person with a well-considered wish to die reaches a carefully balanced decision after consultation with intimates (if present) and preferably also after consultation with a down to earth doctor or a trained helper with experience in this area (2.2.4). This consultation will often continue during the steps that follow. In the course of these discussions it should become clear who one may wish to have present when the life-ending plan is carried out. Any invited person must be willing and feel comfortable with being present at a humane planned death.
2. *Choice of particular method:* a choice is made for a particular lethal method (Chapters 3 to 8), the sleeping pills to be taken with it (2.2.7) and an anti-emetic (2.2.8).
3. *Collecting ingredients:* the lethal drug, at least one long-working benzodiazepine and the anti-emetic are collected (2.4.3). If the preferred drug is not available, one may choose another that is easier to obtain. Alternatively, one collects a helium tank (Chapter 8).
4. *Storing drugs:* the drugs collected are kept in a safe location that is not accessible to others (2.2.2).
5. *A refusal of life-saving treatment is written* (2.2.5).
6. *An authorized person is named.* As soon as the date of the planned death is fixed, the authorized person is informed (2.2.5).
7. *Withdrawal period:* The withdrawal period must be taken into account when chosing a date for carrying out the ending of one's life. Withdrawal is necessary in the case of barbiturates, opiates and benzodiazepines. For the length of this period (usually about 5 weeks) see 2.2.6 and the instructions that relate to the lethal drug. Withdrawal is not necessary with chloroquine, anti-depressants and orphenadrine.
8. *Alcohol:* Anyone wishing to use alcohol when taking the drugs should know his or her reaction to alcohol (2.2.9). It is NOT necessary to take alcohol as part of a humane planned death.

2.3 The final phase: what to know and what to do

After all the steps in the preparation phase have been taken, it is not uncommon to postpone the date for carrying out the plan, sometimes indefinitely. The certainty that death is available makes it easier to bear certain kinds of suffering. Recall that drugs collected will remain usable for at least 10 years if stored properly (2.2.2).

When the decision is later taken to carry out the plan, the preparation steps need to be rechecked. In particular, withdrawal may once again be necessary if pain-killers or benzodiazepines have been used in the interim.

2.3.1 The final phase: how to take the drugs

The basic guidance is:

1. Sprinkle the lethal drugs and the long-acting benzodiazepines in one (or a maximum of two) bowls of applesauce, custard or yogurt. By 'bowl' we mean a small soup-bowl containing 5 to 7 ounces (150-200 ml) of custard.
2. Stir them together well and use a spoon to swallow the mixture. To avoid choking, do this without talking and without pause. Be prepared for a bitter taste. Adding a sweetener may improve the bitter taste.
3. Wash the bitter taste away with one or two glasses of apple juice, water or milk. More glasses may provoke vomiting.
4. Take the fast-acting sleeping-pill (if available). This is done after completion of the steps 1-3 in order to avoid the risk of falling asleep while taking the drugs.[5] Immediately after taking the drugs, alcohol may be used provided one knows that one can tolerate it.

Variations on this basic advice are possible, depending on circumstances and individual preference. For instance, if one has very many tablets to take one can grind them to powder in a mortar or in a coffee bean grinder and sprinkle the powder in the applesauce, custard or yogurt. Some find it easier to swallow a large quantity of tablets when they are finely ground. Grinding them also speeds up their effect. Do

5. With midazolam some people are so sleepy within five minutes that the steps remaining are not carried out properly. With the other fast-acting sleeping-pills (lorazepam and temazepam) this will only happen after 10 to 30 minutes.

not grind chloroquine tablets because this drug is extremely bitter in powder form and can provoke retching.

Some try to make the taste less bitter by adding concentrated orange juice or a sweetener (saccharin or aspartame) while others do not find this an improvement. There's no arguing about taste: everyone must follow their own preference.

Dissolving the drugs in alcohol, as suggested in 'Departing Drugs', is not necessary. Indeed, not all drugs are dissolved by alcohol. The advantage of dissolving is that drugs take effect faster. The disadvantage is that it is not easy (and sometimes impossible) to dissolve drugs well. Moreover, dissolved drugs can result in a nasty tasting solution. Last of all, some people cannot tolerate alcohol well.

Others advise dissolving the drugs in water. Although dissolving will help the drugs take effect sooner, this may also produce a nasty taste. To find out about the solubility of drugs and the taste, try dissolving a single tablet in water or in alcohol but be aware this will not give any idea of how it will be with a large quantity of tablets.

Drugs that are sold in the form of a hard coated tablet cannot be ground up. Swallowing a large number of them is much easier for many people if they are sprinkled into custard or yogurt than if they are swallowed one by one.

The drug dextropropoxyphene (Chapter 4) comes in capsules. To achieve a faster effect, one is strongly advised to twist the capsules open and sprinkle the contents into custard or yogurt along with the long-acting benzodiazepines.

Sometimes one is advised to take a test dose to see how one reacts to the drug one has chosen for ending one's life. There is, however, very little point in doing this because it gives no idea at all of how one will react to a lethal dose. Only with the anti-emetic metoclopramide we advise a test to see whether or not one pill induces drowsiness. If so, one should try one of the other anti-emetics (2.2.8).

2.3.2 The final phase: position to adopt when taking the drugs

The working group advises taking the drugs in a semi-upright position, either in a bed with pillows behind one's back or in a slightly tipped-back chair with armrests. It is important that one cannot fall out of the chair while falling asleep "like a log".

The experience of anesthesiologists is that in this position the head sometimes falls forward which will impede breathing. A cardiac arrest will then occur somewhat sooner. This may be accompanied with

unpleasant snoring noises but since the person is sleeping deeply there is no sense of suffocation.

Anyone who prefers to lie down may certainly do so. The indicated dose of the various drugs is such that death is certain provided the drugs are not vomited and no life-saving action takes place.

2.3.3 The final phase: a summary

Below is a summary and chronological order of the steps that need to be taken in carrying out a humane ending of life. This summary assumes that all steps of the preparation phase have been completed successfully (see 2.2.10).

This summary is not sufficient on its own. It is necessary to read the full account above as well as the information that comes with the lethal drug chosen. Be aware that some drugs require deviations from the information below (e.g. do not grind chloroquine tablets).

The final phase: a summary

1. The final phase can begin only when the withdrawal period has been completed (2.2.6).
2. Anti-emetic (2.2.8): 6 tablets or suppositories are necessary. Start 36 hours before with 1 tablet or suppository, followed by one more every 6 or 8 hours. The last one is taken one hour before taking the lethal drugs.
3. If one wishes to grind the drugs, it is a good idea not to leave this until the last day.
4. On the day of self-chosen death, put the following items in place for use at the intended moment:
   - the lethal pills and the sleeping pills;
   - a small bowl of custard or yogurt (keep some extra custard or yogurt in reserve); it is easier to take a large number of pills with custard or yogurt than separately, one by one;
   - a biscuit or cracker with filling;
   - water or milk to wash away the taste.

   Note: one sometimes reads that a carbonated drink speeds up the intestinal passage and absorption of drugs into the body. This is not correct. Anyone who prefers to choose a carbonated drink can do so but the working group does not recommend it.
   - alcohol as desired provided one can take it well.
5. No food for 12 hours. There is no objection to drinking water or tea.
   - One hour before the planned taking of the drugs take the last anti-emetic.
   - Half an hour before, eat a biscuit or cracker with filling. This will activate the stomach which has been without food for half a day.
6. The authorized person is present at, or close to, the place of dying in order to effectively prevent life-saving treatment (2.2.5).
7. Sprinkle lethal drugs and long-acting sleeping pills in the custard or yogurt, finely ground if preferred. Stir. Swallow with a spoon without pause and without speaking to prevent choking. If pills remain in the bowl, these can be taken with a little extra custard or yogurt. Wash away the unpleasant taste with one or a maximum of two glasses of water or milk.
8. If one uses a fast-working benzodiazepine (2.2.7), take this with yogurt or custard only after all other drugs have been swallowed.
9. Alcohol should be used only if one can tolerate it (2.2.9). Some prefer to start drinking alcohol before or during the ingestion of drugs. This is acceptable as long as one knows from experience one will not get mixed up, which could lead to making a mistake.

2.4 Notes about collecting lethal drugs

Inquiries about the collecting of lethal drugs can be made through organizations concerned with the humane ending of life (for addresses see Appendix 1).

The working group does not wish to provide specific addresses where lethal drugs can be obtained. First, concern for people with an impulsive wish to die obliges a scientific publication to be cautious on this point. Furthermore, published addresses quickly become outdated. The drugs discussed are (in some countries) obtainable only on prescription and sale without prescription is illegal. Such sales do occur on Internet. These Internet addresses, however, change constantly because of the illegal character of those sales. Any list of addresses where lethal drugs can be bought would therefore be out of date as soon as it was published (see 2.4.3).

This book may offer guidance to people who have reached a well-considered decision to end life in a humane way by providing practical information on the options available, the required dose of particular drugs and precautions to be taken. However, how to obtain the drugs should be a matter of individual searching based on information from right to die societies in one's own country.

2.4.1 Collecting drugs: what courses have been followed in the Netherlands?

We have explored how people collect lethal drugs for a humane ending of one's life. Chabot (2003) had interviews with relatives of 31 individuals who ended their lives humanely.[6] Some of the deceased had followed more than one route, therefore the numbers in Table 2.4 add up to a little more than 31.

Table 2.4: How lethal drugs were collected in the Netherlands

from doctor/specialist who knew of the planned death	9
from doctor who is a friend of the family	2
with excuses given to a doctor or specialist (not knowing the planned death)	9
with excuses given to a doctor or pharmacist abroad	4
from another professional helper	3
from relatives or friends in the Netherlands	4
from relatives or friends abroad	4
with a forged prescription	1
through access to the pharmaceutical wholesale trade	1
unknown	1

6. Chabot, B. E. (2003). A self-chosen death. In: Adams, M., Griffiths, J., ▸

Table 2.4 shows that doctors treating the person in question were sometimes prepared to prescribe the lethal drug in small quantities without being present at the planned death. In these cases the doctor did not take responsibility for the success of the ending of life and was often not aware of the time it was to take place. Death was in some cases reported as 'natural cause' sometimes as 'unnatural cause' (suicide). Of course no mention was made of the role played by the doctor. About half of the deceased did not obtain their lethal drugs from a physician or specialist.

These humane self-chosen deaths share similarities with the standard practice in Switzerland, according to Bosshard (2003).[7] If there is a terminal illness which is no longer amenable to treatment, a majority of the general practitioners in Switzerland will prescribe a lethal drug (barbiturate) on request to a member of Exit Deutsche Schweiz. The doctor is usually not present at the planned death. The Exit member and a witness will be present when the barbiturate is taken. The Exit member then reports to the legal authorities and the coroner the self-inflicted death with barbiturates prescribed by a doctor.

From Table 2.4 it can be concluded that in the Netherlands a doctor is sometimes willing to do the same. The difference being that in the Netherlands there is no official accountability of this underground practice as there is in Switzerland.

2.4.2 Legal collection of lethal drugs

The working group notes that it is legal to collect chloroquine which is lethal in an appropriate overdose. It is obtainable without a prescription in most countries. The Drug Table identifies the trade names of drugs in 11 countries.

To date, no research has been done into whether drugs that are not prohibited by law such as chloroquine (Chapter 5) and the tricyclic antidepressants (Chapter 6) could be successfully ordered by an individual customer through a virtual pharmacy.

In Chapter 4, it is indicated that in the Netherlands there is a black market for one or two opiates that are suitable for a humane self-chosen death. An outsider who buys these streetdrugs can never be sure of

▸ & Hartogh, G. (Eds.) *Euthanasie, nieuwe knelpunten in een voortgezette discussie.* (pp. 87-115). Kampen: Kok.

7. Bosshard, G., Ulrich, E., & Bär, W. (2003). 748 cases of suicide assisted by a Swiss right to die organization. *Swiss Medical Weekly, 133*, 310-317.

receiving what he thinks he is buying.[8] This route for obtaining a lethal dose of opiates requires the help of a reliable middleman who is not himself a seller but can put the buyer in contact with an authentic seller.

In North America, there are reports that veterinary Nembutal (liquid pentobarbital) has been purchased from veterinary suppliers in Mexico.

2.4.3 Collecting drugs through the Internet

In line with our general policy not to discuss or include doubtful methods, we do not provide websites that might contain mistaken information. The research committee sees no point in referring people with a serious wish to die to sources of information that are incomplete and without instructions to separate the wheat from the chaff. A humane self-chosen death with relatives and friends present should not be a scene of Russian roulette.

Some people presume that lethal drugs can be ordered easily from the Internet. This presumption is exaggerated. For example, one may read that someone obtained dextropropoxyphene (Chapter 5) through the Internet, but after an intensive search, the website in question appears to have been removed. The Dutch NVVE had a similar experience: as a test case this organization placed orders for opiates with dozens of virtual pharmacists. In very few cases were the drugs delivered. In those cases the suppliers quickly disappeared without a trace.[9]

This sort of experience is to be expected with drugs prohibited by law. Opiates, for example, are only supplied with a doctor's prescription that satisfies strict conditions. An Internet supplier is vulnerable to prosecution, and for this reason will constantly relocate the business address.

The chance of prosecution is small for an individual who orders an opiate for purposes of hastening death, but this can be different for a right to die organization that acts in order to supply a lethal drug to its members.

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8. Smith argues that it can be more intimidating trying to get drugs on the street than from a doctor. See Smith, C. K. (1995). Street drugs. In Smith, C. K., Docker, C. G. & Hofsess, J. (Eds.), *Beyond Final Exit*. Victoria: Right to Die Society of Canada.

9. Verbal report from *Right to Die-NL'* (NVVE).

2.4.4 Customs controls and importing from other countries

Anyone who buys lethal drugs abroad must be able to justify the possession of these drugs on the grounds that they are for medical use. For example, the possession of opiates is not a punishable offence if one can show that they are medicines for one's own use. This can be demonstrated when the name of the patient, the drug and daily dose are labeled on every packet. The total amount in one's possession must correspond with the daily dose stated and the intended duration of one's travels.

If one has drugs sent by post, perhaps through people one knows abroad, it is often not necessary for the sender to put his name on the package.

2.5 The report form for eyewitnesses: A strategy to increase knowledge

After a humane self-chosen death it is desirable that an anonymous report of the whole sequence of events be documented. From the reported cases in Chapters 3-8 it will become clear that more detailed reports are required to improve our still fragmentary knowledge. More specifically, such reports should give information about all the drugs used, the dose, the time taken to end life, and other aspects, such as information about using helium. The report form is given in Appendix 2.

When a carefully prepared planned death fails, a report of all the circumstances is even of greater importance to ensure that others do not suffer the same misfortune. Appendix 2 can be copied. It is important that the witness of a self-chosen death be familiar with the form and knows which details to document.

The form can be submitted entirely anonymously, to protect the identity of the person who has ended his or her life as well as the person submitting the form.

Please send the report form through the post to:

Russel Ogden (one of the authors of this guide).
207 Osborne Avenue
New Westminster, BC
V3L 1Y7 Canada

2.6 Overview of Chapters 3 to 7

This book has been put together with the greatest possible care. Even so, neither its authors nor the WOZZ Foundation can guarantee that death will be achieved. It is particularly important that one not deviate from the instructions given in this book if one hopes to achieve a humane death.

Chapters 3 (barbiturates) and 4 (opiates) discuss drugs that are known as narcotics and listed as controlled substances. Organizations concerned with self-chosen death have most of their experience with these two groups of drugs. Barbiturates, however, are rarely prescribed and opiates are difficult to obtain for most people.

In Chapter 5 (chloroquine), Chapter 6 (antidepressants) and Chapter 7 (orphenadrine), drugs are discussed that are not controlled substances. They are less difficult to collect. Chloroquine can be obtained without a prescription in many countries. Although antidepressants require a prescription, it is usually not very difficult to have them prescribed if one presents the proper complaints over a period of time.

At present, there are not yet many well-documented experiences of planned death using the drugs in Chapters 5-7. The authors conclude on the basis of the toxicological literature that ending one's life with chloroquine (Chapter 5) or tricyclic antidepressants (Chapter 6) is effective provided all the precautions are taken that have been discussed in Chapter 2. The few well-documented cases known to the working group confirm this. There is less information on orphenadrine (Chapter 7).

Each of the following points are discussed with regard to barbiturates, opiates, chloroquine, antidepressants and orphenadrine:

- cause of death
- availability of the drug
- lethal dose
- tolerance and withdrawal
- necessary sleeping pills
- how to take the drug
- reported cases
- summary

CHAPTER 3

Barbiturates and glutethimide

The barbiturate class of drugs that is on the market includes (in alphabetical order) seven varieties: amobarbital, brallobarbital, butobarbital, cyclobarbital, pentobarbital, phenobarbital and secobarbital. All barbiturates are controlled substances.[1]

Vesparax is a mixture of two barbiturates; secobarbital (150 mg) and brallobarbital (50 mg) and also contains the antihistamine hydroxyzine 50 mg. In total, Vesparax contains 150 + 50 = 200 mg barbiturate per tablet.

Glutethimide is not a barbiturate but it is nearly similar in chemical structure, cause of death, habituation and effectiveness. Therefore, it is discussed in this Chapter.

Cause of death

Death occurs through a combination of apnea (cessation of breathing) and cardiac arrest.

Availability

Vesparax is no longer available in the Netherlands neither in many other countries.[2] See the Drug Table at the end of this book for the availability of barbiturates in eleven different countries. For instance, Vesparax was still available in the UK, Italy and Belgium in 2003. But this may change anytime. The reader needs to check which barbiturates are prescribed in one's own country and how many milligrams each tablet contains.

Nembutal (pentobarbital in liquid form) can sometimes be obtained from a veterinarian surgeon (e.g. in Mexico).

