

SHOULD EUTHANASIA AND ASSISTED SUICIDE BE LEGAL? ADDRESSING KEY ARGUMENTS AND ANALYZING THE CONSEQUENCES OF LEGALIZATION

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1. *Introduction*

In this paper, I will examine whether countries should legalize euthanasia and assisted suicide. Debate on euthanasia and assisted suicide is becoming more and more actual in numerous countries in the world, even though majority of them are rejecting its legalization. This shows the need for a thorough philosophical, legal, medical and social analysis of the issue, in order to provide understanding of it and offer adequate solutions.

Firstly, I will provide the context of the debate by defining the key terms and giving the overview of how the debate evolved throughout history. Secondly, I will address the key arguments in favor of legalizing euthanasia and assisted suicide, namely the argument from autonomy and self-determination and the claim for the “right to die with dignity”. After addressing the arguments, I will analyze the consequences which were showed to occur in the countries which legalized euthanasia and/or assisted suicide. More specifically, the case study on the Netherlands and Belgium will be made. Finally, I will propose a model for the dignity-respecting health-care and make the conclusions.

The methods used in conducting this research were: philosophical and linguistics assessment of the argumentation and terminology, collection of the data and statistics from the relevant publications, legal analysis of the legislation in the field of international human rights law and peer-reviewed literature analysis.

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2. *Context of the debate*

2.1. Definitions

The debate on euthanasia and assisted suicide usually revolves around many technical and expert terms, which can make it harder to understand issues at stake. In the scientific and legal literature often there are different definitions of the same terms. For example, the American College of Physicians (ACP) defines euthanasia as “The act of intentionally ending a life to relieve pain or other suffering (e.g., lethal injection performed by a physician).”¹ The Parliamentary Assembly of the Council of Europe (PACE) in Resolution 1859 (2012) states that Euthanasia is the “intentional killing by act or omission of a dependent human being for his or her alleged benefit”², while the World Medical Association says that euthanasia is “the act of deliberately ending the life of a patient.”³

Physician assisted suicide (PAS) is the term used to describe “physician participation in advising or providing, but not directly administering, the means or information enabling a person to intentionally end his or her life (e.g., ingesting a lethal dose of medication prescribed for that purpose).”⁴ PAS differs from euthanasia insofar as the patient is the one administering the drug to him or herself, while in the euthanasia the third person (usually a doctor) is the one who administers the lethal drug.

What the PACE definition rightly emphasizes is that euthanasia can be committed both by act and omission. As John Finnis explained, “This inclusion of ‘non-activities’, omissions, ‘passive’ conduct, is entirely reasonable. Euthanasia, on any view, is an exception or proposed exception to the law of homicide, more specifically the law of murder. And you can unquestionably commit murder by omission. Parents murder children sometimes with a pillow but sometimes by starvation, omitting to feed them. To inherit the fortune, I omit to give the diabetic child his insulin. To be free to marry his secretary, Dr D. omits to switch his wife’s life-support system back on after its daily service break.”⁵

1 Lois Snyder Sulmasy & Paul S. Mueller, *Ethics and the Legalization of Physician-Assisted Suicide: An American College of Physicians Position Paper*, 167 *Annals Internal Med.* 576, 578 (2017).

2 Eur. Parl. Ass. Res. 1859, 5, Council of Europe (Jan. 25, 2012).

3 World Medical Association, WMA Declaration on Euthanasia (Oct. 1987), <https://www.wma.net/policies-post/wma-declaration-on-euthanasia>.

4 Lois Snyder Sulmasy & Paul S. Mueller, *Ethics and the Legalization of Physician-Assisted Suicide: An American College of Physicians Position Paper*, 167 *Annals Internal Med.* 576, 578 (2017).

5 John Finnis, *Euthanasia, Morality and Law*, 31 *Loy. L. A. L. Rev.* 1123, 1127 (1998).

Euthanasia by omission is usually called “passive,” while euthanasia by action is called “active.” What both active and passive euthanasia, as well as PAS have in common, is the “intent to cause or hasten the patient’s death.”⁶ The intent also distinguishes euthanasia and PAS from stopping what is sometimes characterized as “overly aggressive therapy.”

“Overly aggressive therapy describes an exaggeratedly stubborn struggle against inevitable death.”⁷ Sometimes prolonging treatment is disproportionately burdensome on the patient, with no prospect of improvement. Such futile treatment can be withdrawn on the request of a patient. There is a long-standing medical and legal tradition supporting the rights of patients to refuse unwanted treatment, even though this refusal may hasten death.⁸

As European Association for Palliative Care states: “Withholding or withdrawing ineffective, futile, burdensome, and unnecessary life-prolonging procedures or treatments does not constitute euthanasia or PAS because it is not intended to hasten death, but rather indicate the acceptance of death as a natural consequence of the underlying disease progression.”⁹

On other occasions, the doctor can administer pain killers with the primary intent to alleviate the patient’s pain, even though hastening death can occur as an unintended consequence. In both cases, there is no primary intention to hasten the patient’s death and in both cases the physician’s action is not the cause of death, but it is the underlying disease. Therefore, these actions should be clearly distinguished from “passive euthanasia” as explained above.

Further distinctions can be made between “nonvoluntary” and “involuntary” euthanasia. The term “nonvoluntary” euthanasia is used to describe euthanasia with patients incapable of requesting it, while “involuntary” euthanasia is performed on patients who did not request it, but were capable of doing so.¹⁰

Finally, in some cases of severe suffering, the person can be sedated to alleviate pain. In this case, “a physician uses sedatives to reduce or take away the consciousness of a patient until death follows.”¹¹ In this case, the intent behind the action also plays the crucial role. If the intent is to hasten

6 Giacomo Perico, *Problemi di etica sanitaria* 138 (1992).

7 Etienne Montero, European Institute of Bioethics, *Ethical points of reference in caring for people nearing the end of life 2* (2010) available at <https://www.ieb-eib.org/fr/document/ethical-points-in-caring-for-people-nearing-end-of-life-260.html>.

8 See *Cruzan v Director*, Missouri Dept of Health, 497 US 261 (1990).

9 Liliana De Lima et al., *International Association for Hospice and Palliative Care Position Statement: euthanasia and physician-assisted suicide*, 20 *J. Palliative Med.* 8, 14 (2017).

10 Herbert Hendin, *The Dutch Experience*, in *The Case Against Assisted Suicide* 101 (Kathleen Foley & Herbert Hendin, eds., 2002).

11 Kasper Raus, Sigrid Sterckx, et al., *Is Continuous Sedation at the End of Life an Ethically Preferable Alternative to Physician-Assisted Suicide?*, 11 *Am. J. Bioethics* 32, 32 (2011).

the patient's death through sedation, the action is usually termed "terminal sedation." If the primary goal is to alleviate pain, while accepting the death as a possible consequence, the act is termed "palliative sedation."

2.2. History

The word euthanasia comes from the Greek *eu* (good) and *thanatos* (death), literally translating to "good death." The term was coined in the seventeenth century by English philosopher Francis Bacon to refer to "an easy, painless, happy death."¹²

Various philosophers in ancient Greece and Rome discussed suicide and how the state and society should respond. Some of them condemned suicide, and some tolerated it, although there is little evidence that such toleration was linked in any way to concern for the terminally ill.¹³ Athenian law treated suicide as a crime, "punishing" the "guilty" by amputating the corpse's right hand and denying traditional burial rituals; Plato similarly condemned suicide on multiple occasions.¹⁴ Aristotle argued that suicide imposes no harm on third persons, but it does impose harm on the state and for that reason was unjust.¹⁵ Stoics "considered suicide an acceptable response to physical adversity," while Pythagoras strongly opposed it.¹⁶ Under Roman law, criminals committing suicide to avoid punishment or their worldly obligations and their surviving family members were regularly punished, but other forms of suicide were generally allowed.¹⁷ Intentional suicide was generally not accepted in the Early and Middle Age Christianity.¹⁸ Christians celebrated martyrs who accepted death for their beliefs, but distinguished this acceptance from intentionally ending one's life.¹⁹

Despite variations in how much or little a society tolerated suicide, there was no proposal of physician-assisted suicide until the eighteenth century, with the discovery of analgesics and anesthetics which could relieve pain, but also more easily and painlessly end life.²⁰ The first articles advocating for euthanasia in the context of modern medicine appeared in England and

12 Kathleen Foley & Herbert Hendin, *Foreword*, in *The Case Against Assisted Suicide* 5 (Kathleen Foley, Herbert Hendin, eds., 2002).

13 Neil Gorsuch, *The Future of Assisted Suicide and Euthanasia* 22 (2006).

14 *Id.*

15 *Id.*

16 *Id.* at 24.

17 *Id.* at 25.

