BESTMUN'22

GA 6: LEGAL

STUDY GUIDE

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LETTERS FROM SECRETARIAT

Letter from Secretary General

Esteemed Delegates,

My name is Sarp Sever and I am the Secretary General of BESTMUN'22. Welcome to the second edition of our conference where we are hosting two General Assembly committees. One of them is GA:6 Legal and it will be focusing on the Legality of Euthanasia.

In the committee, you must be ready to discuss your agenda in a very diplomatic manner and cooperate with your fellow delegates to reach a consensus. You are expected to write a resolution paper that has covered all of the points made in this guide which was carefully prepared by our amazing Under-Secretary General Sesil Yalçınduran to aid your research.

The secretariat has worked hard and will work hard to provide you with an entertaining and informative experience. I have to thank my Deputy Asya Arslan and the Under Secretary General for this committee, Sesil Yalçınduran for their contributions.

Best Regards,

Sarp Sever

Letter from Under Secretary General

Most distinguished participants,

I am Sesil Yalçınduran and I am a Medicine Student in Başkent University. I will be the Under-Secretary-General of the GA:6 LEGAL committee. Euthanasia is one of the most sensitive topics that we can discuss because it can be discussed from very different aspects such as its ethical, political, medical, economic, moral sides. Every single delegate's opinion has the same importance level on this topic. That is why I want you, delegates, to not only research your country's policy but also other countries' opinions too. I have made a great effort to find the most efficient data about this agenda item and I believe this study guide will prove useful to you during sessions. Therefore, it is very important for you to read and understand this study guide so you can participate in the discussion effectively.

BESTMUN was one of the first MUNs I have ever joined and I can assure you that it is going to be one of the most unforgettable conferences for you too.

Lastly, I want to give my thanks to Sarp Sever the Secretary-General, and Asya Arslan, the Deputy Secretary-General, for having me as part of the academic team. If you have any questions about the committee topic or procedure do not hesitate to contact me any time from sesil2003@gmail.com. I hope you have the greatest time at BESTMUN

Yours Sincerely,

Sesil Yalçınduran

DEFINITION OF EUTHANASIA

“Euthanasia” has had different meanings depending on usage. The word “euthanasia” was first used in a medical context by Francis Bacon in the 17th century, to refer to an easy, painless, happy death, during which it was a "physician's responsibility to alleviate the 'physical sufferings of the body’." Bacon referred to an “outward euthanasia”—the term “outward” is used to distinguish from a spiritual concept—the euthanasia “which regards the preparation of the soul.” In current usage, euthanasia has been defined as the “painless inducement of a quick death”. However, this approach fails to define euthanasia, because some actions would meet the requirements of the definition, however they would not be seen as euthanasia. For example, killing someone painlessly but for a personal reason. The definition offered by the Oxford English Dictionary incorporates suffering as a necessary condition, with “the painless killing of a patient suffering from an incurable and painful disease or in an irreversible coma”, This approach is included in Marvin Khol and Paul Kurtz's definition of it as “a mode or act of inducing or permitting death painlessly as a relief from suffering”. The third element incorporated into many definitions is that of intentionality – the death must be intended, rather than being accidental, and the intent of the action must be a “merciful death”. Michael Green argued that “the principal thing that distinguishes euthanasia from intentional killing is the agent's motive: it must be a good motive as the good of the person killed is concerned.” Draper argued that any definition of euthanasia must incorporate four elements: an agent and a subject; an intention, causal proximity (the measure of whether the actions of the agent lead to the outcome) and an outcome. Based on this, she offered a definition incorporating those elements, stating that euthanasia must be defined as death that results from the intention of one person to kill another person, using the most gentle and painless means possible, that is motivated solely by the best interests of the person who dies. Before Draper, Beauchamp, and Davidson had also offered a definition that includes these elements. Their definition specifically discounts fetuses to distinguish between abortions and euthanasia.

HISTORY OF EUTHANASIA

Euthanasia was first practiced in Ancient Greece and Rome. It became more accepted during the Age of Enlightenment. In the mid-1800s, the use of morphine to treat "the pains of death" emerged, with John Warren recommending its use in 1848. A similar use of chloroform was revealed by Joseph Bullar in 1866. However, in neither case was it recommended that the use should be to hasten death. In 1957, the Vatican proclaimed that passive euthanasia was acceptable, according to Thomas R. Cole's review of A Merciful End. Passive euthanasia is the deliberate decision to withhold lifesaving measures, like a ventilator, knowing that death will result. After the Second World War, euthanasia was legalized only in 1977, when the world's first law was passed in the USA (California) "On the Human Right to Die," according to which passive euthanasia was allowed. However, today only three US states (Oregon, Washington, Vermont) have legalized active euthanasia, provided that the patient himself takes the lethal injection (or drinks the appropriate medicines with the permission of the doctor). The fourth state, which also uses euthanasia, but with significant limitations, is Montana. Whereas in most countries of the world, not only active but also passive euthanasia is not prescribed or banned by law, there are countries, which are exceptions to this rule.