The only barbiturate that is still prescribed (under different trade names) in most European and Commonwealth countries is phenobar-

1. e.g. USA *Controlled Substances Act*

2. In the past, the Dutch Inspector of Health strongly advised physicians not to prescribe any barbiturates given the danger of suicide. Physicians have followed that advice. Chabot gives suicide statistics in the Netherlands that demonstrate that the decline in the number of suicides with barbiturates has had no perceptible influence on the total number of suicides. Chabot, B. E. 1996 *Dying adrift*. (in Dutch) Nijmegen: SUN, pp. 210-214.

bital. Phenobarbital is available in tablets of 25, 50 or 100 mg. Doctors prescribe it as a remedy against epilepsy.

With other barbiturates, death usually comes within twelve hours (see Chapter 9). But phenobarbital acts more slowly than the other barbiturates and death may take as long as three days to occur. It is most essential that a long-acting benzodiazepine is taken simultaneously: at least 300 mg of diazepam or flurazepam. In cases of failed suicide with phenobarbital that have been reported to us, no long-acting benzodiazepine had been ingested. Moreover, it is absolutely necessary to avoid life-saving treatment (artificial feeding and respiration) during these three days.

Glutethimide is available in tablets of 250 mg. It is occasionally prescribed for persistent insomnia that does not respond to other sleeping pills. It is only available in Australia.

Lethal dose

In the Netherlands, doctors who offer to help with hastening death provide a drink with 9 grams of pentobarbital or secobarbital.[3] The instruction for pharmacists on how to prepare this drink is given in Chapter 9.1. The research committee considers 9 grams a perfect dose but, given the difficulty of collecting this lethal drug, 9 grams is not really necessary. Nobody has ever woken up after ingestion of 6 grams of a barbiturate if not tolerant to the drug and provided no vomiting occurs.[4]

Departing Drugs suggests 3.5 grams as the lethal dose for secobarbital.[5] This may be true in some cases but we think that a dose of 30 tablets of Vesparax (which contains 6 grams of barbiturates totally) is more reliably effective in all cases.

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3. *Toepassing en bereiding van euthanatica* (4th edition) [Translation: Application and preparation of non-therapeutic drugs for euthanasia (2006)]. The Hague: Royal Dutch Pharmaceutical Society.

4. In chapter 9, we present evidence from three different sources that show that the fatal dose of fast-acting barbiturates is by now well established. Barbara Insley Crouch, a clinical toxicologist, argued ten years ago that no good scientific data are available to identify the fatal dose of a drug in humans. See Crouch, B. I. (1996). Toxicological issues with drugs used to end life. In: Battin, M. P. & Lipman, A. G. (eds). *Drug use in Assisted Suicide and Euthanasia* (pp. 211-222). New York: The Pharmaceutical Products Press.

5. See p. 64, Docker, C. G. & Smith, C. K. (1993). *Departing Drugs*. Edinburgh: VESS.

For all barbiturates we recommend 6 grams as the lethal dose. Recommended number of tablets necessary:

Cyclobarbital: lethal dose 6 grams, i.e. 30 tablets of 200 mg.
Phenobarbital: lethal dose 6 grams. Available in 100, 50 or 25 mg tablets. Combination with a long-acting benzodiazepine (Chapter 2.2.7) is necessary. Recommended quantity: at least 60 tablets of 100 mg, 120 tablets of 50 mg, or 240 tablets of 25 mg.[6]
Vesparax: Recommended quantity: 30 tablets containing a total of 6 grams of barbiturates.
Glutethimide: lethal dose 8 grams, i.e. 32 tablets of 250 mg.

Time to death

Experience in the Netherlands has learned that after taking 9 grams of the most commonly used barbiturates such as secobarbital or pentobarbital, death generally occurs within two hours (see Chapter 9). In some other cases death occured within 24 hours. Very rarely did death take longer than 24 hours.[7,8,9,10] When someone ingests the recommended dose and no life-saving treatment is begun, he or she will die without regaining consciousness. There is no need for worrying that the planned death will fail.

In Oregon one failure in 246 cases has been reported though doubts remain whether the whole amount of barbiturates was taken (see Chap-

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6. B.I. Crouch (1996) and L. Minelli (personal communication 2005) have doubts about the effectiveness of phenobarbital. Neither of them has reported the blood-concentration of phenobarbital in cases that have survived. On toxicological and clinical grounds, we are almost certain that a dose of 6 grams for a person weighing 70 kg combined with at least 300 mg of diazepam or flurazepam will be lethal as long as no artificial hydration or ventilation is started. Witnesses need to know that death may take 72 hours to come.
7. Bosshard, G., Ulrich, E., & Bär, W. (2003). 748 cases of suicide assisted by a Swiss right to die organization. *Swiss Medical Weekly*, *133*, 310-317.
8. Horikx A. & Admiraal, P. V. (2000). Toepassing van euthanatica; ervaringen van artsen bij 227 patiënten, 1998-2000 (Application of euthanatics; experiences of physicians in 227 patients, 1998-2000). *Ned Tijdschr Geneeskd*, *144*, 2497-2450.
9. Kimsma, G. K. (1996). Euthanasia and Euthanizing Drugs in the Netherlands. In: Battin, M. P. & Lipman, A. G. (eds). *Drug use in Assisted Suicide and Euthanasia* (pp. 193-210). New York: The Pharmaceutical Products Press.
10. In Oregon, the median time to death in 246 cases with 9-10 grams of barbiturates is 25 minutes, with a range of 5 minutes to 48 hours, according to the Oregon Department of Human Services, 2006.

ter 9.1). Relatives should be aware that time to death may take somewhat longer than the data given above when 6 grams instead of 9 grams is taken.

In cases where time to death has taken longer than a few hours, Dutch physicians have reported that they sometimes end the stress of waiting for the relatives. After about five hours have passed, they may give an injection to hasten death, which by that time has become inevitable.[11]

Tolerance and withdrawal

All barbiturates and glutethimide lead to tolerance. Anyone who regularly uses any of these drugs must first stop taking them. For the total length of withdrawal the standard recommendation of 2 + 3 weeks applies. At least two weeks of cutting the dose down to nil and at least three weeks being 'clean' preceding the self-chosen death (see 2.2.6).

The following is of great importance: if hastening death with barbiturates or glutethimide is planned, any use of benzodiazepines must also be stopped. The reason for this is of a technical pharmacological nature.[12]

For withdrawal from benzodiazepines the same standard recommendation of 2 + 3 weeks applies. The cutting-down phase may also be extended. Some people find 4 + 3 weeks easier to manage because of a more gradual adjustment of the central nervous system.

Withdrawal from phenobarbital deviates from the standard recommendation. Epilepsy patients use this drug regularly so in their case tolerance is well established. Anyone wishing to use this drug for hastening death must be 'clean' for at least four weeks. The total withdrawal period for phenobarbital, therefore, lasts six weeks: two weeks cutting down and four weeks 'clean'. During these six weeks an epileptic attack may be induced. This is a serious drawback to be discussed with a neurologist in order to switch to a non-barbiturate anti-epileptic. This alternative anti-epiletic drug should not be a benzodiazepine for the reason given in the previous paragraph (footnote 12).

11. When a refusal of treatment document is prepared and presented to medical personnel, no life-saving treatment should be given. Under those circumstances death is inevitable in case five hours have passed since 6 grams of barbiturate were taken.

12. Cross-tolerance between barbiturates and benzodiazepines probably takes place, since both operate on the GABA-receptors.

Necessary sleeping pills

For a self-chosen death, the barbiturates and glutethimide do not necessarily have to be combined with benzodiazepines. It is likely, though, that in combination with a benzodiazepine death will come faster. Up till now, little experience has been acquired on this.

In case one uses phenobarbital, the combination with 300 mg of a long-acting benzodiazepine is absolutely essential (see 2.2.7 for different options).

How to take the drug

The standard recommendation applies as given in Chapter 2.3. In case liquid pentobarbital is used, one might mix it with peach or apricot nectar, which masks the taste.

Reported cases from the Netherlands and North America in which no asistance by a doctor was given[13]

In the reported cases in this section no recent prescription or other assistance had been given by a doctor. Under those circumstances there is some risk that life-saving treatment is carried out if one is discovered still alive.

The authors of this book have received eyewitness reports of 42 planned deaths by barbiturates without assistance from a doctor: 22 with liquid pentobarbital (Nembutal), 18 with Vesparax which had been collected years ago. One reported case had taken butobarbital and one had swallowed phenobarbital.

Four of the 18 Vesparax cases had taken it in combination with other lethal medicines that will be discussed in the following Chapters.
We will now discuss a few aspects of these cases that are of general interest:

- 22 persons had swallowed 6 - 12 grams of liquid pentobarbital, often preceded by 160 - 360 mg propranolol (a beta-blocker). On average, sleep occurred in less than 6 minutes. Average time to death was 67 minutes (with a range of 15 minutes to 5.5 hours).

The authors do not see sound toxicological arguments for the combination of pentobarbital with a beta-blocker like propranolol, neither do they have empirical data against using it. On clinical pharmaceutical

13. In chapter 9 we report cases from Switzerland, the Netherlands and Oregon, where barbiturates are legally prescribed by doctors to assist in a self-chosen death.

grounds an overdose of beta-blocker may in some people induce cardiac fibrillation while in others it may protect against this. What we do know is that no one has ever woken up after taking 6 grams of a barbiturate provided no life-saving treatment had been started. If the intention of the combination was to speed up death, the committee would recommend either to take more than 6 grams of barbiturates or to add 300 mg of a long-acting benzodiazepine (Chapter 2.2.7).

- 12 persons took at least 30 tablets of Vesparax (some of them up to 60 tablets), which amounts to 6-12 grams of barbiturates. Time to death varied between 20 minutes and 36 hours (in one case). Several persons have combined this drug with benzodiazepines. We should stress that even a large quantity of benzodiazepines should not tempt one to use less than the advised 6 grams of barbiturates.
- 3 persons took less than 6 grams of barbiturates but swallowed 3 grams of dextropropoxyphene as well (this is a lethal opioid discussed in Chapter 4). One of them took 4 grams and another took 5 grams of barbiturates and died. Anyone who ingests less than 6 grams of barbiturates risks waking up. This risk was nil in these two cases because they combined the barbiturates with a lethal dose of dextropropoxyphene.
- 1 person took 13 grams of barbiturates that had been collected 25 years earlier (in 1981). The tablets had been kept in a dry and dark place (see Chapter 2.2.2). Even under the best of circumstances, the effectiveness of medicines declines after 10 years though it is difficult to establish how quickly this happens. In this case (87-year-old woman, no serious illness), time to death took 40 hours. After 17 hours she was admitted to a hospital. Her friend (Authorized Person) and a recent advance directive that forbade any life-saving treatment prevented doctors from starting artificial respiration and nutrition. She died after 23 hours in hospital.

After storage of more than 10 years, 6 grams of barbiturates is not enough; we would advise to increase the lethal dose with 20% for every year medicines are preserved longer than ten years. There is, however, no certainty of death if medicines have been stored for much more than ten years.

- 1 person (age 82) took 37 pills of butobarbital together with 1 gram of barbiturates (in Vesparax) and died after 4.5 hours. The total amount of barbiturates equaled the 6 grams we have recommended.

- 1 person died after taking 3 grams of barbiturates (in Vesparax) together with 225 mg of dextromoramide (Palfium), an opioid that has a lethal dosage of 2000 mg (2 grams; see Chapter 4). We consider the quantities of both drugs insufficient to be certain of death.
- 1 person (age about 85) took only 3 grams of barbiturates (in Vesparax) and died 36 hours later. No artificial hydration was given. This self-chosen death might well have failed because of the small quantity of barbiturates.
- 1 person died after taking 4.5 grams of phenobarbital together with unknown other substances. Time to death is unknown. We consider at least 6 grams necessary.

When glutethimide was still prescribed in the Netherlands, 8 grams of it appeared to be as effective for self-chosen death as 6 grams of barbiturates. It need not necessarily be combined with a benzodiazepine, although that may hasten death.

Summary

Barbiturates and glutethimide are effective means for a self-chosen death via a deep sleep. But in many countries these substances are nearly impossible to obtain. The Drug Table at the end of this book provides the names under which they are obtainable in some of the countries mentioned.

Phenobarbital is available on prescription as a medicine against epilepsy but requires three precautions:

1. for a preceding period of 4 weeks phenobarbital must not be used ('clean' period);
2. use in combination with a long-acting benzodiazepine;
3. ensure that no life-saving treatment takes place for at least three days.

We have been informed that liquid pentobarbital can be bought from veterinary suppliers in some countries.

CHAPTER 4

Opiates[1]

48 This Chapter discusses four opiates that can be used for a humane self-chosen death. All are controlled substances. They are only available on prescription.

- dextropropoxyphene (also propoxyphene);
- methadone;
- dextromoramide;
- fentanyl (brand name: Duragesic) as transdermal patch.

Morphine is not discussed here because tablets of morphine will only partly be absorbed from the intestines into the blood, making it an unreliable means of ending one's life. In case one is skilled in self-injecting it into a muscle, and provided one is 'clean', 500 milligrams of morphine would be lethal. If injected into a vein, less than 500 milligrams would be lethal in a clean person. But this guide does not recommend drugs that need to be administered by injection because that often requires the help of another person. A helper would be committing a criminal offence by giving a lethal injection.
Heroin has the very same properties as morphine, which makes it as unreliable as morphine for a humane self-chosen death. That is why we do not discuss it in this book. Moreover, use of heroin by injection is very unreliable because on the black market it is diluted into unknown concentration. For a non-regular user it is impossible to find out what dose one is buying. Smoking heroin is not an effective means of self-chosen death because one gets drowsy before a large enough dose to cause death can be inhaled.

Cause of death
With opiates death occurs through apnea (cessation of breathing).

Availability
Dextropropoxyphene (capsules of 150 mg) is prescribed for chronic pain (rheumatism, cancer with metastasis). It is less difficult to obtain

1. The pharmacologically correct term 'opioids' is replaced here by the more current term 'opiates'.

on a doctor's prescription than barbiturates. Dextropropoxyphene will probably be removed from the market within a few years because more effective and less toxic painkillers have become available.

Methadone is sold as a tablet of 5 mg and a drink containing 2 mg per ml. It is prescribed to treat severe pain and as a substitute drug in treating heroin addiction. Because of the latter, methadone is in some countries extensively sold as a street drug. Persons addicted to opiates who receive methadone as a substitute may save up some of the methadone in order to sell it and buy other drugs. Even so, methadone is not easily obtainable for everyone and inexperienced buyers are easily misled on the black market. One risks buying a fake substance resembling methadone.[2]

Anyone trying to buy methadone is advised to use a reliable middleman familiar with the drug underground in big cities. This middleman will not himself deal in methadone but can put the buyer in contact with a bona fide seller. Collecting the large quantity of methadone needed (200 tablets of 5 mg) may require several separate purchases.

Dextromoramide (brand name Palfium) is still prescribed in Australia, UK, France and Belgium.

Fentanyl is only available as a transdermal patch (brand name Duragesic). The patches vary in strength from 25, 50, 75 or 100 micrograms of fentanyl. These allow 25, 50, 75 or 100 micrograms of fentanyl per hour to enter the blood stream through the skin over a period of two or three days. This drug is used to treat chronic pain and in the palliative care for cancer patients. It is difficult to obtain.

Lethal dose

Dextropropoxyphene: Experience has shown that 3 grams of dextropropoxyphene (20 capsules of 150 mg) is lethal if combined with at least one long-acting benzodiazepine (2.2.7). The research

2. We remind the reader of the conclusion by Smith (in: *Beyond final Exit* 1995) that in the USA "Obtaining street drugs may be even more difficult and intimidating than getting lethal drugs from a physician".

committee does not consider it necessary to use a *second* benzodiazepine but in practice (see below) adding oxazepam has proved effective.

Methadone: On the basis of toxicological literature,[3] we recommend 1 gram (200 tablets of 5 mg) as the lethal dose. It is necessary to combine methadone with at least one long-acting benzodiazepine (2.2.7) because methadone on itself will not produce a sufficient long-lasting and deep sleep, which means that suffocation while more or less conscious may occur.

Dextromoramide: 2 grams (400 tablets of 5 mgs) is lethal provided the person is 'clean' from opiates. It must be combined with a long-acting benzodiazepine for the same reason as given for methadone.

Fentanyl: The working group recommends 500 micrograms per hour as the lethal dose. Duragesic transdermal patches with a combined dose of 500 micrograms should be applied simultaneously on a piece of hairless, well circulated skin. Usually the abdomen is a good place to put the patches.
After applying a 500-microgram fentanyl skin patch, one may fall asleep only after *several hours*. Therefore, the use of at least 300 mg of one long-acting benzodiazepine is necessary to bring about a deep sleep within 30 to 60 minutes (2.2.7). If one fails to observe ingesting benzodiazepines one might experience suffocation before falling asleep. Relatives should be aware that it might still take about 24 hours before death by apnea occurs. This is considerably longer than with the other three opiates. It is essential that during the first 36 hours no life-saving treatment is started.

A few cases have been reported where heat around the transdermal patch speeds up absorption considerably. One might facilitate the absorption by covering the skin patch with a small piece of plastic so that body heat warms it up. A patch of 100 micrograms might in theory be lethal when warmed up but no precise data are available (see below). The authors warn that these data are not precise enough to be certain of a successful ending of life with less than the recommended dose of 500 micrograms.

3. Wolff, K. (2002). Characterization of methadone overdose: clinical considerations and the scientific evidence. *Therapeutic Drug Monitoring*, 24, 457-470.

Tolerance and withdrawal

All opiates lead to a high degree of tolerance. Therefore, they are NOT lethal for a regular user. Be aware that if any other opiate (e.g. morphine) has been used as a painkiller in the last weeks before the planned death, hastening death with these drugs has a high risk of failure.

Pharmacotherapeutic reference works provide information as to whether or not a painkiller is classified as an opiate. One may also get this information from a member of one of the organizations listed in Appendix 1, one's doctor or a reliable database such as Medline Plus on the Internet.[4]

The standard recommendation for withdrawal applies to all of these drugs (2.2.6). At least five weeks prior to self-chosen death, one must, over a two week period reduce the dose to zero. Then one must stay 'clean' for at least three weeks. For all opiates, withdrawal takes 2 + 3 = 5 weeks. As all regular users know, stopping opiates abruptly can bring on very unpleasant symptoms. It is preferable to gradually cut down use of the drug over several weeks.