18 Guenter Lewy, *Assisted Death in Europe and America: Four Regimes and Their Lessons* 2 (2017).

19 Gorsuch, *supra* note 13, at 26.

20 Kathleen Foley & Herbert Hendin, *Foreword*, *supra* note 12, at 6.

the United States in the 1870s, and the first proposal to legalize euthanasia was made and defeated in Ohio in 1905.²¹

The modern euthanasia movement developed from early 20th century in concert with the eugenics movement. This movement, motivated by advances in genetics, aimed to hasten the process of natural selection described by Charles Darwin the century before. Its proponents understood it as “[T]he science of improving stock... to give the more suitable races or strains of blood a better chance of prevailing over the less suitable than they otherwise would have had.”²² They “envisioned a perfection of the human race, initially through sterilization of the unfit or degenerate, variously defined as criminals, prostitutes, alcoholics, epileptics, and the mentally ill.”²³

Sterilization of the mentally ill was one of the first inroads of the eugenics movement to the society, but in no case the only one. The same reasons and arguments used to defend forced sterilization were also used to support euthanasia. The Illinois Homeopathic Medical Association in 1931 defended euthanasia for “imbeciles and sufferers from incurable diseases.”²⁴ Harvard professor and social darwinist Earnest Hooton advocated for euthanasia as an appropriate solution for “the hopelessly diseased and the congenitally deformed and deficient.”²⁵ In 1937, a bill was proposed, and defeated, in the U.S. state of Nebraska to legalize euthanasia not just for competent adults suffering from fatal diseases, but also included “provisions for killing, without their consent, mental incompetents and minors suffering from incurable or fatal diseases.”²⁶ One year later, The Euthanasia Society of America (ESA) was founded and it included among its founders and leaders a number of proponents of eugenics, who advocated for “legalized, safeguarded, and [state-]supervised mercy killing for suffering patients in the final stages of life”, but also mercy killing for disabled infants, mentally disabled, and others who were deemed “unfit.”²⁷

The eugenics movement was also strong in Germany in the early 1920s, led by some prominent scientists, such as Ernest Heackel, who advocated for euthanasia for the “hundreds of thousands of incurables — lunatics, lepers, people with cancer, etc.”²⁸ When the Nazis came to power, they first

21 *Id.*

22 Francis Galton, *Inquiries into Human Faculty and Its Development* 24 (1883), *quoted in* Diane Paul, *Controlling Human Heredity: 1865 to the Present* 3 (1996).

23 Kathleen Foley & Herbert Hendin, *Foreword*, *supra* note 12, at 6.

24 *Death for Insane and Incurable Urged by Illinois Homeopaths*, *New York Times* (May 9, 1931, at 4.), *quoted in* Gorsuch, *supra* note 13, at 34.

25 Earnest Hooton, *The Future Quality of the American People*, 154 *The Churchman* 11–12 (1940). *quoted in* Gorsuch, *supra* note 13, at 34.

26 Gorsuch, *supra* note 13, at 35.

27 *Id.*

28 Kathleen Foley & Herbert Hendin, *Foreword*, *supra* note 12, at 7.

legalized voluntary euthanasia, but later expanded it beyond measure.²⁹ News that Nazi euthanasia practices killed more than 200,000 disabled and elderly persons³⁰ caused worldwide consternation. It also curbed the growth of the euthanasia movement in the US and elsewhere. Nevertheless, in 1943 ESA empaneled a committee to draft a bill “legalizing nonvoluntary euthanasia for so-called idiots, imbeciles, and congenital monstrosities.”³¹

Interest in euthanasia and assisted suicide revived in the 1970s and 1980s, and was primarily focused on compassion for suffering patients and patient autonomy.³² The Netherlands was the first country to legalize assisted suicide and euthanasia in 2001 after tolerating the practice for some years,³³ and some other countries followed, such as Belgium in 2002³⁴ and Luxembourg in 2009.³⁵ Modern euthanasia movement often embraces the “rights” argumentation, thus asserting that there should be a “right to die” or a “right to die with dignity” recognized by international law. According to some authors, this right stems from the right of the human person to choose what he or she considers to be a good life, and consequently also what constitutes a good death. The advocates argue that the respect for individual autonomy also implies the right to choose how one wants to die.³⁶ Besides respect for the autonomy of the dying patients, advocates for the legalization of euthanasia and assisted suicide usually present it as an act of compassion for persons who are suffering and nearing death.

3. *Addressing key arguments for legalization*

3.1. Argument from autonomy

One of the most common arguments in favor of legalizing euthanasia and assisted suicide is the argument from autonomy and self-determination. As the argument usually goes, the mentally competent and terminally ill adults

29 Cf. Gorsuch, *supra* note 13, at 36–38.

30 Gorsuch, *supra* note 13, at 36.

31 *Id.*

32 Kathleen Foley & Herbert Hendin, *Foreword*, *supra* note 12, at 8.

33 Herbert Hendin, *The Dutch Experience*, in *The Case Against Assisted Suicide* 97 (Kathleen Foley, Herbert Hendin, eds., 2002).

34 Loi du mai 2002 relative à l’euthanasie [Law of May 2002 on euthanasia] of May 28, 2002, Moniteur Belge [M.B.] [Official Gazette of Belgium], June 22, 2002.

35 Loi du 16 mars 2009 sur l’euthanasie et l’assistance au suicide [Law of 16 March 2009 on euthanasia and assisted suicide], Memorial A No. 46 Journal Officiel du Grand-Duché de Luxembourg 615 [Official Gazette of Luxembourg] *available at* <http://legilux.public.lu/eli/etat/leg/memorial/2009/46>.

36 Gorsuch, *supra* note 13, at 99.

should have the right to decide in which way they want to end their lives and when they want to do so. The government should protect that right by not interfering and with prohibiting others from interfering with one's autonomous decision.

However, what the argument essentially misses is that legalizing euthanasia and assisted suicide is not only about allowing persons to die in the way of their choice, but it also requires a doctor's participation in the suicide and the social acceptance of the act. "Euthanasia is not a private matter of self-determination. It is an act that requires two people to make it possible, and a complicit society to make it acceptable."³⁷ Self-determination in the case of euthanasia can only be achieved "by the moral and physical assistance of another. Euthanasia is thus no longer a matter only of self-determination, but of a mutual, social decision between two people."³⁸

The autonomy argument is clearly expressed in the decision of the United States Supreme Court in *Planned Parenthood v. Casey*: "At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life."³⁹ Applying this principle in *Compassion in Dying v. Washington*, the federal district court for the state of Washington reasoned that "the decision of a terminally ill person to end his or her life involves the most intimate and personal choices a person may make in a lifetime and constitutes a choice central to personal dignity and autonomy."⁴⁰

Individual autonomy, however important it may be, is always limited by the protection of the fundamental goods of society. One such good is the life of a human being which should be always protected and the intentional taking of the life of another should be always prohibited. The principle of the inviolability of life is a fundamental principle of the common law,⁴¹ and this principle has been enshrined in numerous human rights conventions.⁴² This principle is grounded in an "understanding of each human being as having an intrinsic and inviolable dignity. The essence of the principle is the prohibition on the intentional taking of human life, intention used in its or-

37 Daniel Callahan, *When Self-Determination Runs Amok*, 22 *The Hastings Center Report* 52, 53 (1992).

38 *Id.* at 52.

39 *Planned Parenthood v. Casey*, 505 U.S. 833, 851 (1992)

40 *Compassion in Dying v. Washington*, 850 F. Supp. at 1459–60.

41 John Keown, *A Right to Voluntary Euthanasia? Confusion in Canada in Carter*, 28 *Notre Dame J.L. Ethics & Pub. Policy* 1, 5 (2014).

42 See for example: ICCPR art. 6; Convention on the Rights of the Child art. 6, opened for signature Nov. 20, 1989, 1577 U.N.T.S. 3; Convention on the Rights of Persons with Disabilities art. 10, opened for signature Mar. 30, 2007, 2515 U.N.T.S. 3.

dinary sense of aim or purpose.”⁴³ Canadian House of Lords Select Committee on Medical Ethics described the prohibition on intentional killing as “the cornerstone of law and of social relationships” which “protects each one of us impartially, embodying the belief that all are equal.”⁴⁴ As numerous court decisions indicate, the State has a legitimate interest in preserving life.⁴⁵

England’s Court of Appeal has observed that some cases present an apparent conflict between the patient’s interest in “self-determination” and society’s interest in “upholding the concept that all human life is sacred.”⁴⁶ While acknowledging that the right of self-determination is of “paramount” importance, the court held that in cases where doubt exists about whether the individual is actually exercising that right, “that doubt falls to be resolved in favour of the preservation of life for if the individual is to override the public interest, [she] must do so in clear terms.”⁴⁷ Similarly, the European Court of Human Rights (ECtHR) stressed that “the concept that ‘everyone’s life shall be protected by law’ enjoins the State not only to refrain from taking life ‘intentionally’ but, further, to take appropriate steps to safeguard life.”⁴⁸ In the Case *Pretty v. United Kingdom*, the ECtHR underlined that it has always placed “consistent emphasis . . . [on] the obligation of the State to protect life.”⁴⁹

Yet the patient’s autonomy, which legalization of euthanasia and PAS claims to protect, is in fact illusory, because the final decision rests in the hands of the doctor, not the patient. “The physician decides when the patient is suffering intolerably enough to use the last resort. The physician controls the availability of the medication and its dose. The physician makes a judgment about the quality of the patient’s life and suffering and what is good for the patient.”⁵⁰ Thus, as some authors have argued, making physicians the arbiters of assisted suicide and euthanasia is the return to one of the most severe forms of paternalism, not a victory for patient autonomy.⁵¹

Therefore, the justification of voluntary euthanasia rests “fundamentally not on the patient’s autonomous request but on the doctor’s judgment that the request is justified because the patient no longer has a life ‘worth’ living. If a

43 Keown, *supra* note 41, at 5.

44 *Id.* at 6.

45 Gorsuch, *supra* note 13, at 10.

46 *Id.* at 187.

47 *Id.*

48 *L.C.B. v. the United Kingdom*, App. No. 23413/94 § 36, Eur. Ct. H.R., June 9, 1998; *see generally Association of Parents v. the United Kingdom*, No. 7154/75, Eur. Ct. H.R., July 12, 1978.

49 *Pretty*, No. 2346/02 § 39.

50 Edmund D. Pellegrino, *Compassion Is Not Enough*, in *The Case Against Assisted Suicide* 48 (Kathleen Foley & Herbert Hendin, eds., 2002).