If it is impossible to stop using the opiate for at least three weeks prior to the planned death, a non-opiate drug will have to be used. Even doubling or tripling of the recommended dose does not guarantee success for somebody tolerant to opiates because of regular use.

Necessary sleeping pills

The opiates described have a sleep-inducing effect. But none of them provides a sufficiently *long-lasting* and *deep* sleep. Therefore, combination with at least one long-acting benzodiazepine is necessary. This will help to avoid experiencing the toxic phenomena produced by the opiates before death takes place (2.2.7). If one is a habitual user of a benzodiazepine, withdrawal from all benzodiazepines is essential (2.2.6).

How to take the drug

For all of the opiates mentioned, it is necessary to take an anti-emetic starting 36 hours before the planned death. This applies also to the use of fentanyl transdermal patches because of the long-acting benzodiazepine that must be taken.

Dextropropoxyphene is in some countries available as granules-containing capsules. These granules release the drug after some delay. By opening the capsules and sprinkling the granules into yogurt or custard the delay can be partially reduced. Grinding up the granules (e.g. in a mortar) can even further reduce the delay.

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4. http://www.nlm.nih.gov/medlineplus/druginformation.html

When taking a large number of tablets, as with methadone (200 tablets), it is recommended that they are ground finely beforehand.

Reported cases

Dextropropoxyphene

73 persons are reported to have used dextropropoxyphene; 71 out of 73 died. We shall first discuss the two failed attempts.

One failed planned death involved a woman who had cancer with metastases that no longer reacted to chemotherapy. We suspect that this failure was due to tolerance to an opiate painkiller that she used. No withdrawal period was observed. Due to this tolerance for opiates, dextropropoxyphene did not result in death.

The other failure involved some substance that was delivered by a pharmacist in a foreign country where the person was spending a holiday. The client asked the pharmacist for the painkiller dextropropoxyphene (a controlled substance) saying she had forgotten to take enough with her from home. The pharmacist asked the person to come back next morning. He then delivered 20 capsules that were not contained in the original strips. The self-chosen death failed and was reported to WOZZ. We suspect that the pharmacist had delivered some other capsules containing a white powder. He possibly sold it as 'dextropopoxyphene' wondering whether the 'tourist-customer' was addicted to this opiate or planning a self-chosen death.

The authors warn never to take less than the recommended dose of dextropropoxyphene: at least 3000 mg, which is 3 grams or 20 capsules of 150 mg.

We subdivide the 71 reported cases that resulted in death into 6 cases that will be discussed below and 65 cases in which the recommended 300 mg of a long-acting benzodiazepine has been used (see Chapter 2.2.7); either flurazepam, flunitrazepam or diazepam.

Most of them (48 cases) used another benzodiazepine as well: oxazepam (39 cases), temazepam (4 cases), lorazepam (2 cases), midazolam (2 cases), nitrazepam (1 case). Though we do not consider this second benzodiazepine necessary, this may be useful as an extra help to speed up death.

In 17 out of 65 cases just one long-acting benzodiazepine was used in (at least) the recommended dosage.

Unfortunately, time to death was reported only in a quarter of the 65 cases. Among those where time to death was reported and that had

carried out their self-chosen death in accordance with the information in this Chapter, time to death varied between 75 minutes and 14 hours.

The remaining six cases are discussed separately below:

- 1 person used dextropropoxyphene and a barbiturate (cyclobarbital 600 mg) instead of a benzodiazepine. We consider 600 mg barbiturate not enough to be certain of a sleep that is long and deep enough; 1200 mg barbiturate would be safe for this purpose.
- 1 person used dextropropoxyphene with morphine (MS Contin) instead of a benzodiazepine and died seven days later in an intensive-care unit. This self-chosen death might well have failed by using two opiates (dextropropoxyphene and morphine) without a long-acting benzodiazepine.
- 2 persons used dextropropoxyphene with hydroxyzine. Hydroxyzine is an antihistaminic with mild sedative properties. One person died after 17 hours, in the other case time to death is unknown. The committee strongly advises against the use of hydroxizine to induce sleep. It does not induce a long-lasting (more than 12 hours) deep sleep.
- 1 person combined dextropropoxyphene with oxazepam and the analgesic tramadol. This combination risks conscious experience of a painful death because oxazepam is not a long-acting benzodiazepine. Tramadol is not a sedative.
- 1 person died using dextropropoxyphene with an unknown combination of sleeping pills.

Methadone

No reports have been received of a planned deaths using methadone.

Our argument that the recommended dose of this substance is lethal if combined with 300 mg of a long-acting benzodiazepine, is based on toxicological evidence. As long as no actual cases have been reported to us, we cannot be certain that our advice is correct. The same applies to dextromoramide.

Dextromoramide

No reports have been received of a planned death using this drug.

Fentanyl

Fentanyl transdermal patches have been on the market since 1995. In the toxicological literature we found two case reports with fentanyl.

One person, described by Kramer,[5] used 2 patches of 75 micrograms/hour each (total 150 micrograms/hour) plus diazepam and cocaine. The authors conclude that death probably resulted from the fentanyl overdose. We consider the dose of 150 micrograms very low and therefore uncertain to attain death.

The other person, described by Edinboro et al.,[6] used 3 patches of 100 micrograms/hour each (total 300 micrograms/hour). The authors think that in this case, an 83-year-old woman, her metabolism may have been slowed down and contributed to death.

The working group has not received reports on the use of fentanyl in planned death.

The US Food and Drug Administration reports more than one hundred fentanyl deaths per year. By no means are these all cases of a deliberate self-chosen death, the majority of them are accidental deaths. Nevertheless, these accidents throw some light on the lethal properties of fentanyl transdermal patches: persons who used the prescribed dose of fentanyl died while having a fever, going to the sauna, using an electric blanket, a warm water bottle near the patch or a hot compress on it. We warn again that these reports are not precise enough to be certain of a humane self-chosen death with less than the recommended dose of 500 micrograms combined with long-acting benzodiazepines.

Summary

Dextropropoxyphene is a lethal drug *provided that:*

a. no opiates and no benzodiazepines have been used for three weeks;
b. it is combined with at least one long-acting benzodiazepine.

Methadone, dextromoramide and fentanyl cause intense respiratory depression. According to the toxicological literature they are almost certainly lethal *provided that:*

a. no opiates and no benzodiazepines have been used for three weeks;
b. they are combined with at least one long-acting benzodiazepine.

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5. Kramer, C. & Tawney, M. (1998). A fatal dose of transdermally administered fentanyl. *Journal of the American Osteopathic Association*, *98*, 385-386.
6. Edinboro, L. E., Poklis, A., Trautman, D. Lowry, S., Backer, R. & Harvey, C. M. (1997). Fatal fentanyl intoxication following excessive transdermal application. *Journal of Forensic Science*, *42*, 741-743.

CHAPTER 5

Chloroquine

Chloroquine is used as a medicine against malaria and for treating rheumatism of the joints. It is marketed in three forms:

- as a base;
- as a salt with sulphate or phosphate;
- as a hydroxyl compound.

For practical purposes the only thing one needs to know is that chloroquine salts and hydroxychloroquine are not as strong as the chloroquine base. For this reason, in addition to the lethal dose of chloroquine base about 3 extra grams of the salts and the hydroxyl compound are required for the lethal effect.

Cause of death

Death occurs through cardiac arrest.

Availability

In countries of the European Union chloroquine can be obtained in many pharmacies without a prescription, for instance in Belgium, France, Spain and Portugal and the UK. Outside western Europe, it can be bought easily without a prescription in all countries where malaria occurs as well as in many other countries.

In some European countries (e.g. in the Netherlands) chloroquine is more difficult to collect. It may be refused to people who merely say they are going to the tropics because the malaria parasite is resistant to chloroquine in many regions. Other drugs are then prescribed by public health authorities and by physicians or advised by pharmacists. To receive chloroquine one should state the intention of traveling to a country where the malaria parasite is still sensitive to chloroquine. The list of these countries changes every year which is why it is useless to give more details in this book.

Chloroquine is generally only prescribed by doctors in combination with another anti-malaria drug (e.g. proguanil, doxycycline, mefloquine). For travelers an emergency dose of chloroquine is sometimes given (together with e.g. doxycycline) which is to be taken when the drug of first choice in these countries gives insufficient protection.

These other anti-malaria medicines (proguanil, doxycycline, mefloquine etc.) are not suitable for a self-chosen death.
For every week on travel, 300 mg of chloroquine is prescribed. At least 80 tablets of 100 mg of chloroquine-base are required (see below). Therefore, one should collect enough chloroquine for a journey of 6 months (or 2 people for 3 months).

Lethal dose

The lethal dose is:

- 8 grams of *chloroquine base* (80 tablets of 100 mg);
- 11 grams of *chloroquine sulphate* and chloroquine phosphate (110 tablets of 100 mg);
- 12 grams of *hydroxychloroquine* (60 tablets of 200 mg).

Tolerance and withdrawal

Chloroquine use does not lead to tolerance. People living in malaria zones and who regularly use chloroquine do not have to stop using it prior to a planned death.

When chloroquine is used for a self-chosen death, the use of sleeping pills is necessary (see below). The standard recommendation for withdrawal applies (2.2.6) to these sleeping pills.

Necessary sleeping pills

Chloroquine leaves the consciousness clear. For this reason, the combination with sleeping pills is necessary in case of a self-chosen death so that one does not consciously experience either the toxic effect on the heart nor the muscular contractions and epileptic seizures that may occur as a side effect of a chloroquine overdose.

According to *Departing Drugs* (1993), chloroquine should not be combined with benzodiazepines: 'Benzodiazepines (particularly diazepam) could negate the lethal effect of chloroquine and so are less suitable' (p. 22). The WOZZ research committee questions this advice.

The background to the advice in *Departing Drugs* is that in cases of overdose with chloroquine, diazepam (Valium) is recommended as an antidote. The writers of *Departing Drugs* concluded from this that diazepam and all the other benzodiazepines are unsuitable for use with chloroquine to end one's life. Research into the literature shows this advice to be unfounded. Diazepam is indeed used to counteract chloroquine poisoning. But this does not allow us to conclude that diazepam

is an antidote to the lethal effect of chloroquine on the heart.[1] Tests on animals have not confirmed this.[2] Also, on theoretical grounds diazepam would not be expected to prevent cardiac arrest brought on by chloroquine.

In our view, diazepam has been used by clinicians in emergency cases against chloroquine poisoning because it suppresses muscular contractions and epileptic seizures. It is also exactly these contractions and seizures that one will want to suppress in the case of a chloroquine overdose for a humane self-chosen death. Diazepam and the other benzodiazepines are suitable for this. They are not an antidote to the lethal effect of chloroquine on the heart.

Instead of benzodiazepines, *Departing Drugs* (1993) recommends the sleeping pill zopiclone, which has a different chemical structure from that of the benzodiazepines. Zopiclone can be quite slow in inducing sleep. After taking it, one may have to wait more than an hour before falling asleep. Two cases in which this happened have been reported to wozz. This implies that there is the risk of still being conscious when painful muscular contractions occur. This has been a frightening experience both for the person concerned and for those present. We therefore advise against the use of zopiclone.

Advise of the research committee regarding sleeping pills in combination with chloroquine

We recommend using a combination of benzodiazepines that work quickly to provide both a deep and long-lasting sleep when using chloroquine to hasten death. The long-acting benzodiazepines provide

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1. Demaziere, J., Saissy, J. M., Vitris, M., Seck, M., Ndiaye, M., Gaye, M., & Marcoux, M. (1992). Effects of diazepam on mortality from acute chloroquine poisoning. *Annales Françaises d'anesthèsie et de Rèanimation*, *11*, 164-167.
Clemessy, J. L., Taboulet, P., Hoffman, J. R., Hantson, P., Barriot, P., Bismuth, C., & Baud, F. J. (1996). Treatment of acute chloroquine poisoning: A 5-year experience. *Critical Care Medicine*, *24*, 1189-1195.
Clemessy, J. L., Angel, G., Borron, S. W., Ndiaye, M., Le Brun, F., Julien, H., Galliot, M., Vicaut, E., & Baud, F. J. (1996). Therapeutic trial of diazepam versus placebo in acute chloroquine intoxications of moderate gravity. *Intensive Care Medicine*, *22*, 1400-1405.
2. Buckley, N. A., Smith, A. J., Dosen, P., & O'Connell, D. L. (1996). Effects of catecholamines and diazepam in chloroquine poisoning in barbiturate anaesthetised rats. *Human & experimental toxicology*, *15*, 909-914.

deep sleep but can sometimes take an hour to work so that one might *not yet* be deeply asleep when muscular contractions are brought on by the chloroquine. To fall into a deep sleep quickly, the chloroquine and long-acting benzodiazepines should be combined with another, fast-acting benzodiazepine (2.2.7).

How to take the drug

Anti-emetics are essential and the first choice is metoclopramide (See 2.2.8).

Chloroquine is so bitter that it can bring on retching or vomiting. It is best not to grind the tablets, but to mask the bitter taste by taking the tablets with some custard or yogurt. The bitter taste can then be washed away with water or milk. It is advisable not to drink too much as this can provoke vomiting.

The long-acting benzodiazepines must be taken at the same time as the chloroquine.

It is better to take the fast-acting benzodiazepines last, to avoid falling asleep while taking the chloroquine. With a very fast-acting benzodiazepine, such as midazolam, one risks falling asleep within 5 minutes (2.2.7).

Reported cases

12 planned deaths with chloroquine have been reported, all of them successful.

- 1 person used 14 grams of chloroquine sulphate;
- 5 others used 10 grams chloroquine sulphate each;
- 1 person used 8 grams of chloroquine base;
- 5 persons: the dose is unknown.

In 5 persons, death took place after 2-3 hours. In the other cases the elapsed time to death is not known because no one was present.

The sleeping pills used were:

- 5 persons used zopiclone as a sleeping pill;
- 2 of them took 300 mg zopiclone;
  for the others the dose is not known;
  for 2 persons who took zopiclone it took more than an hour to fall asleep; one of them experienced painful muscular contractions brought on by chloroquine while fully awake so his death certainly was not humane. For the relatives present, this was a most upsetting experience. The committee, therefore, advises against the use of zopiclone.

- 1 person used 6 tablets of Vesparax (containing 1200 mg barbiturates) as a sleeping pill together with 60 mgs of midazolam. This produced a long-lasting deep sleep without any muscular contractions.
- 2 persons used 3 tablets of Vesparax as a sleeping pill; death took place without unpleasant side effects. The working group regards this as risky because 3 tablets of Vesparax (containing 3 x 200 = 600 mg barbiturate) are too little to provide a long-lasting sleep. The use of 6 tablets of Vesparax (= 1200 mg barbiturate) provides more guarantee of a long-lasting deep sleep.
- 2 persons used a large number (exact dose unknown) of temazepam. They died alone so it is unknown whether side effects occurred. Temazepam is not a long-acting benzodiazepine. Therefore, there is some risk that its sleep-inducing effect fades away while the toxic effects on the heart by chloroquine are not lethal yet.
- 1 person used 4 grams of hydroxine as a sleeping pill – an antihistaminic agent with a sedative effect. Antihistaminic drugs do not guarantee a long-lasting and deep sleep so one may wake up experiencing the toxic effects of chloroquine, which means a cruel death.
- 1 person: not known what sleeping pill was used.

Summary

8 grams of chloroquine base are effective in causing death (11 grams of the chloroquine salts or 12 grams of hydroxychloroquine). In many countries chloroquine is sold in pharmacies and drugstores without prescription. This makes chloroquine one of the easiest available lethal medicines for use in a humane self-chosen death.

Use of a sleeping pill in a sufficient dose is essential to repress the unpleasant effects that precede death. Barbiturates (1200 mg) as sleeping pills work fast enough to provide a sufficiently deep and long-lasting sleep. Barbiturates are, however, very hard to obtain.

The authors advise to use a long-acting benzodiazepine as well as a fast-acting benzodiazepine (2.2.7).

CHAPTER 6

Tricyclic antidepressants

60 This Chapter discusses eight antidepressants that can be used for humane ending of life. Although other antidepressants may also be lethal in heavy doses, the working group concludes from the toxicological literature that their lethal effects are uncertain.

There are eight tricyclic antidepressant drugs, in alphabetical order:

- Amitriptyline: tablets of 10, 25, 50 and 75 mg.
- Clomipramine: tablets of 10, 25 and 75 mg.
- Desipramine: coated tablet of 25 mg.
- Dosulepine: capsule of 25 mg, coated tablet of 75 mg.
- Doxepine: capsules of 10, 25, 50, 75 and 100 mg.
- Imipramine: tablets of 10 and 25 mg.
- Nortriptyline: tablets of 10, 25 and 50 mg.
- Trimipramine: tablets of 25 mg.

Cause of death

Death is caused by heart failure (arrhythmia), possibly in combination with cessation of breathing.

Availability

In case of depressive complaints of some duration, physicians often prescribe as a first choice antidepressants from another group: SSRI-antidepressants, e.g. Prozac or Seroxat. If no therapeutic response occurs and the depression becomes more severe, the tricyclic group of antidepressants is given a try, in particular amitriptyline, clomipramine or nortriptyline. Amitriptyline is also prescribed in case of insomnia and chronic pain. Although available only on prescription, these antidepressants are relatively easy to collect.[1]

1. Recent information on tricyclic antidepressants in a Dutch medicinal bulletin concludes that there are no indications that the large-scale prescribing of other, less lethal antidepressants has led to a decrease in the number of suicides with tricyclic antidepressants. See Bijl, D. & Verhoeven, W. M. A. (2002). Antidepressiva bij depressie: een kritische beschouwing. *Geneesmiddelenbulletin, 36*, 51-59.

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Lethal dose

For all tricyclic antidepressants the research committee advises a dose of 6 grams. Combination with benzodiazepine(s) to induce a long and deep sleep is necessary (see below). Tricyclic antidepressants slow down the digestive process, therefore also slowing the absorption of antidepressants. Death should generally occur 12 to 24 hours after taking these lethal drugs.[2] But one should be aware of the possibility that death sometimes takes between 24 and 48 hours. For the self-chosen death to succeed, it is essential that no life-saving treatment is started during the first 48 hours.

Tolerance and withdrawal

Tricyclic antidepressants do not lead to tolerance. If they have been used prior to a planned death, there is no need to stop taking them and to go through a withdrawal phase. But it is essential that one complete withdrawal from any benzodiazepines that are used (2.2.6).

Necessary sleeping pills

No antidepressant gives a deep, long-lasting sleep. Combination with benzodiazepine(s) is necessary to ensure that the toxic symptoms preceding death are suppressed and go unnoticed. These symptoms include epileptic attacks and high temperature.

We advise that together with these antidepressants at least one long-acting benzodiazepine is used in the dose indicated (2.2.7).

How to take the drug

The use of anti-emetics for 36 hours preceding the hastening of death is essential (2.2.8).

A very large number of tablets must sometimes be taken (6 grams = 240 tablets of 25 mg.) It is advisable to grind them finely and sprinkle in custard or yogurt.

Capsules or coated tablets are sometimes prescribed. The former can be opened and the contents sprinkled. Coated pills cannot be ground up or opened – these must be swallowed wholly with yogurt or custard. If a fast-acting benzodiazepine is used as well, it is important to ensure that one does not fall asleep while taking the drugs. For this

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2. Smith, C. K. (1995). Tricyclic antidepressants: A new look. In C. K. Smith, Docker, C. G., Hofsess, J. & Dunn, B. (Eds.), *Beyond Final Exit* (pp. 29-39). Victoria: Right to Die Society of Canada.

reason the fast-acting benzodiazepine should be taken only *after* all antidepressant pills and the long-acting benzodiazepine have been swallowed.

Reported cases

Only one self-chosen death has been reported to WOZZ, using 4 grams of amitriptyline and only 120 mg flurazepam. It is known that less than 6 grams can sometimes be a lethal dose. To be certain, the authors recommend to use 6 grams.

The low dose of 120 grams of flurazepam was in this case probably compensated by the sedative effect of amitriptyline. With the other antidepressants that have been named, an insufficient dose of sleeping pills can result in the person being conscious during the toxic symptoms. This makes the death inhumane.

Summary

There is toxicological evidence that tricyclic antidepressants are lethal in a dose of 6 grams. For death to be humane they should be taken together with at least the recommended dose of one long-acting benzodiazepine.

Tricyclic antidepressants are not difficult to collect in many countries.

CHAPTER 7

Orphenadrine

This Chapter discusses orphenadrine, a drug that is used to treat muscle stiffness caused by strains and sprains. It is also prescribed to treat the trembling caused by Parkinson's disease.

Cause of death

Death is caused by cardiac arrest and apnea (cessation of breathing).

Availability

Orphenadrine comes in a coated tablet of 50 mg. In many countries it is rarely prescribed these days because there are more effective medications to treat Parkinson's disease. Although difficult to obtain in some countries, one may succeed in getting it if one politely insists the physician prescribes this drug because it's the only one that relieves one's complaints.

Lethal dose

The working group advises 3.5 grams (70 coated pills of 50 mg) as the lethal dose. Like the antidepressants, orphenadrine slows down the emptying of the stomach and absorption from the intestines so a high blood level is reached slowly. For this reason, death can take a long time (more than 24 hours) to occur. It is, therefore, essential that no life-saving interventions take place for the first 48 hours after taking the drugs.

Tolerance and withdrawal

Orphenadrine does not lead to tolerance. If one has been using the drug *prior to the planned death there is no need to stop using it. Withdrawal* from any benzodiazepines that have been used is essential (2.2.6).

Necessary sleeping pills

Orphenadrine leaves the consciousness clear. When using it for hastening one's death, it must be combined with at least one long-acting benzodiazepine (2.2.7) so that one is unaware of the toxic effects.

How to take the drug

Use of an anti-emetic starting 36 hours before the planned death is necessary (2.2.8). Orphenadrine-coated pills cannot be ground up or opened: they must be ingested whole. To swallow 70 tablets takes some time. They are somewhat easier to take if mixed into custard or yogurt than if taken individually.

Reported cases

The working group has received six reports of planned death with orphenadrine. Two of these failed. Both failures occurred with persons addicted to alcohol. We suspect that the precautions may have been carelessly followed while under the influence of alcohol. The cause of failure, however, is uncertain because no reliable account is available.

In one witnessed case, death was reported to occur 14 hours after ingestion of orphenadrine.

Summary

From the toxicological literature it appears that orphenadrine can be effective in a dose of 3.5 grams provided all the precautions mentioned are taken. Combination with at least one long-acting benzodiazepine is essential.

The two reported failures underline the importance of great precision in carrying out the plan. Where possible, the lethal drugs discussed in previous Chapters are preferred to orphenadrine.

CHAPTER 8

Helium gas: a non-drug method

Helium is the inert gas commonly used to make party balloons float in the air. It has no odor or color and it is non-flammable. If helium is breathed in a confined space, such as inside a plastic bag, one can lose consciousness due to lack of oxygen after a few breaths. Death will follow shortly afterward.

Many people will be familiar with the "Donald Duck" voice that can be achieved by talking after inhaling a small amount of helium gas from a balloon. For healthy people, this voice altering amusement is relatively harmless as long as one is in a well-ventilated area so that normal breathing will reintroduce oxygen to the body's circulatory system.

Although rare, accidental deaths by helium inhalation can occur. For example, in Japan, a 14-year-old boy died after he climbed into a large advertising balloon filled with pure helium.[1]

The breathing of helium gas is a relatively new technique for humane planned death. Simply, one breathes helium while one's head is fully enveloped inside a plastic bag. This method was first discussed by right to die activists in 1999[2] and soon became a favored method for many carefully planned deaths in North America.[3]

The contents of this Chapter are informed by eyewitness reports on 119 self-chosen deaths from helium inhalation.

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1. Yoshitome, K., Ishikawa, T., Yamamoto, Y., Miyaishi, S., & Ishizu, H. (2002). A case of suffocation by an advertising balloon filled with pure helium gas. *Acta Medica Oyama*, *56*, 53-55.
2. Ogden, R. D. (2001). Non-physician-assisted suicide: The technological imperative of the deathing counterculture. *Death Studies*, *25*, 387-401.
3. In addition to this guide, other publications give details on self-chosen death using helium. For example, readers might explore Chapter 23 in the third edition of *Final Exit* (2002). ERGO, the Euthanasia Research and Guidance Organization sells a "how-to" DVD and VHS video, which explicitly describes the helium method and also demonstrates a simulated helium suicide (Appendix 1). Note that these sources give advice that deviates on some points with our argued preferences.

People who do not wish to take any drugs, or who wish to die more quickly than usually possible with oral medications, might consider helium as a means to a carefully planned and humane death.

Cause of death

Inhalation of 100% pure helium (which is not mixed with oxygen) causes rapid death due to oxygen deprivation. When breathing pure helium inside a plastic bag, unconsciousness follows after about 5 breaths. In 62 cases where "time to unconsciousness" was reported, the average was 35 seconds (range 10 to 120 seconds). Death will often follow in about 10 minutes, sometimes as quickly as 5 minutes. Elapsed "time to death" was reported in 108 cases. The average was 13 minutes (range was 2 to 40 minutes).

While breathing pure helium there is no feeling of suffocation or choking. This is because the breathing of helium permits the lungs to continue exhaling carbon dioxide.[4] The brain never receives any warning signal of suffocation when breathing helium (or any other inert gas).[5]

Death by helium inhalation is not detectable through any known toxicological test. Only a witness, or materials left at the scene can confirm helium inhalation as a cause of death.[6] This is because helium rapidly dissipates into the surrounding air and does not remain in the body tissues or blood cells.

Helium delivered into a plastic bag poses no risk to anyone breathing air outside the bag. Even when the contents of a large tank of helium are released into normal air space, the helium will quickly dilute and presents no harm as long as oxygen is present.[7]

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4. The feeling of suffocation is brought on by the physiological reflex to remove an excess of carbon dioxide from the body. When breathing helium, unconciousness comes so extremely quickly (see below) that by the time the carbon dioxide concentration increases any conscious experience of suffocation has become impossible

5. Auwärter, V. Pragst, F. & Strauch, H. (2004). Analytical investigations in a death case by suffocation in an argon atmosphere. *Forensic Science International*, *143*, 169-175.

6. Ogden, R. D. & Wooten, R. H. (2002). Asphyxial suicide with helium and a plastic bag. *The American Journal of Forensic Medicine and Pathology*, *23*, 234-237.

7. In contrast to helium, death by inhalation of carbon monoxide poses a serious risk to anyone in the same room. The reason is that even small quantities of carbon monoxide bind to the hemoglobin and actually prevent oxygen absorption for quite some time. Helium does not have any such effect (see chapter 10.2).

Availability

Helium gas is available in a number of forms. The most convenient source is in small non-refillable tanks designed for inflating party balloons. In the USA and Canada these can be purchased from many toy stores. These "balloon kit" tanks usually come in 4.5, 8.9 and 14.9 cu. ft. sizes and weigh between 5 and 9 pounds (2.5 to 4 kg.). The prices range from $20 - $50 US. For a self chosen death, the minimum recommended size is an 8.9 cu. ft. tank. If a larger tank is available, this is even better.[8]

Helium balloon kits are less popular in Europe, but they are available. Refillable tanks can also be rented or purchased through party equipment suppliers. There may be a registration process that accompanies rental of refillable helium tanks.

Additional materials are required–plastic tubing, a plastic bag, and an elastic athletic headband. The flexible tubing (approximately 7 feet) can be purchased in most hardware stores. A high strength plastic bag (e.g. oven roasting bag, 19 x 24 inches) is available in grocery stores.

Lethal dose

Nearly all of the 119 reported cases used non-refillable party balloon kits. A small tank (4.5 cu. ft.) contains enough helium to cause death when breathed inside a plastic bag. This assumes the tank is full and the plastic bag has no obvious leaks. We strongly advise an 8.9 cu. ft. tank. This gives more certainty in case the tank is not completely full.

Tolerance and withdrawal of existing medication

With helium, one need not be concerned about any other medications that one is taking.

Sleeping pills

To be sure that one does not make any errors in the procedure, sleeping pills are not recommended. In 31 reported cases, the patient took no medication at all (e.g. sleep medication). Witnesses report no complications arising from being drug free. Average time to death is also unchanged.

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8. Some people have combined two small tanks (4.5 cu ft) with a T-junction that is attached to the tube leading to the plastic bag. We do not show this technique and advise against it, because it means 5 connections instead of one, thus more risk of leaking helium. A single 8.9 cu ft tank or larger is best. Sizes of helium tanks may vary outside North America.

How to use helium

Ideally, the pressure of the helium tank should be tested with a pressure gauge. Most tanks are set to a working pressure of about 260 psi (pounds per square inch). Some of our informants have said it is also a good idea (but not necessary) to attach a flow meter to the tube coming from the tank, set to allow a gas flow of 10 liters per minute. WOZZ does not recommend this unless one is quite handy with such equipment. Fewer pieces of equipment means fewer connections, and less chance for leaking connections. A large (8.9 cu. ft.) tank set to a slow flow of helium into a plastic bag secured around one's neck will last at least 30 minutes before the tank is empty. A flow of 30 minutes before the tank is empty is more than sufficient for death to occur.

Several right to die organizations in the United States and Canada have members who are quite knowledgeable about the use of helium for self-deliverance. Readers who feel the procedure described below is too complicated may wish to contact one of them.[9] Some advise the use of two tanks connected by a T-junction. This means five connections instead of one, thus more risk of leaking helium at the junctions. Therefore we do not show this technique in our drawings. A single large 8.9 cu ft tank that is new contains enough helium and is most simple to construct with a tube running straight from the tank to the balloon. We do not recommend a back up tank, as some do, because they fear the first tank may not be full. We advise that one buys a new tank. Moreover, connecting a back up tank when the first tank runs out of gas prematurely would necessitate active steps by other people which puts them into serious legal risks (Chapter 11).

It is critical that one rehearse the steps for a planned death by helium (but without actually breathing helium). Below are the necessary steps:

1. Collect the following items:
   a. One large helium tank (8.9 cu. ft.).
   b. Oven roasting bag (19 x 24 inch; 45 x 60 cm.), purchasable in grocery stores (do not substitute oven roasting bags with ones of less strength).

9. See Appendix 1 for addresses of the Final Exit Network, Ergo, Compassionate Chaplaincy, or the Right to Die Society of Canada. One can ask for a referral to discuss this technique with a member.

c. Soft plastic tubing, approximately 6 feet (2 meters). The tubing must fit snugly over the tank nozzle (Fig. 1). For most party balloon kits, this requires tubing with an inner diameter of either 3/8 inch or 5/16 inch.[10]
d. Terry cloth elastic athletic headband.
e. Adjustable wrench or pliers (Fig. 1 on page 71).

2. Preparation of the helium tank and tubing (see diagrams):
   a. Use an adjustable wrench or pliers to remove the plastic nozzle assembly from the helium tank (Fig. 1). This will expose a small threaded metal nipple.
   b. Dip the tip (1/4 inch) of the tubing into hot water for a few seconds. This should make the tube pliable enough to slip snugly over the threaded metal nipple (Fig. 1).
   c. Allow the plastic tube to cool and check that the fit is snug. If it is loose, use smaller diameter tubing. Secure the tubing to the tank with tape.
   d. Inspect the bag carefully and blow it up like a balloon to ensure there are no holes. Place the other end of the tube inside the plastic bag. Secure it with tape (Fig. 2).
   e. To prevent accidental tipping of the tank and dislodging of the tubing connection, leave the tank in the box in which it is delivered, or secure it with bungee cords to the leg of a bed or chair.

3. The helium procedure:
   Warnings:
   * *Carry out several practice runs, without helium, so that you are comfortable with each step in the procedure.*
   * *Avoid breathing helium during practice runs. Breathing helium inside a plastic bag for only 30 seconds can cause serious and irreversible brain injury.*
   * *It is mandatory that a new helium tank is used. This ensures adequate tank pressure and contents.*

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10. There are suppliers in North America who sell kits comprising tubing and a plastic bag with an elastic collar. Readers might contact ERGO, Final Exit Network, Compassionate Chaplaincy, or the Right to Die Society of Canada for a referral to these suppliers (Appendix 1).

a. If one has long hair, tie it high up in a bun so that all hair is well away from the neckline. It is very important that hair not interfere when the bag and elastic band are later pulled down to the neck (see Fig. 6).
b. Sit upright or semi-upright in a comfortable chair or even better in bed propped up with pillows, which avoids the necessity of later moving the body of the deceased into bed. Place the plastic bag on your head, covering the ears and forehead only. Secure the bag with the athletic headband (Fig. 3).
c. Open the valve on the helium tank, and then close it immediately. This loosens the valve and will give you more control to adjust the helium flow in the next steps.
d. Roll or scrunch the bag down with one or two hands to remove most of the air. The bag is covering the forehead, ears, and the back of the head at the hairline–just like a shower cap (Fig. 3).
e. Slowly open the valve on the helium tank so that the bag starts to inflate (Fig. 4). The flow of helium should be low, enough to allow the bag to remain inflated. If the helium flow is too fast, you may run out of gas too soon.
f. When the bag is inflated, grasp it at the bottom along with the athletic headband. Prepare to pull the bag down over your head and under your chin, so that the headband will act as a collar to seal the bag at your neck. The seal should not be airtight: under the pressure of the continuous helium flow, any air in the bag will be driven out through gaps between the neck and bag. Some helium should also escape from these gaps.
g. *Before* pulling down the bag, exhale to empty your lungs of air (Fig. 5). Then hold your breath until the inflated bag is pulled down over your head (Fig. 6). Your first inhaled breath will be a deep one, inside the helium-inflated bag. Note that some helium continues to escape through the seal around the neck. This is acceptable because the flow from the tank will keep the bag inflated.
h. Continue breathing normally (Fig. 7). Unconsciousness will often come within 5 breaths. In some cases, unconsciousness has been reported after the second breath.

The Helium Procedure

Fig 1 *Remove plastic nut and nozzle (may require wrench or pliers). Attach tubing to nipple on tank valve*

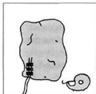

Fig 2 *Insert other end of tubing inside bag and secure with tape*

Fig 3 *Place bag on head like a shower cap, with elastic as shown. Long hair must be tied up above neckline. Scrunch bag to remove air from the bag*

Fig 4 *Start flow of helium so that bag slowly inflates on top of head*

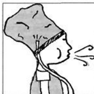

Fig 5 *Exhale deeply to remove air from lungs*

Fig 6 *Pull inflated bag down so that elastic sits at the neck*

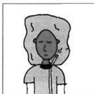

Fig 7 *Breathe normally. Unconsciousness will occur very quickly*

Drawings by Meghan Ogden

Reported cases

Over a 4 year period, reports on 121 planned deaths using helium have been received. A plastic bag was used in all cases except two, in which helium was delivered via a mask with the direct aid of another person. We advise against that sort of assistance (see Chapter 11).