51 *Id.*

doctor can make this judgment in relation to an autonomous patient, he can, logically, make it in relation to an incompetent patient. Moreover, if death is a 'benefit' for competent patients suffering certain conditions, why should it be denied incompetent patients suffering from the same conditions?"⁵²

Numerous cases of non-voluntary and involuntary euthanasia worldwide testify to this. In the Netherlands by 1990, there were 1,000 cases (0.8% of all deaths) where physicians administered a drug hastening the end of life "without an explicit request of the patient,"⁵³ and in 4,000 cases physicians "withdrew or withheld treatment without request" with the explicit intent to shorten life.⁵⁴ The number remained high in 1995, with 900 cases of *active* euthanasia without the explicit request of the patient.⁵⁵ Replication studies in Australia and Belgium both found incidence of ending the life without explicit request of the patient to be over 3%.⁵⁶ Dutch studies show that in 8% of the cases in which "a life-terminating act was performed without explicit request of the patient", other treatment alternatives still existed.⁵⁷ Physicians justified their actions on the grounds that the suffering was considered unbearable, standard medical care failed to help, and death would occur most likely within a week.⁵⁸ The numbers are even more alarming when they include death by deliberate act of omission. Dutch 1995 numbers show that there were 15,528 cases (59%) of intentionally terminating life without any explicit request.⁵⁹ The numbers for the United States show that 54% of the patients who received a lethal injection did not make the request for euthanasia themselves.⁶⁰ According to a Dutch study from 2001, 16% of patients whose lives were ended without request were fully competent, and there is no good explanation of why a request to die was not obtained.⁶¹

One survey of critical care nurses calculated that at least 7% of the nurses interviewed had at least once carried out assisted suicide or euthanasia with-

52 John Keown, *Euthanasia in the Netherlands: Sliding down the Slippery Slope*, 9 Notre Dame J.L. Ethics & Pub. Policy 407, 408 (2002).

53 *Id.* at 417.

54 *Id.* at 418.

55 Gerrit van der Wal, P. J. van der Maas, *Empirical Research on Euthanasia and Other Medical End-of-Life Decisions and the Euthanasia Notification Procedure*, in *Asking to Die* 171 (David C. Thomasma, et al., eds., 1998).

56 Raphael Cohen-Almagor, *Non-voluntary and Involuntary Euthanasia in the Netherlands: Dutch Perspectives*, 18 *Issues in Law & Medicine* 239, 241 (2003).

57 *Id.* at 242.

58 *Id.*

59 John Finnis, *Euthanasia, Morality and Law*, 31 *Loy. L. A. L. Rev.* 1123, 1128 (1997-1998).

60 Meier et al., *A National Survey of Physician-assisted Suicide and Euthanasia*, 338 *N Engl J Med* 1193, 1200 (1998).

61 Antonia Grundmann, *Das Niederländische Gesetz über die Prüfung von Lebensbeendigung* 210 (2004).

out a request from either the patient or a surrogate.⁶² Another 4% had hastened a patient's death by only pretending to provide the life-sustaining treatment ordered by a physician. Some nurses reported engaging in these practices without a request or advance knowledge of physicians.⁶³ In another Dutch study, the researchers went so far as to suggest that "the person responsible for avoiding involuntary termination of life is the patient" and that "the person who does not wish to have his or her life terminated should declare this clearly, in advance, orally and in writing, preferably in the form of a living will."⁶⁴

Finally, euthanasia for mentally competent terminally ill persons raises the problem of diagnosing and estimation how much time people have left until the end of life. Doctors often report problems with determining whether the disease is terminal and how much time is left for the person. One study from 2011 conducted on 1622 patients, showed that physicians accurately estimated the duration of the patient's survival in only 34% of the cases.⁶⁵ In a 1996 survey approximately 50 percent of Oregon physicians have acknowledged the "lack of confidence in their own ability to predict whether patients have more or less than six months to live."⁶⁶ The 1999 survey of Oregon physicians showed that "one in six were not confident about finding reliable lethal prescribing information, and one in four were not confident in determining six-month life expectancy."⁶⁷ The problem with medical prognoses is that they are based on statistical averages, which are nearly useless in determining what will happen to an individual patient.⁶⁸

3.2. Claims for the "right to die" and "right to die with dignity"

"Death with dignity" and its variations are often used by euthanasia and PAS advocates, even though the terms are inherently vague.⁶⁹ The term may be

62 David A. Asch, *The Role of Critical Care Nurses in Euthanasia and Assisted Suicide*, 334 *New Eng. J. Med.* 1374 (1996).

63 *Id.*

64 Herbert Hendin, *The Dutch Experience*, in *The Case Against Assisted Suicide* 117 (Kathleen Foley, Herbert Hendin, eds., 2002).

65 Debbie Selby, Anita Chakraborty, et al., *Clinician Accuracy When Estimating Survival Duration: The Role of the Patient's Performance Status and Time-Based Prognostic Categories*, 42 *Journal of Pain and Symptom Management* 578 (2011).

66 Melinda A. Lee, et al., *Legalizing Assisted Suicide—Views of Physicians in Oregon*, 334 *New Eng. J. Med.* 310, 334 (1996).

67 Linda Ganzini, et al., *Oregon physicians' attitudes about and experiences with end-of-life care since passage of the Oregon Death with Dignity Act*, 285 *JAMA* 2363, 2368 (2001).

68 Marilyn Golden & Tyler Zoanni, *Killing us softly: the dangers of legalizing assisted suicide*, 2 *Disability & Health J.* 16, 21 (2010).

69 Kevin Yuill, *Assisted Suicide: The Liberal, Humanist Case Against Legalization* 13–15 (2015).

understood differently or in multiple ways, which is often the case. In the arguments for PAS, these elements pit autonomy against an unknown hour and manner of death, and suggest that the suffering and pain experienced by many at the end of life is undignified and therefore should be avoided. Numerous PAS advocacy organizations have presented this as a “right to die with dignity,” suggesting a legal obligation despite most courts finding that no right to die, in any manner, exists.⁷⁰

Similar wording was used recently by the United Nations Human Rights Committee (UNHRC), which adopted a General Comment 36 stating the: “States parties that allow medical professionals to provide medical treatment or the medical means in order to facilitate the termination of life of afflicted adults, such as the terminally ill, who experience severe physical or mental pain and suffering and wish to *die with dignity*, must ensure the existence of robust legal and institutional safeguards to verify that medical professionals are complying with the free, informed, explicit and, unambiguous decision of their patients, with a view to protecting patients from pressure and abuse.”⁷¹ Although this comment is not binding, as it comes from a treaty monitoring body, it is influential as a statement of the committee’s interpretation of the right to life.

Using the terminology of “dying with dignity” by the UNHRC is problematic and raises questions in the field of international human rights law. International human rights are created by treaty and by custom.⁷² Treaties are binding agreements between States.⁷³ The United Nations adopted several human rights treaties, which are binding for the States which signed them. States parties submit reports to treaty monitoring bodies (TMBs) who offer non-binding⁷⁴ recommendations to assist them in meeting their

70 Gorsuch, *supra* note 13, at 45 (2006).

71 Human Rights Committee General comment No. 36 on article 6 of the International Covenant on Civil and Political Rights, on the right to life, U.N. Doc. CCPR/C/GC/36 (Oct. 30, 2018). Emphasis mine.

72 David J. Bederman, *The Spirit of International Law* 33 (2006); Statute of the International Court of Justice art. 38(1), June 26, 1945, 33 U.N.T.S. 993.

73 Vienna Convention on the Law of Treaties arts. 2(1)(a), 11, *opened for signature* May 23, 1969, 1155 U.N.T.S. 331, 333.

74 TMBs have only limited authority granted in the treaties which create them, which does not include the authority to create rights. *See, e.g.*, International Covenant on Civil and Political Rights art. 40–42, *opened for signature* Dec. 19, 1966, 999 U.N.T.S. 171 [hereinafter ICCPR]; International Covenant on the Elimination of All Forms of Racial Discrimination part II, art. 8–9, *opened for signature* Mar. 7, 1966, 660 U.N.T.S. 195 [hereinafter CERD]; Convention on the Elimination of All Forms of Discrimination against Women arts. 17–22, *opened for signature* Mar 1, 1980, 1249 U.N.T.S. 13 [hereinafter CEDAW]; Convention on the Rights of the Child arts. 42–45, *opened for signature* Nov. 20, 1989, 1577 U.N.T.S. 3 [hereinafter CRC]; Convention on the Rights of Persons with Disabilities art. 34, *opened for signature* Dec. 13, 2006, 2515 U.N.T.S. 3 [hereinafter CRPD].

treaty obligations.⁷⁵ The right to life is recognized in several human rights treaties,⁷⁶ such as Article 6 of the International Covenant on Civil and Political Rights (ICCPR),⁷⁷ but no similar right to die or control the manner of one's death exists in the treaties.

The UN Human Rights Committee formally condemned the Dutch euthanasia of infants sanctioned under the "Groningen Protocol": "The Committee is gravely concerned at reports that new-born handicapped infants have had their lives ended by medical personnel."⁷⁸ The same Committee repeated its concern: "The Committee remains concerned at the extent of euthanasia and assisted suicides in the State party[.] The Committee reiterates its previous recommendations in this regard and urges that this legislation be reviewed in light of the Covenant's recognition of the right to life."⁷⁹

The issues of assisted suicide and euthanasia have come before the European Court of Human Rights several times. The court has generally refused to overrule practices in Member States related to the end of life, leaving matters, including bans on assisted suicide and withdrawal of sustenance, to national legislatures and procedures. The case of *Pretty v. United Kingdom* involved the fullest examination of whether a right to die exists under European human rights law. In that case, the Court has argued that Article 2 of the European Convention on Human Rights (ECHR), ensuring the right to life, "cannot, without a distortion of language, be interpreted as conferring the diametrically opposite right, namely a right to die; nor can it create a right to self-determination in the sense of conferring on an individual the entitlement to choose death rather than life. The Court accordingly finds that no right to die, whether at the hands of a third person or with the assistance of a public authority, can be derived from Article 2 of the Convention."⁸⁰ In the same case, the ECHR has also held that the first sentence of Article 2 (1) obliges the State not only to refrain from the intentional

75 Office of the High Comm'r for Hum. Rts., *The United Nations Human Rights Treaty System: An Introduction to the Core Human Rights Treaties and the Treaty Bodies 21* [hereinafter OHCHR, Human Rights Treaty System], www.ohchr.org/Documents/Publications/FactSheet30Rev1.pdf (last visited Nov. 25, 2018).

76 ICCPR art. 6; Convention on the Rights of the Child art. 6, *opened for signature* Nov. 20, 1989, 1577 U.N.T.S. 3; Convention on the Rights of Persons with Disabilities art. 10, *opened for signature* Mar. 30, 2007, 2515 U.N.T.S. 3

77 ICCPR art. 6.

78 U.N. Human Rights Committee, *Concluding Observations of the Human Rights Committee, The Netherlands* ¶ 6, U.N. Doc. CCPR/CO/72/NET (July 23, 2001).

79 U.N. Human Rights Committee, *Consideration of Reports Submitted by States Parties Under Article 40 of the Covenant, Concluding observations of the Human Rights Committee—Netherlands* ¶ 7, U.N. Doc. CCPR/C/NLD/CO/4 (Aug. 25, 2009)

80 *Pretty v. United Kingdom*, No. 2346/02 § 39, Eur. Ct. H.R., Apr. 29, 2000.

and unlawful taking of life, but also to take appropriate steps to safeguard the lives of those within its jurisdiction.⁸¹

Several other rulings of the European Court of Human Rights addressed similar issues. In *Haas v. Switzerland*, the court reiterated: “Article 2 [of the Convention] guarantees no right to die, whether with the assistance of a third party or of the State; the right to life has no corresponding negative freedom.”⁸² However, the Court suggested that its *Pretty* decision *had* found that the right enshrined in the Article 8 of the ECHR (respect for private and family life) does include the choice to avoid an undignified death, as long as “he or she is capable of freely reaching a decision on this question and acting in consequence.”⁸³ Still, the Court upheld a law requiring a prescription for a lethal dose of medication, recognizing the State’s interest in protecting life and preventing abuse.⁸⁴ In a case *Koch v. Germany*, the Court recognized that “the State enjoys a significant margin of appreciation” in the application of rights connected to the Article 8 with respect to assisted suicide, noting that “majority of Member States do not allow any form of assistance to suicide” and it did not enjoy consensus within the treaty.⁸⁵ It obliged Germany to thoroughly examine the claim domestically,⁸⁶ but not necessarily to permit the requested action.

These rulings also suggest that no right to die or end one’s life as one likes exists in the customary international law. Customary international law arises from the practices of states acting out of a sense of legal obligation (*opinio juris*).⁸⁷ The first part involves questions such as whether the rule has been followed, and how consistent and how long the practice has been.⁸⁸ The second element is more challenging, as it requires an assessment of whether a practice has been accepted as law—indicating that states believe it is an obligation, rather than simply a beneficial option.⁸⁹ It is the harder element to establish of the two. As the vast majority of countries do not allow the practice, general practice does not exist. This implies also that states do not believe that they have an obligation to permit it. Moreover, in the *Pretty* case discussed above, the European Court of Human Rights

81 *Id.* § 7.

82 *Haas v. Switzerland*, No. 31322/07, § 16, Eur. Ct. H.R., Jan. 6, 2011.

83 *Id.* §§ 50–51.

84 *Haas*, §§ 56–58.

85 *Koch v. Germany*, No. 497/09 §§ 69–70, Eur. Ct. H.R., Dec. 12, 2012.

86 *Id.* § 71.

87 Bederman, *supra* note 72 at 33.

88 *Id.*

89 *Id.* at 33, 36.

declined to read into a failure to condemn countries which allow assisted suicide any implication that it was therefore legal or legally required.⁹⁰

The concepts of the “right to die” and “right to die with dignity” are inherently problematic, regardless of whether we include euthanasia and assisted suicide in the concept of “dying with dignity” or not. It is problematic because it suggests that there could equally be a situation in which a person could die “without dignity”. One scholar summarizes it as: “Death with dignity, either alone or with others, is certainly preferable to death without dignity, whether it be lingering or rather sudden.”⁹¹ This view is radically mistaken, because a human person is never “without” his or her dignity. Human dignity can obviously be disrespected or not recognized, but this doesn’t change the fact that even the gravest injustices do not deprive a person of his dignity.

It is important to grasp this distinction, since the opposite view can suggest that rights given to man by the society, conditions he finds himself in or the level of his well-being can grant or rescind his dignity. What is more, human dignity can be seen as one of the rights given to man by the State or the international community. This is reflected in the argument by the mentioned scholar who argued that the “most relevant with respect to choice about the death and dying, however, is the general and pivotal right of each person to human dignity.”⁹² Again, this explanation is seriously problematic. Human dignity is prior to all human rights and serves as their foundation. Human rights, living and dying conditions, and well-being all must be conformed to human dignity. There are ways of dying that respect this human dignity and those that do not, but no manner of death can be without dignity because no person is ever without dignity.

Further, the same author argues that “the right to human dignity necessarily includes a right to live with dignity, and thus, a right to end one’s life in dignity — indeed, a right not be compelled to live the remainder of life in indignity.”⁹³ Connected to this line of the thinking is the common phrase used by the proponents of euthanasia and assisted suicide, who describe it as “death with dignity”. Again, this confusion in semantics suggests that the elderly, suffering, disabled or terminally ill may be deprived of their dignity, thus undermining the fundamental equality of all persons in their dignity by their condition, and the equal worth of all persons which is the basis of the equal protection before the law. This kind of understanding would un-

90 *Pretty*, No. 2346/02 § 41.

91 Jordan J. Paust, *The Human Right to Die With Dignity: A Policy-Oriented Essay*, 17 *Hum. Rts. Q.* 463 (1995).

92 *Id.* at 463, 479.

93 *Id.*

dermine the foundations of the human rights project as expressed in the preamble of the Universal Declaration of Human Rights.⁹⁴ Within human rights law, “dignity” takes on a more precise meaning: the value of an individual human being simply by virtue of being human.⁹⁵ This value is intrinsic, inherent, and universal;⁹⁶ it does not decrease or increase in proportion to any personal characteristic, experience, or action. That includes manners of dying: no one loses his dignity because he has become reliant on others for care, or suffers, or struggles. To suggest otherwise suggests that human life does not have objective value, which would undermine not only laws banning assisted suicide, but the foundation of human rights itself.

Equally wrong are the terms of “dignified death” and “dignity of death.” Death is the moment in which human life ends. The death itself, considered biologically, is “the degradation of the biological dimension of the human being, nothing dignified.”⁹⁷ In all the other aspects (psychological, emotional, social and mental) death also indicates disintegration of man. Since life is a fundamental value for a man (there can be no non-living man; dead body is a corpse and not a dead man) and death signifies the moment in which this fundamental value ceases to exist, there is nothing of dignity in the death *per se*.

Thus, concepts of “dignified death” and the “dignity of death” should be abandoned. Rather, we should talk about respect for dignity in end of life care. The process of dying can be more or less in accordance with human dignity, and thus can be more or less respectful of human dignity. What we should aim for is the end of life care which ensures a high level of this respect for human dignity for those who are dying, so that end of life care is understood as process of dying in accordance with human dignity or process of dying worthy of human person.

4. *Consequences of legalizing euthanasia and assisted suicide*

4.1. Pressures on vulnerable groups

The fact that legalizing euthanasia and assisted suicide would necessarily lead to physicians having to determine which lives can be considered unworthy of living, would inevitably lead to increased pressured put on

94 See Universal Declaration of Human Rights, G.A. Res. 217A, Preamble, art. 1, U.N. GAOR, 3d Sess., 1st plen. Mtg., U.N. Doc. A/810 (Dec. 12, 1948) [hereinafter UDHR].

95 See *Id.*

96 *Id.*, at Preamble.

97 Valentin Pozaić, *Palliative care and the human dignity of patients*, 5 Glas. pul. boln. 153, 154 (2009).

vulnerable groups. A right-to-die mentality has been shown to exert psychological pressure upon vulnerable persons,⁹⁸ and this pressure raises the question whether any real autonomy can be exercised in these conditions.

The case of Kate Cheney, as described by both Cheney and members of her family, illustrates this point.⁹⁹ Kate was an eighty-five-year-old widow diagnosed with terminal stomach cancer. She wanted the option of assisted suicide “in case she was in pain or if the indignities of losing control of her bodily functions became unbearable.”¹⁰⁰ Her daughter Erika went with Kate when she made the request to her physician. Erika described the physician as “dismissive” and requested a referral to a second physician. He arranged for a psychiatric consultation, which was a standard procedure. The psychiatrist, who visited Kate at her home, found that Kate did not “seem to be explicitly pushing for [assisted suicide]” and that she lacked the “level of capacity ... to weigh options about [it].”