In 119 cases using helium with plastic bags, the following information is of importance:

- In about 50% of the reported cases, the patient took sleep medication and an assistant pulled down the plastic bag and turned on the helium. If discovered, these actions risk prosecution. WOZZ advises against this course of action. Most terminal patients are still able to open the valve on the helium tank and to pull down the bag under their chin. By these two acts they can take the responsibility for their own death instead of making someone else responsible.
- Nearly all cases used non-refillable party balloon kits. Although convenient, this source is less reliable than an industrial size tank, which holds a much larger supply of helium.[11]
- In one case a smaller oven roasting bag was used (14 x 20 rather than 19 x 24 inches). The witness reported that the helium tank took longer than usual to run out. This is probably due to the reduced volume in the smaller bag.
- In 62 cases where "time to unconsciousness" was reported, the average was 35 seconds (range 10 to 120 seconds). In cases where unconsciousness took longer than average, there were reports of difficulties with gas flow, leaking tube/nozzle connections, or improper seals between the bag and the neck (e.g., hair not tied up or bag not properly pulled down). Proper preparation and "practice runs" would eliminate most of these difficulties.
- Elapsed "time to death" was reported in 108 cases. The average was 13 minutes (range was 2 to 40 minutes).
- In the single death that reportedly took only 2 minutes, the patient suffered from ALS. The degree to which ALS already compromised breathing is unknown. In a total of 13 reported ALS cases, average time to death was 11 minutes (range 2 to 18 minutes).
- Witnesses report muscular contractions (clonus) in about half of helium deaths. These spasms occur between 2 minutes and 8 minutes into the procedure. Arms and legs will tighten and relax a few times,

11. We have been informed that in July 2006 a major supplier of helium will increase distribution of the 8.9 cu ft tank, so people can expect easier access to this size of tank.

from about 10 seconds to 2 minutes duration. An inexperienced observer may misinterpret arm-tightening contractions as an effort to remove the bag. This is not the case. These contractions are also common during anesthesia in surgery settings. Witnesses who have attended several helium suicides say that they have never seen a case where the hands have actually reached as far as the plastic bag. They also report that when family members or loved ones are told about these muscular contractions, they are not troubled when they see it happen. Because the patient is unconscious at this point, there will be no experience of discomfort.

- Additional to muscular contractions, some deep gasps are common.
- In 31 cases, the patient took no medication at all (e.g. sleep or relaxant medications). Witnesses report no complications arising from being drug free. Average time to death is also unchanged.
- Being medication free appears unrelated to muscle tightening or spasms. In 18 of the 31 drug free cases, spasms were reported in 11, no spasms in 7, and no information provided in 13 cases.
- In most cases the helium equipment was removed prior to reporting of the death. Cause of death in such circumstances is usually attributed to an underlying illness. WOZZ does not recommend that one interfere by removing evidence of a self-chosen death. In case one decides to remove the bag one should postpone this for at least 15 minutes after breathing has stopped. This is a precaution to make sure the person really has died.

Summary

Helium gas inhaled inside a plastic bag is a highly effective means for hastening death.[12] It is available in disposable party balloon kits and in refillable tanks from party supply shops. No withdrawal period from any medications is required. No other medications need to be used with helium. If helium is to be used, it is very important that one carefully adhere to the prescribed steps, including practice sessions, to ensure that equipment is operational and that the proper technique is followed.

12. See Ogden, R. D. & Wooten, R. H. (2002). Asphyxial suicide with helium and a plastic bag. *The American Journal of Forensic Medicine and Pathology*, 23, 234-237. Gallagher, K. E., Smith, D. M., & Mellen, P. F. (2003). Suicidal Asphyxiation by Using Pure Helium Gas: Case Report, Review and Discussion of the Influence of the Internet. *The American Journal of Forensic Medicine and Pathology*, 24, 361-363. Gilson, T., Parks, B. O., & Porterfield, C. M. (2003). Suicide with Inert Gases: Addendum to Final Exit. *The American Journal of Forensic Medicine and Pathology*, 24, 306-308.

CHAPTER 9

How doctors do it: physician-assisted suicide in Switzerland, the Netherlands and Oregon

As outlined in Chapter one, our basic rule for the methods discussed in this book is that a person should be able to perform the actual life-terminating actions without substantial help from others. During the preparatory phase, however, some help from relatives or others may well be needed because of terminal or crippling illnesses or frailty due to old age.

The reason why we have included this Chapter in this book is that there is one obvious exception to this basic rule. If a patient cannot move his arms or cannot swallow anymore, for instance in ALS or Lou-Gehrig's disease, the final phase of a self-chosen death cannot be performed independently. In such cases assistance from a compassionate doctor is indispensable. Many doctors still don't know exactly how to do that. Therefore this Chapter explains the technicalities of a self-chosen death with the lawful assistance of a physician, or in the case of Switzerland, a trained health care worker (for instance a volunteer of a right to die organisation).

In the countries that permit assistance with a self-chosen death a great deal has been learned about the technical aspects. We have collected the published experiences on technical aspects from Switzerland (the Canton of Zurich), the Netherlands and Oregon, USA. In Belgium, euthanasia under strict conditions was legalised in 2002, but technical data on euthanasia performed by doctors are not available.

In this Chapter we will use the term "physician-assisted suicide" (PAS) that has become standard in the literature. Because this Chapter discusses technical aspects of how doctors do it, lay readers may find some points more complicated than other Chapters in this book.

In Chapter 9.1 we summarise data about the oral ingestion of drugs in assisted suicide in Switzerland and physician-assisted suicide in the Netherlands and Oregon. In Chapter 9.2 we give the technical aspects of the intravenous route, based on data from the Netherlands.

9.1 Physician-assisted suicide by a lethal dose of barbiturates taken orally

Switzerland

Bosshard et al. (2003) analysed 748 case records of assisted suicide by the Swiss right to die organisation *Exit Deutsche Schweiz* over an eleven year period (1990-2000).[1] Of the 748 deaths, 276 of *Exit's* case records were verified against official city records in Zurich. A total of 261 of the 276 took between 10 - 12 grams pentobarbital. This is more or less double the 6 grams we advised in Chapter 3. As we stated there, nobody has ever woken up after ingestion of 6 grams of a barbiturate, if not tolerant to the drug and if no vomiting occurred.

In the majority of cases the prescribing physician was not present at the self-chosen death. Instead, a volunteer of *Exit Deutsche Schweiz* was present in all cases and then reporting death to the authorities. This is common practice in Switzerland. Over the period 1997-2000 the barbiturates were prescribed by the attending or family-physician in 31% of the cases and by a physician working for the right to die organisation in 52%. In the remaining 17% it was unknown by whom the barbiturates were prescribed. Death followed within one hour in 88% of all cases (see Table 9-1, data from Bosshard 2003).

Table 9-1: Time interval between oral ingestion of 10 - 12 grams pentobarbital and death (261 cases)

0-15 min	70	(27%)
16-30 min	115	(44%)
31-60 min	44	(17%)
1-2 h	11	(4%)
2-12 h	20	(8%)
> 12 h	1	(0.4%)
total	261	(100%)

Instead of pentobarbital, in 15 cases the prescribed drug was 10 - 15 grams of secobarbital. The median time to death was 25 minutes (range 11 minutes to 6.5 hours). An anti-emetic was swallowed beforehand in all pentobarbital and secobarbital cases. All 276 persons died as a result of the overdose of barbiturates.

1. Bosshard, G., Ulrich, E., & Bär, W. (2003). 748 cases of suicide assisted by a Swiss right to die organization. *Swiss Medical Weekly*, 133, 310-317.

The Netherlands

Horikx and Admiraal (2000) have documented 60 cases of oral ingestion of 9 grams of either liquid secobarbital or pentobarbital.[2] Below is the recipe used by pharmacists to prepare a lethal drink of 100 ml (the content of a small glass), which is quite bitter. For patients who find 100 ml too much the same ingredients can be dissolved in a 75 ml mixture. Using a lemonade straw to drink has the disadvantage that the patient sometimes falls asleep before the glass has been emptied.

Nontherapeutic mixture of pentobarbital or secobarbital:

Barbitalum natricum	9 g	(pentobarbital or secobarbital)
Alcohol 96%	16.2 g	(20 ml)
Aqua purificata	15 g	
Propylenglycolum	10.4 g	(10 ml)
Saccharinum natr.	250 mg	
Sirupus simplex	65 g	
Anisi aetheroleum	1 g	

Instruction for preparation by a pharmacist:
Dissolve pentobarbital or secobarbital by shaking in the mixture of water, propylenglycol and alcohol. Dissolve saccharine and add sirupus and anisi. This solution will be stable for one month.

We received unpublished data on 123 cases from A. Horikx, staff member of the Royal Dutch Pharmaceutical Society (these include the 60 cases in her publication with Admiraal).

Table 9-2: Time to death after oral ingestion of 9 grams pentobarbital (102 cases) or secobarbital (21 cases)

0-15 min	39	(32%)
16-30 min	40	(33%)
30-60 min	21	(17%)
1-2 h	9	(7%)
Euthanasia by the physician after 2 or more hours waiting*	9	(7%)
unknown	5	(4%)
total	123	(100%)

Data from A. Horikx, staff member of the Royal Dutch Pharmaceutical Society

2. Horikx A. & Admiraal, P. V. (2000). Toepassing van euthanatica; ervaringen van artsen bij 227 patiënten, 1998-2000 (Application of euthanatics; experiences of physicians in 227 patients, 1998-2000). Ned Tijdschr Geneeskd, ▸

*After a few hours the coma has become irreversible and the patient will certainly die. In cases where the dying processes takes longer than a few hours, most Dutch doctors will end life by an injection to end the stress of waiting for the relatives. They inject a curare-like muscle relaxant which makes breathing impossible (see Chapter 9.2).

All 123 patients died after ingesting 9 grams of pento – or secobarbital. Table 9-2 shows that in 82% of the reported cases, death followed within one hour after oral ingestion of 9 grams of liquid pentobarbital or secobarbital. Note the similarity in registered time to death between the data from Bosshard in Switzerland (Table 9-1) and from Horikx in the Netherlands (Table 9-2).

An anti-emetic, metoclopramide, was taken by 39 out of the 60 cases during the 24 hours preceding the planned time for self-deliverance (every 6-8 hours a 10 mg tablet or 20 mg suppository). None of them vomited. Vomiting was reported in 2 of the 21 cases without metoclopramide, but in spite of this the patient died.

Horikx warns that the absorption of barbiturates given by suppository is very unpredictable, especially so in terminal patients. In the recently updated guidelines of the Royal Dutch Pharmaceutical Society (2006), the use of suppositories for assisted suicide is strongly discouraged.[3]

Oregon

Through an annual report, the Oregon Department of Human Services releases data on physician-assisted suicide. For the period 1998-2005 there were 246 deaths.[4] Of these deaths, 105 (43%) used secobarbital and 137 (56%) used pentobarbital. In the remaining 4 cases, 3 used a secobarbital/amobarbital mixture and 1 used secobarbital and morphine (Table 9-3).

▸ 144, 2497-2450. After this publication, Horikx collected data which have been included in Table 9-2. Additional technical details in: Horikx, A. (2004) [in Dutch]. Questions and answers on carrying out euthanasia: *Pharmaceutical Weekly, 139*, 1322-3.

3. Unfortunately, the Royal Dutch Pharmaceutical Society has not translated these guidelines in English.

4. Department of Human Services Office of Disease Prevention and Epidemiology. (2006, March 9). Eighth annual report on Oregon's Death with Dignity Act. Oregon: DHS. Retrieved May 23, 2006, from http://www.oregon.gov/DHS/ph/pas/ar-index.shtml

The first 3 years of Oregon's reports state that 9 or more grams of barbiturate were prescribed. Subsequent reports do not disclose the dosage prescribed, but we have learned from reliable sources that 9 – 10 grams of barbiturate continues to be the standard dose.

Oregon's annual reports do not separate cases according to the specific drugs given. Therefore, the reported time to death is aggregate data.

Table 9-3: Time to death after oral ingestion of pentobarbital or secobarbital (246 cases)*

Time from ingestion to unconsciousness	range 1 - 38 min.; median 5 min. (24 unknown)
Time from ingestion to death	range 4 min. to 48 hrs; median 25 min. (17 unknown)

*includes 4 "other" cases (3 secobarbital/amobarbital; 1 secobarbital/morphine)

Unlike the Royal Dutch Pharmaceutical Society, the Oregon Board of Pharmacy does not have any guidelines for physician-assisted suicide. We are informed by reliable sources that it is common practice for patients to take anti-emetic medications only 1 hour prior to swallowing the barbiturate. In Chapter 2.2.8 we recommend that one begins using anti-emetics at least 36 hours before carrying out a humane self-chosen death.

Regurgitation has been reported in 12 (5%) of the 246 cases. WOZZ believes this complication would be reduced with an earlier start of the use of anti-emetic medication.

In Oregon there has been one failure reported that merits discussion. In this instance, the patient awakened 65 hours after supposedly taking 9-10 grams of short-acting barbiturates. Two explanations for this failure have been suggested. First, although 9 grams of Seconal were prescribed, it is not certain that the patient ingested all of it. Second, the patient swallowed the barbiturates together with Lactulose (a laxative) to sweeten the bitter taste. Lactulose is a laxative which may well have caused some of the drug to pass through the bowel without being absorbed.

9.2 Euthanasia by two consecutive injections

The Netherlands

Horikx and Admiraal (2000) reported on 152 cases of euthanasia that were carried out by two consecutive injections that is recommended by the Royal Dutch Pharmaceutical Society.

First an intravenous injection is given of 1.5 grams thiopentalnatrium (Pentothal[R]) 3 ampules of 0.5 grams each. These 3 ampules can be solved in 10 ml physiological NaCl but this solution should be used within one hour (after one hour a precipitation may occur in the syringe). Thiopental ampules are usually available in hospital pharmacies (on prescription by a physician) because they are used by anesthesiologists. The purpose of this first injection is to put the patient into a deep sleep or coma, so that there will be no awareness of the respiratory arrest caused by the second injection. In quite a few cases the first injection causes death by cardiac arrest (43 out of 140, see Table 9-4). In these cases there is no need for a second injection.

Only when the physician is absolutely certain that a deep sleep or coma – which usually comes within 1-5 minutes– has been attained, then a second intravenous injection is given with a non-depolarising muscle relaxant. Usually 20 mg of pancuronium dibromide (Pavulon[R]) is given, but other drugs of the same pharmacological group are sometimes used instead (e.g. 45 mg alcuronium dicloride or Alloferin[R]). These curare-like drugs (not curare itself!) cause a respiratory arrest instantly. It may then take up to 10 minutes before the heart stops beating. In the six cases (see Table 9-4) where death took more than 15 minutes, there is serious doubt whether an *intravenous* injection was given correctly, which can be very difficult in old cachectic patients. We suspect that in those cases the injection was in fact given outside the vessel, resulting in a longer time to respiratory arrest.

Warning:

- *Combining thiopental and a non-depolarising muscle relaxant immediately gives a precipitation. They should never be given with the same syringe nor through the same needle.*

Table 9-4: Time to death in euthanasia in the Netherlands 140 cases, 1998-2000).

First injection with thiopental 1.5 grams intravenous route:	37 cases, almost instantaneous death due to cardiac arrest
Same injection, thiopental 1.5 grams	6 cases, death within 5 minutes, before the 2nd injection was given
Second injection of pancuronium 20 mg, intravenous route:	91 cases, death within 15 minutes
Same, pancuronium 20 mg, probably intramuscular route:	6 cases, death after 16-30 minutes

Horikx and Admiraal (2000) have warned that it is difficult to induce a coma by an intramuscular injection of thiopental instead of an intravenous one. On the other hand the second injection of pancuronium is effective if given by intramuscular injection, though it will take more time to cause death.

Groenewoud et al. (2000)[5] have reported clinical problems with the performance of euthanasia and physician-assisted suicide. Horikx and Admiraal (2000) point out that Groenewoud et al. do not specify which euthanatics were in fact used in the problematic cases, nor by which route (intravenous or intramuscular) they were administered. The data given by Groenewoud are incomplete and for that reason provide confusing information.[6]

Switzerland

Bosshard et al. (2003) mention 22 cases in the Canton of Zürich where 10-15 grams of pentobarbital entered the body intravenously using an i.v. drip. A doctor had prescibed the required dose of pentobarbital and an assistant of the right to die organisation had solved the pentobarbital into a drip botle. The gravely ill patient who had requested for assistence in a self-chosen death only had to open the tab of the drip which action legally makes it an (assisted) suicide. This is not euthanasia in the strict Dutch sense. The intravenous route of 10-15 grams of pentobarbital caused death after a median time of 16 minutes (range 4-45 min.)

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5. J. H. Groenewoud, A van der Heide, B. D. Onwuteaka-Philipsen et al. Clinical problems with the performance of euthanasia and physician-assisted suicide in the Netherlands. *N Engl J Med* 2000:342;551-6.
6. The same conclusion is drawn by an experienced general practitioner who has published on this subject: B.V.M. Crul: Dated data. In Dutch. *Med. Contact* 2000:55;303.

after the drip bottle was empty. In two further cases the same amount of pentobarbital was administered by the patient himself through a PEG-tube in the somach. All 22 cases were competent patients.

In these 22 cases an injection of 10-15 grams of barbiturates apparently caused death without any necessity for a second injection of muscle relaxants as is standard practice in the Netherlands. But one should note that the dosage used is ten times the 1.5 grams of thiopental that doctors in the Netherlands use to induce deep sleep.

Oregon

No self-administered death by intravenous drip of pentobarbital has been reported from Oregon.

Belgium

Though euthanasia has been legal since 2002 and openly practiced in the Dutch speaking part of the country (Flanders), no experiences with the technical aspects of euthanasia have been published so far.

CHAPTER 10

Well-known methods that are ineffective or dangerous to others

10.1 Plastic bag with sedatives method

The use of a plastic bag as a supposedly effective suicide method was made famous by the book *Final Exit*. In theory, death occurs by asphyxiation from oxygen depletion inside the bag. But testimonies by eyewitnesses who did not intervene at the scene cast doubt on the percentage of cases that result in death without assistance by someone present (see reported cases below). We will try to untangle the knot of misunderstanding that surrounds this method.

First, there is confusion about the effectiveness of the plastic bag because it is sometimes used in combination with one of the drugs that are deadly in themselves (see Chapter 3-7). In those cases the plastic bag is redundant.