Although Kate seemed to accept the assessment, her daughter became very angry. The hospital then suggested that the family obtain a second assessment from an outside consultant. The second psychologist noted that Kate had memory defects and that her “choices [might have been] influenced by her family’s wishes and [that] her daughter, Erika, [might have been] somewhat coercive,” but felt Kate had the ability to make her own decision. A hospital administrator then saw Kate and decided that she was competent and was making the decision on her own. Kate received the lethal drugs, which were put under Erika’s care. As time passed, Erika and her husband sent Kate to a nursing home for a week. When Erika visited, Kate always asked “when she would be going home.” On the day she returned from the nursing home, she told Erika and her husband that “she had considered going permanently into a nursing home but had decided to use the pills instead and asked for their help.”¹⁰¹ Within a short time, Kate took the pills and died.

Several cases suggest that the family expectations can exert pressure, not only on the patients, but also on physicians to assist in suicide even where it may not be warranted. Helen was a patient who performed aerobic exercises up until two weeks before she contacted the physician to request PAS.¹⁰² She told the physician she could not do them anymore, and she was also unable to continue to garden, which had been one of her favorite activi-

98 Lewy, *supra* note 18, at 153.

99 See Herbert Hendin & Kathleen Foley, *Physician-Assisted Suicide in Oregon: A Medical Perspective*, 106 Mich. L. Rev. 1613, 1624 (2008).

100 *Id.*

101 *Id.* at 1625.

102 *Id.* at 1616.

ties. Apart from that she was not bedridden, was not in great pain, and was still able to look after her own house. Helen's own physician had refused to assist in her suicide, and a second physician refused too on the grounds that Helen was depressed.

Helen's husband then called the advocacy group Compassion in Dying and was referred to a physician who would assist her. The third doctor finally approved the request. He later regretted his decision and the fact that didn't personally discuss the case with her regular physician and had only a very cursory contact with Helen. He also explained the reasons behind his decisions: "The thought of Helen dying so soon was almost too much to bear.... On the other hand, I found even worse the thought of disappointing this family. If I backed out, they'd feel about me the way they had about their previous doctor, that I had strung them along, and in a way, insulted them."¹⁰³

Some studies have shown that in the Netherlands "families request euthanasia more often than patients themselves" and "the family, the doctors, and the nurses often pressured the patient to request euthanasia."¹⁰⁴ "The relatives inability to cope" was also cited by physicians as a major reason (32% of cases) for terminating life without patients consent.¹⁰⁵ Wilfrid van Oijen was a Dutch doctor who in 2001 ended the life of an 84-year-old woman at her daughters' request, and not her own.¹⁰⁶ The woman had heart problems and was increasingly bedridden, but was not in pain and she even said that she did not want to die but could not care for herself. She expressed the desire to be with her daughters who cared for her at home, but the care became burdensome to the daughters, so van Oijen gave her the medication to hasten the process of dying.¹⁰⁷

The legalization of PAS can also foster economic coercion, both due to financial burdens on families and in savings to society as a whole. Recently, a study was published in Canada which tried to argue that legalizing "medical assistance in dying could reduce annual health care spending across Canada by between \$34.7 million and \$138.8 million."¹⁰⁸ Legalizing euthanasia indicates that some groups are a burden for a society and that society would be better off without them. This inevitably leads to a utilitarian view

103 Peter Reagan, *Helen*, 353 *Lancet* 1265, 1266 (1999), quoted in Hendin & Foley, *supra* note 99, at 1619.

104 Cohen-Almagor, *supra* note 56, at 249.

105 Gorsuch, *supra* note 13, at 110.

106 Herbert Hendin, *The Dutch Experience*, in *The Case Against Assisted Suicide* 115 (Kathleen Foley & Herbert Hendin, eds., 2002).

107 *Id.*

108 Aaron J. Trachtenberg & Braden Manns, *Cost analysis of medical assistance in dying in Canada*, 189 *Can. Med. Ass'n J.* E101, E101 (2017).

of human persons, which allows the “sacrifice” of certain groups for the benefit of certain groups who aren’t costly to care for. As the New York State Task Force on Life and the Law, established to consider the possibility legalizing PAS, observed: “Limits on hospital reimbursement based on length of stay and diagnostic group, falling hospital revenues, and the social need to allocate health dollars may all influence physicians’ decisions at the bedside... Under any new system of health care delivery, as at present, it will be far less costly to give a lethal injection than to care for a patient throughout the dying process.”¹⁰⁹

In 2008, Randy Stroup was diagnosed with prostate cancer and he turned to the Oregon state-run health plan for coverage of his chemotherapy treatments.¹¹⁰ Since chemotherapy is expensive, Stroup received a letter that stated his request was denied, but the State would pay for physician-assisted suicide.¹¹¹ Stroup had such a low chance of recovery that the state of Oregon decided he was no longer worth treating.¹¹² In another case in Oregon, a dying patient was euthanized to free a hospital bed.¹¹³ As euthanasia advocate Derek Humphry predicted, “one must look at the realities of the increasing cost of health care in an aging society, because in the final analysis, economics, not the quest for broadened individual liberties or increased autonomy, will drive assisted suicide to the plateau of acceptable practice.”¹¹⁴

This is not a fringe position; in fact, a number of officials around the world have endorsed it more or less openly. A former governor of Colorado has openly and repeatedly defended the view that the elderly have a duty to die to make room (and save resources for) the young.¹¹⁵ In 2014 a Lithuanian Health Minister suggested euthanasia could be a solution for poor people,¹¹⁶ and a Japanese finance minister said that the elderly should be allowed to “hurry up and die”

109 New York State Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* 123 (1994) [hereinafter NYS Task Force on Life and the Law], available at https://www.health.ny.gov/regulations/task_force/reports_publications/when_death_is_sought.

110 Zachary D. Smoll, *Physician-Assisted Suicide Tells People Like Me That Our Lives Are No Longer Worth Living*, *The Public Discourse* (May 8, 2017), available at <http://www.thepublicdiscourse.com/2017/05/19163/>

111 *Id.*

112 *Id.*

113 RJ George, et al., *Legalised euthanasia will violate the rights of vulnerable patients*, 331 *Brit. Med. J.* 684, 685 (2005).

114 Derek Humphry & Mary Clement, *Freedom to Die: People, Politics, and the Right-to-Die Movement* 313 (1998).

115 Gorsuch, *supra* note 13, at 131.

116 *Euthanasia could be option for poor, says Lithuanian health minister*, *BioEdge* (Jul 26, 2014), available at https://www.bioedge.org/bioethics/euthanasia_could_be_option_for_poor_says_lithuanian_health_minister/11071.

to relieve pressure on the State to pay for their medical care.¹¹⁷ Baroness Warnock, the UK ethicist, in a similar manner suggested that dementia sufferers may have a “duty to die.”¹¹⁸ It shouldn’t surprise us then, as one poll in Ohio has shown, that “those most likely to oppose the practice were black, people 65 and older, and those with low levels of income and education.”¹¹⁹

Precisely for this reason, the UK House of Lord rejected the legalization of assisted suicide in 2001 and concluded that a prohibition against the practice was justified precisely because of the possibility that “vulnerable people—the elderly, lonely, sick or distressed—would feel pressure, real or imagined, to request early death . . . [and] the message which society sends to vulnerable and disadvantaged people should not, however obliquely, encourage them to seek death, but should assure them of our care and support in life.”¹²⁰ The New York State Task Force similarly explained: “The Task Force members unanimously concluded that legalizing assisted suicide and euthanasia would pose profound risks to many patients. . . . The practices will pose the greatest risks to those who are poor, elderly, members of a minority group, or without access to good medical care.”¹²¹ Similarly, an Australian euthanasia bill from 1996 was repealed by the Commonwealth Parliament in 1997, with the consideration that it “had an unacceptable impact on the attitudes of the Aboriginal community towards health services,”¹²² and that “evidence was received that hospitals had become feared as places in which Aborigines could be killed without their consent.”¹²³ The poor, elderly, sick, members of minority groups, and people with disabilities already face barriers to healthcare without further undermining their trust that medical providers will provide the same quality of care to them as to everyone else.

4.2. Consequences for the medical profession

Legalizing euthanasia and assisted suicide creates a new set of problems for the medical profession, by distorting the doctor–patient relationship and

117 *Let elderly people ‘hurry up and die’, says Japanese minister*, The Guardian (Jan 22, 2013), available at <https://www.theguardian.com/world/2013/jan/22/elderly-hurry-up-die-japanese>.

118 *Baroness Warnock: Dementia sufferers may have a ‘duty to die’*, The Telegraph (Sept 18, 2008), available at <https://www.telegraph.co.uk/news/uknews/2983652/Baroness-Warnock-Dementia-sufferers-may-have-a-duty-to-die.html>.

119 Gorsuch, *supra* note 13, at 126.

120 *Regina v. Director of Public Prosecutors & Sec’y of State for the Home Dept.*, [2001] 1 A.C. 800 (H.L.) § 29, quoted in Gorsuch, *supra* note 13, at 46.

121 NYS Task Force on Life and the Law, *supra* note 109, at 120.

122 David W. Kissane, *Deadly Days in Darwin*, in *The Case Against Assisted Suicide 206* (Kathleen Foley, & Herbert Hendin, eds., 2002).

123 *Id.*, 205.

undermining the integrity of medicine. Medicine always operated under the ethical framework expressed in the Hippocratic Oath. In its original form, the Hippocratic Oath stated: “I will neither give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect.”¹²⁴ Today’s version of the oath, called the Declaration of Geneva, also says: “I will maintain the utmost respect for human life; I will not use my medical knowledge to violate human rights and civil liberties, even under threat.”¹²⁵

Medicine has always operated under the basic principles that life should be preserved and that promoting and restoring health is a natural goal of medicine.¹²⁶ Whenever possible, the disease should be cured and pain relieved: “Healing is thus the central core of medicine: to heal, to make whole, is the doctor’s primary business.”¹²⁷ Any society that legalizes euthanasia or assisted suicide undermines these basic principles and necessarily endangers the integrity of the medical profession. As the American Geriatric Society states: “Legalization of physician–assisted suicide would create a moral dilemma for geriatricians. Most elderly persons experience serious and progressive illness for extended periods before death and need significant social, financial and medical support. These resources too often are not available, are of inadequate quality, are not covered by insurance, and are not provided by public entitlement programs. By collaborating in causing early deaths, when continuing to live has been made so difficult, geriatricians would become complicit in a social policy which effectively conserves community resources by eliminating those who need services. By refusing to assist with suicides because of patient’s relative poverty and disadvantages social situation is seen as coercive, geriatricians would condemn their patients, and themselves, to live through the patient’s undesired difficulties for the time remaining.”¹²⁸

Legalizing euthanasia or assisted suicide also undermines the trust between patients and the doctor. The Court in *Washington v. Glucksberg* found that “Physician assisted suicide could . . . undermine the trust that is essential to the doctor–patient relationship by blurring the time honored line

124 Encyclopaedia Britannica, entry on Hippocratic Oath, *available at* <https://www.britannica.com/topic/Hippocratic-oath>.

125 World Medical Association, WMA Declaration of Geneva (Sept. 1948), *available at* <https://www.wma.net/policies-post/wma-declaration-of-geneva/>.

126 Leon R. Kass, *Neither for Love nor Money: Why Doctors Must Not Kill*, 95 *Pub. Int.* 25, 29 (1989).

127 *Id.* at 39.

128 Felicia Cohn & Joanne Lynn, *Vulnerable People: Practical Rejoinders to Claims in Favor of Assisted Suicide*, in *The Case Against Assisted Suicide* 250 (Kathleen Foley & Herbert Hendin, eds., 2002).

between healing and harming.”¹²⁹ Medical ethicist Dr. Leon Kass illustrates this vividly: “Imagine the scene: you are old, poor, in failing health, and alone in the world; you are brought to the city hospital with fractured ribs and pneumonia. The nurse or intern enters late at night with a syringe full of yellow stuff for your intravenous drip. How soundly will you sleep? It will not matter that your doctor has never yet put anyone to death; that he is legally entitled to do so—even if only in some well-circumscribed areas—will make a world of difference.”¹³⁰

The majority of medical associations worldwide have consistently opposed the practice, including the World Health Organization, American Medical Association, the American College of Physicians, Canadian Medical Association, British Medical Association, Royal College of Physicians, German Medical Association and over 20 others.¹³¹ The World Medical Association (WMA) has repeatedly highlighted its “strong belief that euthanasia is in conflict with basic ethical principles of medical practice,” even though it is allowed by law in some countries. WMA’s Declaration on Euthanasia, adopted by the 38th World Medical Assembly, Madrid, Spain, October 1987, states: “Euthanasia, that is the act of deliberately ending the life of a patient, even at the patient’s own request or at the request of close relatives, is unethical.”¹³² The WMA Statement on Physician-Assisted Suicide, adopted by the 44th World Medical Assembly, Marbella, Spain, September 1992 likewise states: “Physicians-assisted suicide, like euthanasia, is unethical and must be condemned by the medical profession. Where the assistance of the physician is intentionally and deliberately directed at enabling an individual to end his or her own life, the physician acts unethically.”¹³³ At the same time, AMA recognizes that “withdrawing or withholding of life-sustaining treatment is not inherently contrary to the principles of beneficence and non-maleficence,” while assisting suicide always is, because the latter involves intentionally using the tools of medicine to kill.¹³⁴

The final question raised by the legalization of euthanasia or assisted suicide is the threat to the rights of conscience of the doctors who would refuse

129 *Glucksberg*, 521 U.S. at 731.

130 Kass, *supra* note 126, at 35.

131 Carter Snead, *Carter Snead lecture “Physician Assisted Suicide: Objections in Principle and in Prudence”*, 26 Faculty Lectures & Presentations (2014). available at http://scholarship.law.nd.edu/law_faculty_lectures/26.

132 World Medical Association, WMA Declaration on Euthanasia, *supra* note 3.

133 World Medical Association, WMA Statement on Physician-Assisted Suicide (Sept. 1992), available at http://www.academia.edu/pdf/others/wma/euthanasia_2001.pdf.

134 American Med. Ass’n, Council on Ethical and Judicial Affairs, *Decisions Near the End of Life*, 267 JAMA 2229, 2230, 2233 (1992).

to participate in such practices. If there is a right to assisted suicide, then a doctor will have to take actions to ensure that right can be exercised. Many contemporary advocates of legalization of euthanasia and assisted suicide are, in fact, openly discussing putative professional and legal “duties” for doctors to perform those acts.¹³⁵ Under a legal regime which grants a right to assisted suicide, “what would happen to the medical care professionals who fail to act? Might they open themselves up to suits in negligence by families upset that their relatives suffered needlessly because a doctor or nurse did not advocate their death? Might we eventually have a ‘wrongful life’ cause of action?”¹³⁶ Even though some courts have noted that “a patient has no right to compel a health-care provider to violate generally accepted professional standards,”¹³⁷ there is no obvious reason why the patients and the courts wouldn’t have the right to compel a doctor to perform a certain practice contrary to his conscience, if the “professional standards” change in such a way to make these practices a part of a standard medical care.

Now I will examine what were the consequences of legalization on the case studies of the Netherlands and Belgium.

5. *Case studies on the Netherlands and Belgium*

5.1. The Netherlands

Dutch Termination of Life on Request and Assisted Suicide (Review Procedures) Act of 12 April 2001¹³⁸ legalized euthanasia and assisted suicide, under the conditions that the patient has made a voluntary and carefully considered request, his suffering was unbearable, and there was no prospect of improvement, the attending physician has informed the patient about his situation and his prospects, and has come to the conclusion, together with the patient, that there is no reasonable alternative in the light of the patient’s situation.¹³⁹ The physician must have consulted at least one other, independent physician, who must have seen the patient and given a written opinion on the due care criteria referred to above; and have terminated the patient’s life or provided assistance with suicide with due care.¹⁴⁰

135 Gorsuch, *supra* note 13, at 130.

136 *Id.*

137 *Id.* at 184.

138 Termination of Life on Request and Assisted Suicide (Review Procedures) Act, *available at* <https://www.euthanasia.ws/leyes/leyholandesa2002.pdf>.

139 *Id.*, ch. 2., art. 2.

140 *Id.*

The Dutch experience illustrates the how the limitations on assisted suicide can erode over time. Terminal illness is *not* a prerequisite for euthanasia, and neither is a physical ailment of any kind. Even though the doctor must consider his or her patient to be “suffering,” that suffering doesn’t need to be physical or really present at all: the doctor need only show that he or she “held the conviction” that the patient endured some sort of suffering.¹⁴¹ Also, procedurally, there is no specified waiting period after the request for euthanasia before it may be performed and no requirement that the request be given in writing.¹⁴²

A request for termination of life can also be made by a mentally competent patient who is a minor.¹⁴³ If the minor is aged between twelve and sixteen, then the consent of his parents or guardian is required in addition to his own request.¹⁴⁴ If the patient is sixteen or seventeen, his parents or guardian must be involved in the decision, but their consent is not required.¹⁴⁵

Euthanasia now extends even to the very young in the Netherlands. In 2004, The Groningen Protocol for the euthanasia of newborns was drafted at the University Hospital of Groningen in close collaboration with a district attorney,¹⁴⁶ and was authorised as a national guideline by the Dutch Association for Paediatric Care in July 2005.¹⁴⁷ Under this protocol, the euthanasia is envisioned for newborns with no chance of survival, newborns who require intensive care to survive, with a poor prognosis and very poor quality of life, and the infants for whom there is no hope in the long term and who, in the eyes of the parents and the medical team, are suffering unbearably.¹⁴⁸ One study from 2006, showed that in 2000, 16% of the cases of infant euthanasia were not discussed with the parents.¹⁴⁹

141 Gorsuch, *supra* note 13, at 106.

142 *Id.*

143 Termination of Life on Request and Assisted Suicide (Review Procedures) Act, ch. 2., art. 3 and 4., available at <https://www.eutanasia.ws/leyes/leyholandesa2002.pdf>

144 *Id.*

145 *Id.*

146 Eduard Verhagen, *The Groningen Protocol — Euthanasia in Severely Ill Newborn*, 352 N Engl J Med 959 (2005), available at <https://www.nejm.org/doi/full/10.1056/nejmp058026>

147 *Euthanasia of Newborns and the Groningen Protocol*, Dossiers of the European Institute of Bioethics (February 2, 2015), available at <https://www.ieb-eib.org/fr/pdf/20150204-groningen-eng.pdf>.

148 See Eduard Verhagen, *The Groningen Protocol — Euthanasia in Severely Ill Newborn*, 352 N Engl J Med 959 (2005), available at <https://www.nejm.org/doi/full/10.1056/nejmp058026>

149 Veerle Provoost, et. al., *Consultation of parents in actual end-of-life decision-making in neonates and infants*, 165 Eur J Pediatr 859 (2006).