Second, when the plastic bag is used after taking benzodiazepines only, which usually are not lethal, choking will cause frantic movements resembling the wrestling of someone who is drowning. This will displace the bag even if it is properly closed or sealed at the neck. The instinctive wrestling for air starts after unconsciousness has set in. As soon as one gets air again through a leak, one falls into a deep sleep due to the benzodiazepines. People wake up in shame after many hours and usually don't warn others about the plastic bag failure.[1]

Third, a loved one who has been asked to be present at a self-chosen death with mild sedatives and a plastic bag will notice that the bag moves aside due to the movements that accompany suffocation. The witness realises how dearly the person with the bag longed for death and may well yield to the temptation to replace it around the neck after a deep sleep has come. Alternatively, cases have been reported where the witness may try to hold the hands of the wrestling person, to prevent the bag from being pulled away.[2] Either way they may suffer lifelong

1. Chabot, B.E. and K. Gill: *Tijdschrift voor Huisartsgeneeskunde, 1996, 13, nr 3.*
2. Ogden, R. D. (1994). *Euthanasia, assisted suicide & AIDS*. New Westminster: Peroglyphics Publishing. Jamison S. (1996). When Drugs Fail: Assisted Deaths and Not-So-Lethal drugs. In: Battin, M. P. & Lipman, A. G. (eds). *Drug use in Assisted Suicide and Euthanasia* (pp. 223-243). New York: The Pharmaceutical ▸

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feelings of guilt associated with a lethal action which has to remain a secret. Even more seriously they risk prosecution for murder.

Sometimes the method does work without assistance, particularly when someone slips into a deep coma very quickly and the phase of restless movements is skipped. It cannot be predicted whether this will happen or not.

In 1995 it was suggested that the failures were caused either by a bag that was too small or sleeping pills that worked too slowly. A large plastic bag (60 x 90 cm; 24 x 36 in.) was designed, made of a sturdy plastic that does not cover the face. An adjustable elastic collar around the opening closes around the neck with Velcro. This is the so-called *Exit Bag*.[3] No reports by independent and reliable witnesses on this modified plastic bag are known to the authors. We therefore cannot reach the conclusion that it is a significant improvement of the traditional plastic bag method.

One might argue that if the plastic bag fails at least no harm is done. The authors disagree with that. We consider any method that has a substantial risk of failure harmful for the person who rationally decided to end his life. In case it succeeds it is harmful for anyone who may have actively assisted in dying.

Reported cases

Most reports on the use of a plastic bag in combination with non-lethal sleeping pills (such as benzodiazepines) are inaccurate. Only in six cases reported to WOZZ a reliable witness seems to have been present.

A Dutch woman (age 57) with disseminated breast cancer had asked her physician for assisted suicide but he responded that her suffering was not yet unbearable. She then decided she would try the plastic bag with 600 mgs of Valium, though she was informed this might fail. She urgently requested a relative to put the bag in place in case it would not close around her neck: 'Don't let me wake up again!'. The relative did not want to let her die alone but he had not yet made up his mind what he was going to do. Soon after taking the pills she was too drowsy to put the bag properly around her neck and fell asleep. Two and a half hours

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▸ Products Press. Magnusson R. S. (2002) *Angels of Death. Exploring the Euthanasia Underground*. New Haven and London: Yale University Press.

3. Hofsess. J. (1995). Self-deliverance and plastic bags: Introducing the customized Exit Bag. In C. K. Smith, C. G. Docker, & J. Hofsess (eds.), *Beyond Final Exit*. Victoria: Right to Die Society of Canada.

after taking the pills, when she was in a deep sleep,the relative put the bag around her neck and left the room shortly after. Later that night the plastic bag was removed and a doctor was notified of her death. The doctor reported a 'sudden death' in a patient with disseminated breast cancer. He did not want to add the stress of a police investigation for the relatives and he argued that she was going to die quite soon anyway. No autopsy was performed.

Another report of ineffective use of a plastic bag was discussed extensively in the Dutch press during a court case. An 82-year-old woman suffering a brain tumor used the plastic bag in combination with three different sleeping pills: 71 tablets of Zopiclon (7.5 mg); 56 tablets of nitrazepam (5 mg); and 30 tablets of temazepam (10 mg). To the witnesses present the bag appeared to be well sealed with an elastic band around the neck. The woman died 35 minutes after closing the bag.

A police investigation, however, showed that no condensation had formed on the inside of the bag suggesting the bag was not the cause of death. Blood analysis showed that the overdose of zopiclone was the most likely cause. This 82-year-old woman was in very bad physical state. It is therefore not surprising that she died of a heavy dose of a sleeping pill that is usually not lethal.

In two cases a lethal dose of opiates and some benzodiazepines were taken and the person put the plastic bag in place. Death took place after several hours. The oxygen in a large well sealed bag is used within 30 minutes. Therefore, in these cases death was not due to suffocation but to the drugs taken.

Only in two of the six reported cases at which a witness was present, it can be assumed that death did result from lack of oxygen due to the plastic bag. Both took unspecified benzodiazepines, put the bag in place and died 15 minutes later.

Summary

The few cases that have been reported by a reliable eyewitness suggest a high risk of failure using the plastic bag with sedatives (four out of six). Apart from these few cases, the authors of this book have taken into account the reports by four researchers, independent from each other, on agonizing deaths with the plastic bag method.[4]

4. In chronological order R. Ogden (1994), S. Jamison (1996), B. Chabot (1996) and R. Magnusson (2002).

We advise against using this method to end life because it violates two of our basic rules for a humane self-chosen death. First, if all precautions are met it should almost always result in death. Second, that in *the final phase* the series of acts that together induce a humane death should all be performed by the individual himself (Chapter 1.1). Last but not least, if one is present at the time of a self-chosen death involving the plastic bag method, one risks being tempted to actively assist or being under police suspicion.

10.2 Carbon monoxide

A newspaper reported (integral quotation):

> **Charcoal popular for suicide**
> The sales of barbecue charcoal in Hong Kong supermarkets increases the number of suicides. To commit suicide by burning charcoal in a badly ventilated room was unknown a few years ago. Now it's the second most popular method after jumping from flats. A centre for the prevention of suicide has called upon supermarkets to remove charcoal from their shelves.

We will explain why this information is quite misleading and even dangerous for others in the same ar adjacent rooms. Burning charcoal produces CO, carbon monoxide gas, which is odorless and, in high concentration, flammable and explosive. CO is dangerous for others who attend someone who uses it for suicide and in this respect differs completely from helium gas (Chapter 8).

To understand this, one has to know that oxygen is transported from the lungs to the brain by hemoglobin. CO imperceptibly enters into a chemical bond with hemoglobin that is so much stronger than the bond of oxygen with hemoglobin that after some time CO completely blocks oxygen-transport to the brain.[5] Even a low concentration of CO in the room after some time will cause anoxia in the brain, which at first is experienced as a kind of drowsiness that is not uncomfortable, followed by a coma. The point is that this will not only happen to the

5. Strictly spoken it is not a chemical bond between CO and hemoglobin but a much stronger base-Van der Waals-force.

person with a death wish but also to anyone present in the room.[6] Depending on the concentration of CO they die sooner (within 30 minutes) or later (within hours). If rescued before death one runs serious risk of permanent brain damage.

Suicide by piping automobile exhaust inside a car with the windows sealed used to be common and still is, according to some reports from Japan on adolescent group suicides in a van. Older cars had high emissions of CO. Today's fuel efficient engines produce up to 100 times less CO than engines of the 1960's and 70's. Death by this method is still possible, but it takes much longer and this means a greater chance of discovery and rescue with serious risk of *permanent* brain damage. There are also sad examples of people killing themselves in their garages, unaware that the CO was also leaking into adjacent rooms and killing sleeping children and family members.

Philip Nitschke has constructed an apparatus which produces carbon monoxide by a chemical reaction between two substances that can be easily purchased. This is the so called 'CO-Gen machine' that delivers a high concentration of CO directly to a person's nostrils via a nasal prong. He claims the nasal prong reduces risks of inhaling the gas for other people present, but this is highly unlikely as the machine continues to produce CO after the person attached to the machine has died. The CO then must *necessarily* escape into the room. There are no reports by an independent observer of the use of the device in the presence of loved ones.

Many variations on the CO method exist (see the newspaper report above). All of them share the same dangers: a deadly risk for others present in the same or adjacent rooms and the chance of permanent brain damage to all concerned.

Summary

All known variations of the use of carbon monoxide share the same dangers: the person wishing to die may end up an invalid and it presents serious risk to any other person who wants to be present. This again violates basic requirements of a humane self-chosen death that we have stipulated in Chapter 1.1.

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6. Helium does not enter into a bond with hemoglobin. This difference with CO explains why only a massive overdose of helium kills. This overdose of 100% helium only exists within a balloon-bag over one's head while the helium cylinder is driving all the oxygen out of the balloon. When a large ▸

10.3 Debreather

In 1998, John Hofsess of the NuTech group produced a paper titled "Introducing the Debreather," as part of his series called *The Art and Science of Suicide*. The Debreather was based on rebreather technology, devices that underwater divers use to recycle oxygen. The purpose of the Debreather, however, was to recycle nitrogen exhaled from the lungs, eliminate fresh oxygen supply, and eventually induce death by hypoxia.

In essence, the Debreather was a closed breathing system that contained about five to six litres of air. A person seeking a self-chosen death would breath into a mask and with each breath the amount of oxygen available in the system would decline as it was absorbed by the body. Exhaled carbon dioxide, which causes discomfort when breathed in concentration, would be absorbed in a canister of soda lime solution. Exhaled nitrogen would be recycled and eventually would be the only gas within the system.

Nine cases of self-chosen death by debreather have been reported, resulting in eight deaths. In nearly all cases there were reports of difficulties in getting an airtight seal around the mask, and outside air leaked into the closed breathing system. Attendees reported that they applied pressure to maintain the seal. Research on eliminating these difficulties was abandoned after the helium method proved to be an effective alternative in which the final acts that cause death can be executed by oneself.

Summary

The debreather method often requires acts by someone present to cause death. This takes away the responsibility for the final acts from the person who wants to die, which the authors consider to be an essential characteristic of a humane self-chosen death. Apart from that, this method brings serious legal risk (Chapter 11).

▸ cylinder of helium is diluted in the air of a room (after the person died), no one runs any risk. This has been confirmed in practice: in 119 cases of a self-chosen death with helium no risks to those present have been reported (Chapter 8).

CHAPTER 11

Judicial risks for relatives and trained lay persons in five countries

11.1 Introduction

With the exception of the role played by physicians in the methods described in Chapter 9, the life terminating methods discussed in this guide do not require active assistance from any other person. We feel that a self-chosen death is a good death if it occurs with moral support of family or friends, or even in their company. When a death is planned and deliberate, it is important that relatives and friends are included in the decision-making process, but without performing any actions that might be regarded as criminal (e.g. assisting suicide).

The information presented here is not legal advice. Readers who are concerned about the specific laws in their countries will need to research this.[1] Local right to die organizations can provide information and general guidance on the relevant laws to individuals who are thinking about attending a self-chosen death. An alternative is to seek a formal legal opinion, but be warned that this process is usually expensive and often tends to confuse matters rather than clarify them.

Interestingly, although helping someone with a self-chosen death may be illegal, suicide itself, or as we prefer in this book, self-chosen death, is not a crime in most countries. The legal status of assisting in dying varies around the world. Many individuals consider both (physician) assisted suicide and euthanasia (killing by a doctor on explicit request) as compassionate and morally justifiable. Nevertheless, there are legal and conceptual distinctions that define how a particular action will be interpreted in law. For example, when a lethal cocktail is provided by a doctor to someone, who then swallows it without further assistance, this is 'physician-assisted suicide' according to the law in many countries. In the Netherlands, euthanasia in the strict sense

1. For the Netherlands see Griffiths, J., Bood, A., & Weyers, H. (1998). *Euthanasia & law in the Netherlands*. Amsterdam: Amsterdam University Press. Discussion of the legal situation in Western-Europe will receive attention in the forthcoming book *Euthanasia and Law in Europe* by J. Griffiths, H. Weyers and M. Adams.

"...refers to the situation in which a doctor kills a person who is suffering 'unbearably' and 'hopelessly' at the latter's explicit request (usually by administering a lethal injection)".[2] In Belgium and the Netherlands, a physician may legally administer a lethal injection if a patient has requested it and all the conditions set out in the law are met.

Many countries (e.g. Canada, Australia, UK, France, most of the USA) have laws against helping someone to a self-chosen death and the maximum penalty is often in excess of 10 years. If a country does not have a specific law against aiding in self-chosen death, this does not necessarily mean it is permissible (see below on Germany).

The scope of this Chapter is limited. Our aim is:

1. To give lay persons some idea of the variations in the legal status of being present at or assisting in a self-chosen death by someone who is not a physician. We will focus on five western countries: Canada, the USA, Switzerland, Germany and the Netherlands.
2. Our focus will be on the grey legal area between what is permitted and what is not when relatives, friends and trained professionals of right to die societies become involved with a self-chosen death. We will restrict ourselves to recent test cases and distinguish between assistance given during the preparatory phase (collection of detailed information, medications or equipment) and assistance at the scene of self-chosen death. We will not discuss important cases in court against physicians, like e.g. Jack Kevorkian in the USA or Mrs Postma in the Netherlands, which sparked off the euthanasia debate in their respective countries.

2. Griffiths et al (1998) p. 17.

11.2 Canada

In 1972, Canadian Parliament abolished the offences of suicide and attempted suicide, but "counseling or aiding suicide" were kept as criminal offences, punishable by up to 14 years imprisonment.

Prosecutions under this law are infrequent. A very important court case took place in 1993, when Sue Rodriguez, a terminally woman with Amyotrophic Lateral Sclerosis petitioned Canada's Supreme Court for the right to physician-assistance in her planned self-chosen death.[3] She argued that able-bodied people could take their own lives, but her disability made this impossible without assistance. In a 5-4 ruling the court rejected Rodriguez's case. Undeterred, she died the following year with the aid of an unidentified doctor, and in the presence of a Member of the Federal Parliament, Svend Robinson. Mr Robinson maintained that he was only a witness to the death and he refused to name the doctor who helped Rodriguez to die with an intravenous dose of seconal and morphine.

A Special Prosecutor was appointed to determine whether charges should be laid. The Special Prosecutor concluded that under Canadian law Mr Robinson had no obligation to provide the name of the doctor, nor was he required to assist in the police investigation. Most important for lay relatives and friends is what the Special Prosecutor said: "Mere presence at a suicide, without proof of more, is not sufficient to convict."

In short, the decision of the Special Prosecutor was that no charges could be laid for aiding Rodriguez's self-chosen death because there was no evidence that Mr Robinson had done anything more than be present, and he had "no legal obligation to provide the name of the doctor."

A second case of interest is that of Ms Evelyn Martens, a member of the Right to Die Society of Canada. In 2004 a jury found her "not guilty" of charges that she had used helium gas (see Chapter 8) to assist the self-chosen deaths of two women. In his instructions to the jury the judge followed the principle outlined in the Rodriguez case and clarified that mere presence at a self-chosen death is not a crime. The judge said that for a crime to occur it needed to be shown that: i) Martens did something to "aid or abet" the self-chosen deaths, and ii) that she *intended*

3. *Rodriguez v. British Columbia* (Attorney General) [1993] 3 S.C.R. 519.

that her words or actions would aid or abet the self-chosen deaths. In other words aiding or abetting a suicide means actually helping or facilitating in a significant way, such as *encouraging* someone to die or providing the means (e.g. lethal drugs or helium equipment) to die. The jury did not accept that the Crown had proven its case beyond a reasonable doubt and Ms Martens was acquitted.

There has been only one case where a physician was prosecuted. In 1998, Dr. Genereux was pleaded guilty to two offences of aiding and abetting suicide. He had prescribed lethal quantities of secobarbital to two patients who were HIV positive, but had not yet developed symptoms of AIDS. In separate incidents, the two patients attempted suicide and one died. Dr. Genereux was sentenced to two years less one day in jail, plus three years of probation. The court criticized him for failing to explore treatment alternatives that he knew would have helped his patients.

In a 2005 case that did not result in criminal charges, Marcel Tremblay publicly announced his plan to die. He hired a prominent lawyer to ensure that none of his family members would be accused of aiding his death and he held a press conference to declare his plan to die. Several people watched Tremblay end his life using helium gas, and even the police were on hand. No charges were laid because it was clear that Tremblay was acting independently. Unfortunately, a police officer counseled a family member to call 911 (emergency medical response) and paramedics arrived. By law, the paramedics were obliged to attempt resuscitation, which failed, but it was very upsetting to all involved. The lesson here is that anybody attending a planned self-chosen death should call a family physician to pronounce death, and not emergency personnel.

The last case illustrates the potential legal consequence for family members who directly assist a family member. Charles Fariala suffered from multiple sclerosis and asked his mother to help him die. He first swallowed a cocktail of drugs based on a recipe he had found on the Internet. Then, at his request, his mother, Ms Houle, put a plastic bag over his head and tied his hands so that he could not remove the bag. After Charles died, his mother panicked and called the authorities. She later pleaded guilty to the crime of aiding suicide and received a three year probation sentence.

11.3 USA

The debate about physician-assisted-dying in the USA peaked in 1997 with two Supreme Court challenges that asserted a constitutional right to assisted suicide.[4] The challenges failed to establish such a right, but the nation's highest court also ruled that individual states were free to pass their own laws to legalize aid in dying, if they wanted.

In the past decade more than a dozen states have considered legislation that would permit physician-assistance in self-chosen death. Oregon is the only state to have passed such a law. Since 1997, the Oregon *Death with Dignity Act* has allowed physicians to prescribe lethal medication to mentally competent, terminally ill patients who meet the legal criteria for a self-chosen death. A feature of the Oregon legislation is that the patient must self-administer the lethal dose (usually orally ingested barbiturates), and injections are not permitted. For this reason, the law is often referred to as a "prescribing bill."

Each US state sets its own law and policy on end-of-life decisions. It would be a mistake to conclude that Oregon's *Death with Dignity Act* implies a tolerant environment throughout the country. In the past 10 years at least seven states have passed new statutes against assisted suicide and three others have added civil penalties to their criminal sanctions.

Nonetheless, there are groups that will support people considering a self-chosen death (see Appendix 1 for addresses). For example, Compassion and Choices,[5] the largest right to die organization in the USA, has a volunteer program to support people in the last phase of a terminal illness who consider a self-chosen death. This program adheres to a medical model and does not support options such as the helium method. Patients in the terminal phase of their illness are expected to complete all preparations without assistance by experienced and trained volunteers, who can be a comforting presence at a self-chosen death. Another organization is the Final Exit Network (FEN) which accepts the helium method as a client choice.

It is estimated that services offered by groups such as FEN and Compassion and Choices have supported several hundred self-chosen deaths. None have resulted in any prosecutions. North American read-

4. *Washington v. Glucksberg*, 521 U.S. 702. (1997); *Vacco v. Quill*, 521 U.S. 793 (1997).
5. Compassion and Choices was formed in 2005. The organisation is the result of a merger between the former Hemlock Society and Compassion in Dying.

ers may consult with these organizations before deciding to become involved in supporting someone in a self-chosen death.

Although prosecutions of relatives for helping someone to die are quite rare in the USA, they can still result in jail terms. In 1996, Mr Delury of New York accepted a plea bargained sentence of six months in jail after he helped his wife to die using drugs and a plastic bag. In another New York case, Mr Bement was sentenced to two weeks in jail in 1998 after he fed his terminally ill wife sleeping pills and then placed a plastic bag over her head (see Chapter 10.1).

In another case, in 2000, a South Carolina man admitted that he rented a helium tank that his terminally ill wife used to take her life. Although the man was not present when she died, he was charged with aiding her suicide. The prosecutor later dropped the charge because it was believed that no jury would convict the man for his act of compassion, even though there was clear evidence that he had broken the law.

Western Europe

The choice between assistance with suicide and euthanasia varies across European countries. Without much public debate the Dutch and the Belgians have chosen doctors as the "stage managers" around dying. Under strict conditions a physician is allowed to give a deadly injection at the *explicit, well considered request of a competent patient who is suffering unbearably and hopelessly*.[6] This is fundamentally different in Switzerland and Germany, where the law makes assistance with suicide an option, but not euthanasia. German people would rather avoid the word 'euthanasia' because of its association with the extermination program of the Nazis. This association is particularly strong in Germany. It was suggested that replacing 'euthanasia' with other words, for example, '*Freitod*' or '*Sterbehilfe*', would ease the public debate.[7]

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6. We do not go into the details of these conditions. For a scholarly discussion of them, see Griffiths et al 1998.
7. See M. P. Battin 1994. Assisted Suicide: can we learn from Germany? In: *The Least Worst Death. Essays in bioethics on the end of life*, Oxford University Press. New York, Oxford.

11.4 Switzerland

Swiss law prohibits euthanasia in the strict (Dutch) sense (see above), but permits assistance in suicide provided that such help is given without any self-interest, such as financial motives. Several Swiss right to die groups (e.g. Exit Deutsche Schweiz, Exit International, and Dignitas) have over the past fifteen years developed a practice of assistance in suicide that ensures the element of self-interest is removed. If a patient suffers from a medically documented terminal or seriously debilitating disease the right to die organisation helps to obtain lethal prescriptions from a physician (either a family doctor or doctors who work for the right-to-die organisation). Volunteers consult with the patient to ensure that the choice to die is well considered and voluntary. They arrange for delivery of the medication and accompany patients and their loved ones up to the end. Nowadays, an independent witness is usualy present as well. The volunteer reports this death to the authorities (Bosshard et al, 2003). In most cases, doctors are not present at a self-chosen death.[8] The doctor's role has become restricted to prescribing 10 or more grams of barbiturates. The "stage manager" role performed by family physicians in the Netherlands and Belgium has been taken up by lay persons working for one of the Swiss right-to-die organisations.

Over the past 20 years some relatives were prosecuted after they had (tried to) kill a loved one either at his or her explicit request or without request ('mercy killing'). Some of them received a jail sentence. A volunteer of Exit Deutsche Schweiz killed 3 people several hours after they had ingested a deadly dose of barbiturates. While they were comatose he pressed a pillow on their face. He was sentenced to jail.

Recently the Zurich based Dignitas organisation has challenged the authorities by giving assistance in suicide to people arriving from other countries (e.g. Germany and England) who do not always suffer from a terminal illness. Although Dignitas has been criticized for offering services to non-residents of Switzerland, no legal action has been taken yet.

8. A recent comparative European study about the actual medical decisions around dying revealed that Swiss doctors do in fact practice euthanasia but do not report this to the authorities (van der Heide, A., Deliens, L., Faisst, K. et al (2003). End-of-life decision-making in six European countries: a descriptive study. *The Lancet*, 362, 345-350.

11.5 Germany

The German Penal Code prohibits killing on request (e.g. voluntary euthanasia) but assistance with suicide is not prohibited as long as the person had control over the acts that caused death, was competent and without coercion from others. However, the policies and code of ethics of the German medical association do not allow doctors to provide any assistance.

German legal scholars have argued that the Penal Code imposes a duty on physicians and possibly other persons to try to save the life of a person who has attempted suicide.[9] The 1984 *Wittig* decision of the *Bundesgerichthof* – the German Federal Court – helps to illustrate the point. In this case a doctor found his patient in an unconscious state after she had attempted suicide. He did nothing to revive her, and he argued his medical view that she had already suffered brain damage by the time he arrived. The court accepted Dr. Wittig's "medical decision of conscience" and acquitted him. At the same time, the court confirmed the legal obligation on doctors and other responsible persons to attempt to revive an unconscious patient.[10]

WOZZ is unaware of any test cases in court that did not involve physicians but relatives. However, there has been a case of a suicide pact where one party survived and was found to have committed an offence after they had attempted suicide by breathing carbon monoxide from exhaust fumes of a car (see Chapter 10.2). The woman died and the man only lost consciousness. He was found guilty of "killing on demand" despite the fact that they had planned to die together.[11]

In 1993, the former president of the German Society for Humane Dying (DGHS, Deutsche Gesellschaft für Humanes Sterben) was sentenced to jail for selling cyanide and for tax evasion. For many years afterwards this discredited the reputation of assistance in dying in Germany. Prior to 1993 members of the DGHS could receive suicide information from a book "Dying with dignity on your own responsibility."

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9. Weinhold, S. (1994). *The right to die with dignity in the Federal Republic of Germany and in Canada* (Master's thesis). University of Heidelberg, Faculty of Law.

10. Weyers, H. (2005). Report on the international symposium on physician-assisted suicide held in Giessen, Germany. *Newsletter: Regulation of Socially Problematic Medical Behaviour*, 9, 7-10.

11. Weinhold, S. (1994).

Some combinations of drugs turned out to be wrong and the DGHS stopped dissemination of this information. As of 1994, DGHS -members could after one year of membership order a German translation of "Departing Drugs" (1993) and a loose-leaf edition called "Living and dying humane."

The conclusion drawn by an expert we have consulted is that it would be unwise in Germany to stay with a patient at the bedside when a self-chosen death is attempted because one can never know whether a court will decide that there is an obligation to revive the patient. It seems that, under German law, one may help the patient to make an informed decision and to plan to shorten life. But even this is uncertain.

11.6 The Netherlands

In 2002, Dutch Parliament passed 'The Act on Termination of Life on Request and Assisted Suicide'. This new law establishes an exception for doctors in relation to Criminal Code article 293, which prohibits killing a person at his request ('euthanasia') and article 294, which prohibits assisting a suicide. The latter article concerns us here:

> "A person who intentionally incites another to commit suicide, *assists in the suicide* of another, or procures for that person the means to commit suicide, is liable to a term of imprisonment for not more than three years..." (art. 294, Criminal Code; translation from Griffiths et al (1998) italics added).

Assisting a suicide by *someone who is not a doctor* thus remains a crime. The problem that has haunted Dutch right to die societies is whether giving detailed information on how-to-do-it (such as is given in this book), or being present at a suicide, amounts to *criminal* assistance in a suicide as phrased in the italicized part of art 294. If a competent person wants to die and takes the responsibility for carrying out the suicide, what is the demarcation between compassionate actions by a relative or trained helper that do not fall under art 294, and criminal assistance?

Over the past 15 years Dutch courts have passed judgment on four cases of assisting a suicide that are immediately relevant to this issue. We will first summarise the two cases that went up to the Dutch Supreme Court and then give attention to the other two cases.

In 1991, Mrs Mulder, a doctor who worked for *'Right to Die - NL'* (NVVE), was present at the suicide of a 73-year-old man with a debilitating disease who had asked her advice whether he could kill himself by using the sleeping pills he had collected. She told him that the combination of medicines he had collected was enough to cause death if taken in combination with a plastic bag over his head. He then asked her to be present when he would swallow the pills and he arranged for a plastic bag. On the day of his suicide, about 15 minutes after he had taken the pills, she noticed that he became drowsy and told him: "now put the bag over your head". In court she maintained that she had not acted as a doctor but as a compassionate human being. The courts considered that (1) giving information on how to perform a suicide could not be interpreted as criminal assistance; (2) that being present at a suicide can be regarded as a kind of moral support but, taken on itself, does not imply 'assistance'. But (3) when Mrs Mulder said 'now put the bag over your head', this amounted to giving the deceased an 'instruction'. She had put herself – so the judge said – in the position of a 'stage manager' and thereby had provided *criminal* assistance. She was convicted to a conditional sentence of one month imprisonment.[12]

In 2001 Mr Muns, a humanist counselor affiliated with a small and somewhat radical right to die society known as *'De Einder'* was present at the death of an 83-year-old woman with cancer. The Court of Appeals in Leeuwarden found that some time before, he had given her a written list which specified the medicines and a plastic bag that she would need for her planned suicide. At the scene of her death he put the sleeping pills within her reach, opened a bottle of alcohol for her, put a plastic band around her neck and laid down some bags nearby. The Court held that these actions (though it did not draw a line between specified actions) were forms of assistance that fall within the scope of art 294. The defense argued that actions that precede the scene of the actual suicide cannot be considered 'assistance' in the sense of art. 294. The Court rejected this, holding that 'instructions' or 'concrete actions and skills' can be criminal forms of assistance *irrespective* of the moment these are provided. Muns was convicted to 12 months imprisonment of which 8 months were conditional. This interpretation of 'assistance' was upheld by the Supreme Court in 2005.

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12. This decision by the Court of Appeals, The Hague, was upheld by the Supreme Court (Dutch Jurisprudence 1996, no 322)

Mrs Cornelisse, a psychologist who worked for '*Right to Die - NL*', was consulted in 1999 by a woman (age 53) who had a long history of psychiatric admissions. According to the therapists of the woman, she was competent. The woman asked for information on lethal medicines. Mrs Cornelisse gave that information verbally (i.e. she did not hand over a written list of lethal medicines like Mr Muns had done) while the woman took notes of what was said about options for a deadly combination of medicines. About 6 weeks later, on the day of the actual suicide, the woman phoned Mrs Cornelisse twice, the first time before she swallowed the pills, the second time shortly afterwards. The court considered that Mrs Cornellisse had restricted herself to giving information when she had met the woman and offering moral support on the day of her actual suicide. There was no evidence that she had given any 'instructions' nor had she taken any initiative to contact the woman nor had she acted as a 'stage manager'. Mrs Cornelisse was acquitted by the Court Den Bosch (2003).

Another recent case concerns Mr Hilarius, one of the founders of *'De Einder'*, who was accused of providing some pills for a lethal mixture to a young woman with a psychiatric history who had asked for information and assistance with suicide. Providing 'the means to commit suicide' is explicitly listed as a criminal offence (see art 294 quoted above). The judges particularly reproached Mr Hilarius for not having consulted the woman's general practitioner nor her therapists. He was convicted to imprisonment for a year, which in the Netherlands is a heavy sentence. Hilarius' case is currently on appeal.

Discussion of Dutch cases

Since 2002, there is a statute in the Netherlands that stipulates the conditions under which doctors may give assistance to their patients to carry out suicide. It has been suggested that this statute may have caused judges to be more strict in cases in which trained professional helpers were involved instead of doctors.[13] However, this interpretation is premature. All in all, these court decisisons have not yet clarified under what conditions providing detailed information, such as given in this book, will or will not be considered criminal assistance in a self-chosen death.

The two cases that went up to the Supreme Court have confirmed that:

1. Being present at a self-chosen death in the Netherlands does not amount to criminal assistance if the person concerned does not give specific instructions (like Mrs Mulder did) nor performs several acts that together contribute to the realization of a self-chosen death (see the case of Mr Muns) but gives moral support only.
2. Giving information on how-to-do-it is NOT criminal assistance unless this is provided by someone who assumes the role of 'stage manager' and as such directs a self-chosen death step by step either at the scene or beforehand. Dutch courts have apparently decided that otherwise non-criminal discussions and acts transform into criminal assistance when someone who has superior knowledge about and experience with self-chosen death uses this knowledge and experience to 'stage manage' a self-chosen death.

These distinctions between providing information, giving moral support and giving instructions are very delicate indeed. In the case of Mr Muns, the Court of Appeal has not distinguished between the several different acts that – taken together – formed the basis for its verdict. Professional helpers affiliated with organizations which have stated it their policy to give information on a self-chosen death should remain aware of what has been said under (1) and (2).

Relatives and friends who are invited to be present at a self-chosen death usually do not have superior knowledge and experience in this field. Having superior knowledge and experience in the field of self-chosen death or not appeared to be one important consideration in the outcome of the four cases that went to court. This may perhaps explain why relatives and friends have so far never been prosecuted or convic-

13. J. Legemaate and B.V.M. Crul, 2003 (in Dutch) in *Medisch Contact*, p. 823-6

ted for giving detailed information taken from a guide on how-to-do it like this one, neither for being present at the scene of a self-chosen death nor for providing small items like Mr Muns did.

11.7 Conclusion

Although it is not illegal to be present at a self-chosen death, one's words or actions leading up to a death can be unlawful. First, when talking to someone who is considering a humane self-chosen death, it is important to know that what is said can influence the choices that a person makes. A distinction must be made between *discussing* the subject of self-chosen death and *advising* a person that he or she should die. For example, statements such as "I think you should take your life," or "It would be a good thing for you to exit," could be considered criminal offences in countries that criminalize the "aiding or abetting a suicide."

Second, providing items such as medications (e.g. barbiturates) or equipment (e.g. helium tank) may be interpreted as evidence of criminal behaviour, particularly if it could be proven that these were provided *with the intent* that a self-chosen death takes place. For example, providing someone with a helium tank would not normally be seen as an offence, because this item is not illegal in and of itself. It has other common uses and can easily be purchased. Nevertheless, if it were provided with the intent that it be used in a self-chosen death, then this raises legal risks.

Providing someone with prescription medications can raise serious issues. Doctors prescribe medications to specific patients and they have a responsibility to advice on their proper use. If one passes prescription drugs to someone for whom they are not prescribed, this can amount to a serious offence, particularly if the drugs are considered "controlled substances" (e.g. barbiturates).

We realize that there will be times during the preparatory phase where family members or loved ones will make decisions to help in obtaining medications, grinding them up, or perhaps acquiring equipment. This kind of situation is more likely when someone is particularly frail and unable to carry out such tasks independently. For those who provide such assistance, it is important to be aware that this carries legal risks.

Being present at a self-chosen death in Switzerland and Oregon carries no risk, provided the lethal prescription is signed by a physician and handed over by some official intermediary. Neither is any risk involved in The Netherlands and Belgium as long as a physician has taken the responsibility for assistance in dying or euthanasia. But in all cases where the conditions of the law of one's country are not fulfilled, people everywhere – that is in all countries we know of – may run a small but serious risk of prosecution, even when being present only at a self-chosen death.

If one has given careful thought to the pros and cons and one decides to accept this risk because one does not want to leave a loved one dying alone, then the best thing to do would be to sit on one's hands. By doing so, one protects oneself against the temptation to give assistance in the series of acts that lead up to death. Provided that all elements of the preparatory phase have been carried out carefully, the person who wants to die can carry out all the necessary acts in the final phase.

Nevertheless, we do recognize that a dearly loved person who is longing for death may be very frail and there might be a temptation to help with lifting a glass to the mouth, or opening the valve of a helium tank in case this person has become more or less paralysed. Unfortunately, these compassionate actions carry serious legal risks almost everywhere.