The Dutch data show a steady increase in euthanasia cases. In 2012, there were 4,188 reported cases of euthanasia¹⁵⁰ and the number rose to 6,585 in 2017,¹⁵¹ a 57% increase in only 5 years. The percentage of euthanasia cases in all deaths rose from 1.7% in 1990 to 4.5% in 2015.¹⁵² Also, in 2017, there were 32 more cases of assisted suicide involving people with dementia than in 2016 and 60 cases involving people with severe psychiatric problems.¹⁵³ Cases for psychiatric reasons grew from just two people in 2010¹⁵⁴ to 60 in 2016 (300% growth), and dementia cases rose from 25 in 2010¹⁵⁵ to 169 in 2017¹⁵⁶ (576% growth). According to Dutch experts, in the beginning 98% of cases concerned the terminally ill patients with few days to live and number decreased to 70%.¹⁵⁷ In a number of cases, the due care requirements were not followed,¹⁵⁸ and several recent instances of euthanasia also involved patients who were “tired of life” without any physical suffering or terminal illness.¹⁵⁹ There is also a significant number of cases of euthanasia without patients explicit request, as well as the problem of non-reporting.¹⁶⁰ Estimates are that in 2010, 23% of the cases were unreported.¹⁶¹

150 Daniel Boffey, *'Any taboo has gone': Netherlands sees rise in demand for euthanasia*, The Guardian (Nov. 9, 2017), available at <https://www.theguardian.com/world/2017/nov/09/any-taboo-has-gone-netherlands-sees-rise-in-demand-for-euthanasia>.

151 *More euthanasia in the Netherlands, nearly all cases in line with the rules*, Dutch News (March 7, 2018), available at <https://www.dutchnews.nl/news/2018/03/more-euthanasia-in-the-netherlands-nearly-all-cases-in-line-with-the-rules/>.

152 Agnes van der Heide, et al., *End-of-Life Decisions in the Netherlands over 25 Years*, 377 N Engl J Med 492, 492 (2017).

153 *More euthanasia in the Netherlands, nearly all cases in line with the rules*, Dutch News (March 7, 2018), available at <https://www.dutchnews.nl/news/2018/03/more-euthanasia-in-the-netherlands-nearly-all-cases-in-line-with-the-rules/>.

154 Senay Boztas, *Netherlands sees sharp increase in people choosing euthanasia due to 'mental health problems'*, The Telegraph (May 11, 2016), available at <https://www.telegraph.co.uk/news/2016/05/11/netherlands-sees-sharp-increase-in-people-choosing-euthanasia-du/>.

155 *Id.*

156 *More euthanasia in the Netherlands, nearly all cases in line with the rules*, Dutch News (March 7, 2018), available at <https://www.dutchnews.nl/news/2018/03/more-euthanasia-in-the-netherlands-nearly-all-cases-in-line-with-the-rules/>.

157 *'Any taboo has gone': Netherlands sees rise in demand for euthanasia*, The Guardian (November 9, 2017), available at <https://www.theguardian.com/world/2017/nov/09/any-taboo-has-gone-netherlands-sees-rise-in-demand-for-euthanasia>

158 Johan Legemaate & Ineke Bolt, *The Dutch Euthanasia Act: Recent Legal Developments*, 20 European Journal of Health Law 451, 454 (2013). Thirty-six cases were found in the period 2007–2011.

159 *Id.* at 459.

160 Jose Pereira, *Legalizing euthanasia or assisted suicide: the illusion of safeguards and controls*, 18 Current Oncology 38, 39 (2011). See generally Cohen-Almagor, *supra* note 56.

161 Bregje Onwuteaka-Philipsen, et al., *Trends in end-of-life practices before and after the enactment of the euthanasia law in the Netherlands from 1990 to 2010: a repeated cross-sectional survey*, 380 The Lancet 908, 908 (2012).

Lack of physician training in palliative care and pain management meant that euthanasia was sometimes proposed for the cases in which treatable pain was the primary cause of “unbearable suffering”.¹⁶²

5.2. Belgium

The Belgian legislation on euthanasia was passed on May 28th, 2002.¹⁶³ The law defines euthanasia as an intentional life-ending act by a physician at a person’s explicit request under specific conditions.¹⁶⁴ On February 13th, 2014, the law was amended to make euthanasia possible for minors.¹⁶⁵ Many physicians found that the euthanasia law was “imposed on the medical profession” and that act exemplified “the intrusion of politics into the practice of medicine.”¹⁶⁶ The Order of Physicians, established by law to regulate the medical profession and responsible for professional discipline, had rejected euthanasia before the law was enacted, and article 95 of the Code of Medical Deontology prohibited doctors from providing any assistance in dying.¹⁶⁷

The law requires the patient requesting euthanasia to be a competent adult or emancipated minor, who has “medically futile condition of constant and unbearable suffering that cannot be alleviated.”¹⁶⁸ Unbearable suffering can be physical and/or mental.¹⁶⁹ The patient’s request has to be in writing and it has to be voluntary, well considered and repeated.¹⁷⁰ In a terminal stage of illness one independent physician is required to examine the patient and give advice regarding the request to the physician who received the initial request.¹⁷¹ If the patient is not in a terminal stage, two additional requirements need to be met: at least one month must pass between the written euthanasia request and life determination, and a second independent physician is required to examine the patient and give once again advice

162 Zbigniew Zylich, *Palliative Care and Euthanasia in the Netherlands: Observations of a Dutch Physician*, in *The Case Against Assisted Suicide* 129 (Kathleen Foley, Herbert Hendin, eds., 2002).

163 The Belgian Act on Euthanasia of May, 28th 2002, *supra* note 34.

164 Marc de Hert, et al., *Attitudes of Psychiatric Nurses about the Request for Euthanasia on the Basis of Unbearable Mental Suffering (UMS)*, 10 PLoS ONE 1, 2 (2015).

165 *Id.*

166 Lewy, *supra* note 18, at. ch. 3, p. 12.

167 Three years later the article was modified in somewhat ambiguous manner. *Id.*

168 The Belgian Act on Euthanasia of May, 28th 2002, *supra* note 34, Ch. II, Section 3, para 1.

169 *Id.*

170 *Id.*

171 *Id.*, Ch. II, Section 3, para 2.

regarding the request.¹⁷² This physician needs to be a psychiatrist in case of psychiatric illnesses.¹⁷³ The law does not include a “palliative filter” or requirement that the patient be provided with advice by a palliative care team prior to consideration of a request for euthanasia.¹⁷⁴ When euthanasia is requested by a minor, the procedure is equal except for a required consent of parents or legal guardians.

Deaths by legal euthanasia have increased nearly ten times (982%) from 235 in 2003 — the first full year of legalisation — to 2,309 in 2017.¹⁷⁵ From 2016 to 2017 alone the increase was 13.85%, and officially reported euthanasia accounted for 2.1% of all deaths in Belgium in 2017.¹⁷⁶ However, the total number of euthanasia cases is likely to be significantly higher, since an estimated 50% of the cases go unreported.¹⁷⁷ In 2017 there were 375 cases (16.2%) of reported euthanasia of people whose deaths were not expected in the near future.¹⁷⁸ In 2017, there were also 181 cases (7.83%) of reported euthanasia for “poly pathology” — two or more conditions none of which in itself is sufficient ground for euthanasia — where death was not expected soon, a 69.1% increase from 2015.¹⁷⁹ In 27 (7.2%) of the cases, the mandatory one-month waiting period between the written request for euthanasia and its execution was not complied with by the doctor. The Euthanasia Evaluation and Control Commission took no action on these cases other than sending the offending doctor “a didactic letter to remind the doctor of the procedure to be followed in case of unexpected death in the short term”.¹⁸⁰

According to annual reports of the federal control and evaluation commission on euthanasia in Belgium, requests for euthanasia based on “unbearable mental suffering” are rapidly increasing. In a period from 2002 to 2009, 1,5% (52) deaths were due exclusively to neuropsychiatric disorders.

172 *Id.*

173 *Id.*, Ch. II, Section 3, para 3.

174 Penney Lewis, *Euthanasia in Belgium Five Years After Legalisation*, 16 *European Journal of Health Law* 125, 134 (2009).

175 *Euthanasia in Belgium: updates on a social experiment*, BioEdge (September 2, 2018), available at https://www.bioedge.org/indepth/view/euthanasia-in-belgium-updates-on-a-social-experiment/12791#_edn1.

176 *Id.*

177 Tinne Smets, et al., *Reporting of euthanasia in medical practice in Flanders, Belgium: cross sectional analysis of reported and unreported cases*, 341 *BMJ* 5174 (2010).

178 Commission fédérale de Contrôle et d'Évaluation de l'Euthanasie Huitième rapport aux Chambres législatives années 2016 — 2017, 3. https://organesdeconcertation.sante.belgique.be/sites/default/files/documents/8_rapport-euthanasie_2016-2017-fr.pdf

179 *Id.*

180 *Id.* at 18.

From 2010 till 2011, the number increased to 58 (2.8%).¹⁸¹ Until 2013, the increase was particularly evident in cases with a diagnosis of mood disorder.¹⁸² In 2017 alone, 87 (3.76%) cases involved no physical suffering at all and 18 cases involved “polypathology”.¹⁸³ The psychic suffering, apart from psychiatric conditions, included “addiction, loss of autonomy, loneliness, despair, loss of dignity, despair at the thought of losing ability to maintain social contacts, etc.”¹⁸⁴ A total of 201 people with psychiatric disorders were euthanised in Belgium between 2014 and 2017, for disorders such as depression, bipolar disorder, dementia, Alzheimer’s, autism and other conditions.¹⁸⁵

6. *Dignity-respecting healthcare in the end of life*

The conclusions that were reached indicate that legalizing euthanasia and assisted suicide would bring serious problems and that alternative dignity-respecting healthcare in the end of life should be proposed. Palliative care can be proposed as adequate solution to this. Palliative care seeks to alleviate pain and suffering in a way that is respectful of human dignity. Dame Cicely Saunders created the palliative care approach in 1967 in the United Kingdom.¹⁸⁶ She argued for the approach of “total care” which aims to address all aspects of the pain a patient is experiencing. The term palliative care “describes a medical skill of an optimized expert use of drugs intended to remove or diminish pain, or to put it simple to improve the life quality. The combination of medical palliative care and human hospice care produces a complete human care and love for the sick and the dying.”¹⁸⁷ It is generally understood that while curative medicine aims at curing the disease, the palliative medicine aims at alleviating pain and suffering.¹⁸⁸

181 Marc de Hert, et al., *Attitudes of Psychiatric Nurses about the Request for Euthanasia on the Basis of Unbearable Mental Suffering (UMS)*, 10 PLoS ONE 1, 2 (2015).