APPENDIX 1

Addresses of organizations concerned with humane self-chosen death

AUSTRALIA

Exit International
PO Box 37781
Darwin, NT 0821
Tel: 08 8983 2949
Email: contact@exitinternational.net
www.exitinternational.net

South Australia Voluntary Euthanasia Society (SAVES)
P.O. Box 2151
Kent Town
South Australia 5071
Fax: +61-08-8265 2287
Email: info@saves.asn.au
www.saves.asn.au

Voluntary Euthanasia Society of New South Wales, Inc.
P.O. Box 25
Broadway, NSW 2007
Tel: 02-9212 4782
Fax 02-9211 1498
Email: mail@vesnsw.org.au
www.vesnsw.org.au

Voluntary Euthanasia Society of Queensland
16 Howard St
Rosalie, Queensland 4064
Tel: 0500-858 500
Email: mary22@ozemail.com.au
www.connectqld.org.au/asp/index.asp?pgid=8469

Dying with Dignity Victoria Inc (DWDV)
3 / 9b Salsbury Avenue
Blackburn, Victoria 3130
Tel: 03-9877 7677
Fax: 03-9877 5077
www.dwdvictoria.org.au

West Australia Voluntary Euthanasia Society (WAVES)
PO Box 7243
Cloisters Square
Perth, Western Australia
Tel: 08-9276 9144 or 9387 5126
Email: info@waves.org.au

BELGIUM

Recht op Waardig Sterven vzw
Constitutiestraat 33 - B-2060 Antwerpen
Tel/fax +32 (0)3 272 51 63
Email info@rws.be
www.rws.be/home.html

Association pour le Droit de Mourir dans la Dignité (ADMD)
Rue du Président, 55
B-1050 Bruxelles
Belgique
Tél. +32 (0)2 502 04 85
Fax: +32 (0)2 502 61 50
Email: info@admd.be
www.admd.be

CANADA

Dying with Dignity
802, 55 Eglinton Avenue East
Toronto, Ontario M4P 1G8
Tel: 416-486 3998 or 1-800-495-6156
Fax: 416-486-5562
Email: info@dyingwithdignity.ca
www.dyingwithdignity.ca

The Right to Die Society of Canada,
145 Macdonell Ave.
Toronto, M6R 2A4 Ontario
Tel: 416-535-0690
Fax: 416-530-0243
Email: contact-rtd@RighttoDie.ca
www.righttodie.ca

Choices in Dying Society
P.O. Box 79521
Kingsway RPO
Vancouver, B.C. V5R 5Z6
Tel: 604-451-9626
Email: choicesindying@telus.net

COLUMBIA

DMD Fundacion Pro Derecho A Morir Dignamonte
Carrera 11 No. 73-44 Oficina 508
Tel: 345 4065 or 347 3365
Bogota

FRANCE

Association pour le Droit de Mourir dans la Dignité
50 rue de Chabrol
75010 Paris
Tel: 48 00 04 16 or 48 00 04 92
Email: infos@admd.net
www.admd.net

GERMANY

Deutsche Gesellschaft für Humanes Sterben (DGHS)
D-86152 Augsburg
Lange Gasse 2-4
P.O. Box 11 05 29
Tel: 821-502350
Fax: 821-5023555
Email: info@dghs.de
www.dghs.de

ISRAEL

LILACH: The Israel Society for the Right to Live and Die with Dignity
P.O. Box 14409, Tel Aviv 61143
Tel: 972 3 620 0838
Fax: 972 3528 0619
Email lilach19@zahav.net.il
www.lilach.org.il

ITALY

EXIT – Italia
Corso Monte Cucco 144, 10141, Torino
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Fax: 330-512 712
Email: exit-italia@libero.it
www.exit-italia.it

JAPAN

Japan Society for Dying with Dignity
Watanabe Building 2002
2-29-1 Hongou – Bunkyo-Ku
Tokyo 113
Tel: 3-3818 6563
Fax: 3-3818 6562
Email: songensi@mxl.alpha-web.ne.jp
www.songenshi-kyokai.com

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Fax: +31(0)20 420 7216
www.nvve.nl

Stichting De Einder
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Leerdam 4140 AD
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Email: info@deeinder.nl
www.deeinder.nl

Stichting Vrijwillig Leven
P.O. Box 5098
Maastricht 6202 WE
Tel.: +31(0)43.3688144
Fax: +31(0)43.3688299
Email: info@svleven.nl
www.SVLeven.nl

SPAIN

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08002 Barcelona
Tel: 934 123 203
Email: informacion@eutanasia.ws or admd@admd.e.telefonica.net
www.eutanasia.ws

SWITZERLAND

Exit Deutsche Schweiz
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8047 Zürich
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Fax 043 343 38 39
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Exit A.D.M.D. (Suisse romande)
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Tel: 041-22-735 7760
Fax: 041-22-735 7765

Dignitas
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Zürich
Tel: 980 4459
Fax: 980 1421
Email: dignitas@dignitas.ch
www.dignitas.ch

UNITED KINGDOM

Dignity in Dying
13 Prince of Wales Terrace
Kensington, London W8 5PG
Tel: 0870 777 7868
Email: info@dyingindignity.org.uk
www.dignityindying.org.uk

EXIT
17 Hart Street
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Scotland
Tel: 0131 556 4404
Email: exit@euthanasia.cc
www.euthanasia.cc

Friends at the End (FATE)
11 Westbourne Gardens
Glasgow, Scotland, G129XD
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Email: info@friends-at-the-end.org.uk
www.friends-at-the-end.org.uk

USA

Compassion and Choices
PO Box 101810; Denver, CO 80250
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Fax: (303) 639-1224
Email: info@compassionandchoices.org
www.compassionandchoices.org

Euthanasia Research & Guidance Organization (ERGO)
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Tel: +1(541)998 3285
Fax: +1(541)998 1873
e-mail: ergo@efn.org
http://www.FinalExit.org

Final Exit Network (FEN)
P.O. Box 965005
Marietta, GA 30066
Tel: (800)524-EXIT (3948)
Email: info@finalexitnetwork.org
www.finalexitnetwork.org

Compassionate Chaplaincy
1 877 EXIT-AID (3948-243)
1 877 3948 243

NEW ZEALAND

Voluntary Euthanasia Society New Zealand
PO Box 26 095
Epsom
Auckland 1030
Tel: 09-630 7035
Email: ves@clear.net.nz
www.ves.org.nz

SOUTH AFRICA

South Africa Voluntary Euthanasia Society (SAVES)
PO box 1460, Wandsbeck 3631
KwaZulu-Natal, South Africa
Email: livingwill@3i.co.za

APPENDIX 2

Report Form for Eyewitnesses to a Humane Self-Chosen Death

This information is strictly for research purposes. Any identifying information will be removed from this report. Please send reports and inquiries about privacy/confidentiality to:

Russel Ogden, 207 Osborne Avenue, New Westminster, BC, Canada V3L 1Y7

1. Deceased person is ☐ female ☐ male
2. Estimated age: ________
3. Year of the self-chosen death ________ Month (optional): ________
4. Country of self-chosen death: ________
5. Estimated weight: ________ ☐ kg / ☐ lbs
6. Any recent loss of weight greater than 10 kg / 20 lbs?

   ____

7. Illness or problems that motivated this self-chosen death

   ________ since ________

   ________ since ________

8. Medical specialists and treatments tried (e.g. oncologist, chemotherapy)

   ________ since ________

   ________ since ________

9. Names and dosages of medicines used during last month before self-chosen death

   Sedatives/sleeping pills

   ________ dose ________

   Pain killers

   ________ dose ________

   Other medicines

   ________ dose ________

10. Daily use of alcohol? ☐ Yes ☐ No

    More than 2 glasses a day? ☐ Yes ☐ No

11. Was helium used in this self-chosen death? ☐ Yes ☐ No
12. Medicines used to cause death (give number of pills and mg per pill)

    medicine A: ________ dose ________

    medicine B: ________ dose ________

    medicine C: ________ dose ________

    in case of capsules, were these opened before swallowing? ☐ Yes ☐ No

    in case of pills, were these ground to a powder? ☐ Yes ☐ No

anti-emetic used? ☐ Yes ☐ No Name: ________ Started ____ hours before

alcohol used? ☐ Yes ☐ No Which kind, how much? ________

13. Exact time for: (select appropriate category)

☐ swallowing medicine ________

☐ injecting medicine ________

☐ inhaling helium gas ________

14. Exact time of falling asleep ________

15. Exact time of death ________

16. Were there any unpleasant signs *before* falling asleep? (e.g. anxiety, choking, vomiting)

____

17. Were there any unpleasant signs *after* falling asleep?

____

18. Was a plastic bag used?

With medications to cause death: ☐ Yes ☐No

Any signs of wrestling or discomfort? ☐ Yes ☐ No

(details?) ________

____

____

19. Who established officially that death had occurred? ________

20. What is your relationship to the deceased? ________

21. Were others present at the self-chosen death? (select appropriate categories)

☐ partner or spouse

☐ relatives

☐ friends

☐ physician or nurse

☐ volunteer from right to die organisation

☐ other ________

22. Do you know how this death was documented? (select appropriate categories)

☐ illness

☐ suicide

☐ assisted suicide

☐ other ________

23. Any other comments or matters of importance? ________

____

____

How to order this book

wozz has decided not to publish this guide through a publishing house, bookstores, or on the Internet. It will sell this book to associations of physicians or pharmacists and to right-to-die societies in various countries. These societies and associations can develop their own policies for distribution of this guide, in a manner that is consistent with the practices and laws of their own countries.

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WOZZ Foundation

Generic names and brand names of drugs in eleven countries

Every medicine has a generic name and often several trade or brand names. Because brand names vary from country to country, this guide exclusively uses the generic name for each drug.

We now provide in Table I an *alphabetical survey of the generic names* for the medicines that have been discussed together *with all the trade or brand names* in eleven countries:

USA
Canada
Australia
New Zealand
UK
Germany
France
Italy
Spain
the Netherlands
Belgium.

Most of these medicines are available only on prescription. We must warn that over time the brand names may change. Sometimes a medicine is not available any more in a particular country. One may search for it in another country that is not mentioned in our Drug Table.

In this Drug Table we do not give the trade names of medicines for injection discussed in Chapter 9.2, because these are impossible to obtain for lay people.

fold out ········>

Generic name	Brand name or trade name	USA	Can	Aus	N-Zea	UK	Ger	Fra	Ita	Spa	Neth	Belg
Amitryptiline	Adepril								+			
	Amioxid						+					
	Amitid	+										
	Amitril	+										
	Amitrip			+	+							
	Amitryptiline	+	+	+	+	+	+	+	+	+	+	+
	Amitrol			+								
	Amitron									+		
	Domical					+						
	Elavil	+	+			+		+				
	Emitrip	+										
	EndeP	+										
	Enovil	+										
	Laroxyl			+			+					
	Lentizol					+						
	Levate		+									
	Nobritol									+		
	Novoprotect						+					
	Pantrop						+					
	Saroten						+					
	Sarotex										+	+
	Tryptanol				+							
	Tryptizol					+		+	+	+		+
Amobarbital	Amobarbital	+										
	Amytal	+	+	+		+						
	Amytal sodium	+	+	+		+						
	Neuromyl			+								
	part of Tuinal	+				+						
Brallobarbital	part of Vesparax						+		+			+
Butobarbital	Soneryl					+						
Chloroquine	Aralen	+										
	Avloclor			+		+						
	Chloroquine	+	+	+							+	
	Cidanchin									+		
	Nivaquine			+	+	+		+			+	+
	Resochin						+			+		
Clomipramine	Anafranil	+	+	+	+	+	+	+	+		+	+
	Clomipramine	+	+								+	
	Clopram			+								
	Clopamine		+									
	Placil			+								
Desipramine	Desipramine	+	+									
	Norpramin	+	+									
	Nortimil								+			
	Pertrofran(e)	+		+	+	+	+	+				+
Dextromoramide	Palfium			+		+		+			+	
Diazepam	Atensine					+						
	Calmaven									+		
	Dialar					+						
	Diazemuls		+									
	Diazep						+					
	Diazepam	+	+	+	+	+	+	+	+	+	+	+
	D-pam				+							
	Durazepam						+					
	E-pam		+									
	Evacalm					+						
	Meval		+									
	Novazam							+				
	Pro-pam			+	+							
	Q-pam	+										
	Stesolid				+	+	+			+		
	Valcaps	+										
	Valium	+	+	+	+	+	+	+	+	+	+	+
	Vazepam	+										
	Vivol		+									
Dextropropoxyphene			+								+	
	Algophene											+
	Darvon	+	+							+		
	Deprancol									+		
	Depronal										+	+
	Doloxene			+	+	+						
	Novrad	+										
	Propoxyphene	+										
Domperidon	Domperamol					+						
	Gastrocure											+
* see also Table on page 28	Gastronorm								+			
	Motilium		+	+	+	+	+	+	+	+	+	+
	Motilyo							+				
	Peridon								+			
	Peridys							+				
	Vivadone					+						
Dosulepin	Dopress				+							
	Dothapax					+						
	Dothep			+								
	Idom						+					
	Prepadine								+			
	Prothiaden			+	+	+				+	+	+
	Protiaden								+			
	Thaden					+						
Doxepin	Adapin	+										
	Anten				+							
	Aponal						+					
	Doneurin						+					
	Doxepia						+					
	Doxepin	+	+									
	Mareen						+					
	Quitaxon			+				+				+
	Sinequan	+	+	+	+	+	+	+	+	+	+	+
	Xepin					+						
	Zonalon	+	+									
Fentanyl	Actiq	+										
	Bupafen				+							
	Duragesic	+	+	+	+	+	+	+	+	+	+	+
	Fentanest								+	+		
	Fentanyl	+	+	+	+	+	+				+	
	Sublimaze	+		+	+	+						
Flurazepam	Flurazepam	+	+	+	+	+	+	+	+	+	+	+
	Dalmadorm						+		+	+		+
	Dalmane	+	+	+	+	+						
	Dormodor									+		
	Durapam	+										
	Felison								+			
	Flunox								+			
	Flu Pam		+									
	Remdue								+			
	Som-pam		+									
	Somnol		+									
	Staurodorm											+
	Valdorm								+			
Flunitrazepam	Darkene								+			
	Fluni						+					
	Flunibeta						+					
	Flunimerck						+					
	Fluninoc						+					
	Hypnodorm			+								
	Narcozep							+				
	Rohypnol			+		+	+	+		+	+	+
	Roipnol								+			
	Valsera								+			
Gluthetimide	Doriden			+								
Hydroxy-Chloroquine	Dolquine									+		
	Hydroxychloroquine	+	+									
	Hydroxyquin		+									
	Plaquenil	+	+	+	+	+	+	+	+	+	+	+
	Quensyl						+					
Imipramine	Imipramine	+	+	+	+	+	+	+	+	+	+	+
	Antipress	+										
	Imavate	+										
	Imiprin	+	+									
	Janimine	+										
	Melipramine			+								
	Tofranil	+	+	+	+	+		+	+	+	+	+
Lorazepam	Lorazepam	+	+	+	+	+	+	+	+	+	+	+
	Alzapam	+										
	Ativan	+	+	+	+	+						
	Control								+			
	Duralozam						+					
	Equitam							+				
	Idalprem									+		
	Laubeel						+					
	Lorans								+			
	Loridem											+
	Nu Loraz		+									
	Tavor						+		+			
	Temesta							+			+	+
	Tolid						+					
Methadone	Methadone										+	
	Biodone			+	+							
	Dolophine	+										
	Eptadone								+			
	Matadol		+									
	Metasedin									+		
	Methadose	+										
	Methatabs				+							
	Pallidone				+							
	Physeptone			+		+						
	Pinadone										+	
	Sedo									+		
	Symoron										+	
	Synastone					+						
Metoclopramide	* see extended Table on page 28											
Midazolam	Midazolam	+	+								+	
	Dormicum						+			+	+	+
	Hypnovel			+	+	+		+				
	Ipnovel								+			
	Versed	+						+				
Nortryptiline	Nortryptiline	+		+								
	Allegron			+		+						
	Aventyl	+	+									
	Benpon						+					
	Diazepoxin									+		
	Dominans								+			
	Norfenazin									+		
	Noritren								+			
	Norpress				+							
	Nortab			+								
	Nortrilen						+				+	+
	Pamelor	+										
Orphenadrine	Orfenadrine	+	+								+	
	Disipal		+	+	+	+		+	+		+	+
	Antiflex	+										
	Marflex	+										
	Norflex	+	+	+	+	+	+					+
	Orphenate	+										
	X-Otarg	+										
Oxazepam	Oxazepam	+	+	+	+	+	+	+	+	+	+	+
	Adumbram						+		+			
	Alepam			+								
	Azutranquil						+					
	Benzotran			+	+							
	Durazepam						+					
	Murelax			+								
	Noctazepam						+					
	Novo-Xapam		+									
	Oxpam		+									
	Serax	+										
	Serepax			+	+				+			
	Seresta							+			+	+
	Zaxopam	+										
Pentobarbital	Pentobarbital	+										
	Euthanyl		+									
	Nembutal	+	+	+								
	Pentobarbitone			+								
Phenobarbital	Phenobarbital	+	+			+					+	
	Gardenal				+	+		+	+	+		+
	Lepinal						+					
	Luminal	+				+	+		+	+	+	
	Phenobarbitone			+								
Secobarbital	Secobarbital	+	+									
	Seconal	+	+	+		+						
	part of Tuinal	+		+		+						
	part of Vesparax						+		+			+
Thiopental	Thiopental									+		
	Farmotal								+			
	Intraval sodium		+		+	+						
	Nesdonal							+			+	+
	Pentothal	+	+	+	+				+	+		+
	Trapanol						+					
Trimipramine	Trimipramine						+					
	Apo-Trimip	+										
	Herphonal						+					
	Novo-tripramine		+									
	Rhotrimine		+									
	Stangyl						+					
	Surmontil	+	+	+	+	+		+	+	+		
	Trimudura						+					
	Tripress				+							
	Trimip		+									
		USA	Can	Aus	N-Zea	UK	Ger	Fra	Ita	Spa	Neth	Belg

- Alphabetical survey of the *generic names* for the drugs discussed followed by *all the trade or brand names* for each medicine in eleven countries (USA, Canada, Australia, New Zealand, UK, Germany, France, Italy, Spain, the Netherlands and Belgium).
- + sign means: *available by that name.*
- Some drugs are not available in some countries (e.g. amobarbital is not available in N-Zea, Fra, Spa, Neth.
- Most of these medicines are available only on prescription. We must warn that over time a particular medicine may not be available any more in one of these countries.
- The brand names for the recommended anti-emetic medicines (Metoclopramide and Domperidon) are given in Chapter 2.2.8.

second expanded edition 2006

"A carefully planned humane dying within the limits of the law is possible thanks to this book which is based on reports from witnesses.
This can bring peace of mind to anyone in a desperate end-of-life situation wishing to have control over a death of one's own."

Richard MacDonald, M.D.

This *Guide to a Humane Self-Chosen Death* offers scientifically based information on how to achieve a humane, self-chosen death.

A humane and self-chosen death should take place with emotional support and comfort from others. Suggestions are given for relatives and friends who may wish to be present with a dying loved one, without legal harm to themselves.

The methods in this book require careful planning in order to achieve a peaceful death. An individual can carry out the steps without substantial involvement from other people.

This book will be sold to associations of physicians and to right-to-die societies in various countries. These societies and associations can develop their own policies for distribution of this guide, in a manner that is consistent with the practices and laws of their own countries.

The authors of this guide do not in any way wish to encourage suicide. Someone with a wish to die should receive spiritual comfort, adequate palliative care or professional therapy to make life bearable. But for some people who know they will die soon anyway, the methods discussed provide just that piece of information that brings a humane self-chosen death within reach.

For those individuals this book is written.

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