182 Sigrid Dierickx, et al., *Euthanasia for people with psychiatric disorders or dementia in Belgium: analysis of officially reported cases*, 17 BMC Psychiatry 203, 208 (2017).

183 Commission fédérale de Contrôle et d’Évaluation de l’Euthanasie Huitième rapport aux Chambres législatives années 2016 — 2017, 21. https://organesdeconcertation.sante.belgique.be/sites/default/files/documents/8_rapport-euthanasie_2016-2017-fr.pdf

184 *Id.*

185 *Id.* at 46.

186 Anica Jušić, *Eutanazija*, 9 Rev. soc. polit. 301, 307 (2002).

187 Valentin Pozaić, *Palliative care and the human dignity of patients*, 5 Glas. Pul. Boln. 153 (2009).

188 See generally Morana Brkljačić, *Bioetika i bioetički aspekti palijativne medicine*, 44 Medicina 149 (2008).

The World Health Organization defines palliative care as “an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. Palliative care:

- provides relief from pain and other distressing symptoms;
- affirms life and regards dying as a normal process;
- intends neither to hasten or postpone death;
- integrates the psychological and spiritual aspects of patient care;
- offers a support system to help patients live as actively as possible until death;
- offers a support system to help the family cope during the patient’s illness and in their own bereavement;
- uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated;
- will enhance quality of life, and may also positively influence the course of illness;
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.”¹⁸⁹

In this context, it is also worthy to note that some authors have suggested introducing the model of “*integral* palliative care, in which euthanasia is considered as another option at the end of a palliative care pathway.”¹⁹⁰ Since palliative care is aimed primarily at alleviating pain and not curing the patient, underlying presupposition of this approach is that euthanasia also has the intention to remove pain and thus is complementary to the palliative care approach. However, this view is radically insufficient. Euthanasia is the action or omission by the doctor (or a third person) which, by definition, has the “intent to cause or hasten patient’s death.”¹⁹¹ On the other hand, according to the WHO definition palliative care “intends neither to hasten or postpone death.”¹⁹²

For this reason, palliative care organizations, such as the European Association for Palliative Care (EAPC), reject euthanasia as a part of the palliative

189 Definition of Palliative Care, World Health Organization, *available at* <http://www.who.int/cancer/palliative/definition/en/>

190 Jan L. Bernheim, et al., *Development of palliative care and legalisation of euthanasia: antagonism or synergy?* 336 *BMJ* 864, 867 (2008), emphasis added.

191 Perico, *supra* note 6.

192 *See supra* note 189.

care approach, highlighting that “palliative care clinicians in other countries are concerned about these proposals, as their clinical experience in palliative care has taught them to be sensitive in the acknowledgement but also very careful with the interpretation of the request for euthanasia from palliative care patients.”¹⁹³ Instead, they “stress the importance of refocusing attention onto the responsibility of all societies to provide care for their older, dying and vulnerable citizens. A major component in achieving this is the establishment of palliative care within the mainstream healthcare systems... supported by appropriate finance, education and research.”¹⁹⁴

Palliative care is always interdisciplinary in its approach and it has to include the patient, the family and the community in its scope. It has to offer the most basic concept of care — that of providing for the needs of the patient wherever he or she is cared for, either at home or in the hospital.¹⁹⁵ There are several principles agreed by palliative care experts which portray the approach which palliative care should take:¹⁹⁶

1. Respect for the patient’s autonomy and self-determination.
2. Respect, openness and sensitivity for personal, cultural and religious values, beliefs and practices as well as the law of each country.
3. Collaborative relationship with patients and families.
4. A central goal of palliative care is to achieve, to support, to preserve and to enhance the best possible quality of life.
5. Palliative care seeks neither to hasten death nor to postpone it.
- 6.- Good communication between patient, healthcare professionals, relatives and different healthcare professionals are an essential prerequisite for quality palliative care.
7. Palliative care is supposed to be provided within a multi-professional and interdisciplinary framework.
8. Public education which is essential to build community capacity and to promote preventive healthcare.
9. Palliative care offers support to family and other close carers during the patient’s illness, helps them prepare for loss and continues to provide bereavement support, where required, after the patient’s death.

Palliative care should be provided on different levels, whereby minimum two levels should be provided: general palliative care and specialist

193 Lukas Radbruch, et al. *Euthanasia and physician-assisted suicide: A white paper from the European Association for Palliative Care*, 30 *Palliative Medicine* 1, 8–9 (2016).

194 *Id.* at 11.

195 Lukas Radbruch, et al., *White Paper on standards and norms for hospice and palliative care in Europe: part 1. Recommendations from the European Association for Palliative Care*, in 17 *European Journal of Palliative Care* 278, 280 (2009).

196 *Id.* at 283.

palliative care.¹⁹⁷ General palliative care is provided by primary care professionals and specialists treating patients with life-threatening diseases who have good basic palliative care skills and knowledge. Specialist palliative care is provided by specialised services for patients with complex problems not adequately covered by other treatment options. Generally, a palliative care team should be an interdisciplinary team consisting of, but not limited to, physicians/medical doctors, nurses, social workers, physiotherapists, spiritual advisors and volunteers. The term “palliative care” encompasses the activities of the whole team.¹⁹⁸

Finally, it can be maintained that palliative care provides end of life care respectful of human dignity, and it is an adequate solution to problems which aim to be solved by euthanasia and assisted suicide. Palliative care is an entirely person-centered solution and it seeks the objective good of the patient, thus being ethically unobjectionable. Since it intends neither to hasten or postpone death, it avoids the ethical dangers of euthanasia and assisted suicide, but also of overly aggressive therapy. It keeps the utmost respect for the human life, as the Declaration of Geneva proscribes medical care should do. By seeking to alleviate pain, it contributes to the central goals of medicine. In this way, it also safeguards the patient-doctor relationship, since the patient can be assured that the doctor will always act in his or her best interest. Consequentially, it relieves the pressure from the vulnerable groups which they often experience in cases when euthanasia and/or assisted suicide are legal. For all the mentioned reasons, palliative care can be proposed as morally and medically desirable approach, as well as the adequate policy solution for the end of life care.

7. *Conclusion*

In this paper, I examined should euthanasia and assisted suicide be legalized and reached a negative conclusion. After defining the key terms and giving the historical overview of the debate, I analyzed the arguments in favor of the legalization. Arguments have shown that the autonomy argument misses the fact that legalizing euthanasia and assisted suicide is not only a private matter of self-determination, but it also requires a doctor's participation in the suicide and the social acceptance of the act. Courts have repeatedly emphasized the States' duty to protect life. Also, autonomy is often an illusion, since the final decision rests in the hands of the doctor, not the patient. Moreover, the decision is often made by the relatives, who on other occasions can exert significant pressure on the patient. The claims for the

197 *Id.* at 285.

198 Anica Jušić, *Palliative Medicine — Palliative Care*, 10 *Medicus* 247 (2001).

“right to die” are unfounded since the international law guarantees no such right. “Dying with dignity” is also problematic concept from the moral point of view, since it suggests that there can be a situation in which the person is without his or her dignity.

Statistics and examples from the countries which legalized euthanasia and assisted suicide also showed that the legalization brings several social consequences, such as exerting pressure on vulnerable groups and viewing people in utilitarian way, which runs contrary to the dignity of the human person. Also, legalization creates a new set of problems for the medical profession, by distorting the doctor–patient relationship and undermining the integrity of medicine. The case studies on the Netherlands and Belgium showed that the legal safeguards are in many cases transgressed, that law is amended to include wider groups and that incidence of euthanasia cases increases over time. The conclusions that were reached in the paper showed the need for an alternative dignity–respecting healthcare in the end of life, and palliative care was proposed as an adequate solution. Since it intends neither to hasten or postpone death, palliative care avoids the ethical dangers of euthanasia, assisted suicide and overly aggressive therapy. It keeps the utmost respect for the human life and by seeking to alleviate pain, it contributes to the central goals of medicine. It also safeguards the patient–doctor relationship and relieves the pressure from the vulnerable groups which they often experience in cases when euthanasia and/or assisted suicide are legal. Thus, it should be proposed as morally and medically desirable approach, and the adequate policy solution for the end of life care.

Abstract

SHOULD EUTHANASIA AND ASSISTED SUICIDE BE LEGAL? ADDRESSING KEY ARGUMENTS AND ANALYZING THE CONSEQUENCES OF LEGALIZATION

The article examines whether countries should legalize euthanasia and assisted suicide. Firstly, context of the debate is provided by defining the key terms and giving the overview of how the debate evolved throughout history. The arguments in favor of legalizing euthanasia and assisted suicide are addressed, namely the argument from autonomy and self–determination and the claim for the “right to die with dignity”. The consequences which were showed to occur in the countries which legalized euthanasia and/or assisted suicide are analyzed, and the case study on the Netherlands and Belgium is made. Finally, the model for the dignity–respecting health–care is proposed followed by the call for bigger accessibility and funding for palliative care.

KEY WORDS: Assisted suicide, Autonomy, Dying with dignity, End of life, Euthanasia, Palliative care, Right to die,