CLASSIFICATION

Active And Passive Euthanasia

Euthanasia is classified as active and passive (depending on the nature of the actions). Active euthanasia is the carrying out of certain actions to accelerate the death of a terminally ill person according to his request in order to get rid of especially severe suffering. Active euthanasia can also be carried out by joint actions of the doctor and the patient (for example, taking certain medications). Passive (negative) euthanasia is manifested in the nonuse of medications and the nonfulfillment of medical manipulations that could maintain the life of a seriously ill patient for a definite time, provided that the patient expressed a desire not to perform medical intervention.

In other words purposely giving someone a lethal dose of a sedative is considered active euthanasia. However, passive euthanasia is sometimes described as withholding or limiting life-sustaining treatments so that a person passes more quickly. A doctor may also prescribe increasingly high doses of pain-killing medication. Over time, the doses may become toxic.

Consensual Classification

Euthanasia may be classified into three types, according to whether a person gives informed consent: voluntary, non-voluntary and involuntary.

Voluntary: If someone makes a conscious decision to seek help with ending their life, it's considered voluntary euthanasia. The person must give their full consent and demonstrate that they fully understand what will happen. Voluntary euthanasia is currently legal in Belgium, Luxembourg, The Netherlands, Switzerland, and the states of Oregon and Washington in the U.S.

Non-voluntary: When euthanasia is conducted on a person who is unable to consent due to their current health condition. In this scenario the decision is made by another appropriate person, on behalf of the patient, based on their quality of life and suffering. A close family member usually makes the decision.

Involuntary: when euthanasia is performed on a person who would be able to provide informed consent, but does not, either because they do not want to die, or because they were not asked. In legal status this is called murder, as it's often against the patients will.

There is a debate within the medical and bioethics literature about whether or not the non-voluntary (and by extension, involuntary) killing of patients can be regarded as euthanasia, irrespective of intent or the patient's circumstances. In the definitions offered by Beauchamp and Davidson and, later, by Wreen, consent on the part of the patient was not considered one of their criteria, although it may have been required to justify euthanasia. However, others see consent as essential.

It is important to understand the difference between ınvoluntary and non-voluntary euthanasia. In involuntary euthanasia person is able to give their consent although they do not give it. But in non voluntary euthanasia person is not able to give their consent to this decision is made by another person.

Mercy-killing

The term “mercy-killing” usually refers to active, involuntary or non-voluntary, other-administered euthanasia. In other words, someone kills a patient without their explicit consent to end the patient’s suffering.

It is important to understand the difference between ınvoluntary and non-vouluntary euthanasia. In involuntary euthanasia person is able to give their consent although they do not give it. However, in non-voluntary euthanasia person is not able to give their consent to this decision is made by another person.

HOW DOES EUTHANASIA WORK

What Happens During The Process?

At the decided date of the patient’s choice, the doctor or nurse practitioner must ask the person if they still choose to take the medication before it is given. The doctor or nurse practitioner must remain with them until they die.

If they change their mind – which they can at any stage – the medication is taken away.

There are four methods in which lethal medication can be administered under the act:

- ingestion, triggered by the person;
- intravenous delivery, triggered by the person;
- ingestion through a tube, triggered by the doctor or nurse practitioner; or
- injection, administered by the doctor or nurse practitioner.

In such deaths, patients take a lethal dose of medication which suppresses the central nervous system – the brain and spinal cord, controlling most functions of the body and mind – to essentially cause brain death. They are profoundly unconscious when this happens, and their heart and lungs shut down some time afterwards.

What Drugs Are Given And How Do They Work?

The group of drugs most commonly used to end life are called barbiturates, which act as nervous system depressants.

A large dose will effectively slow down the brain to a point where it stops telling the body to keep the respiratory system working, and breathing ceases.

Pentobarbital (usually known by its brand name, Nembutal) is the drug most commonly used in voluntary assisted dying in many other jurisdictions that allow it.

In Australia, most people will ingest the lethal dose of pentobarbital as a drink – a white powder mixed with about 30 millilitres of a liquid suspension. However, in cases where the person is too ill to ingest the medication themselves, a doctor or nurse practitioner could administer the dose. In Victoria, this involves a series of injections, similar to putting someone off to sleep for surgery.

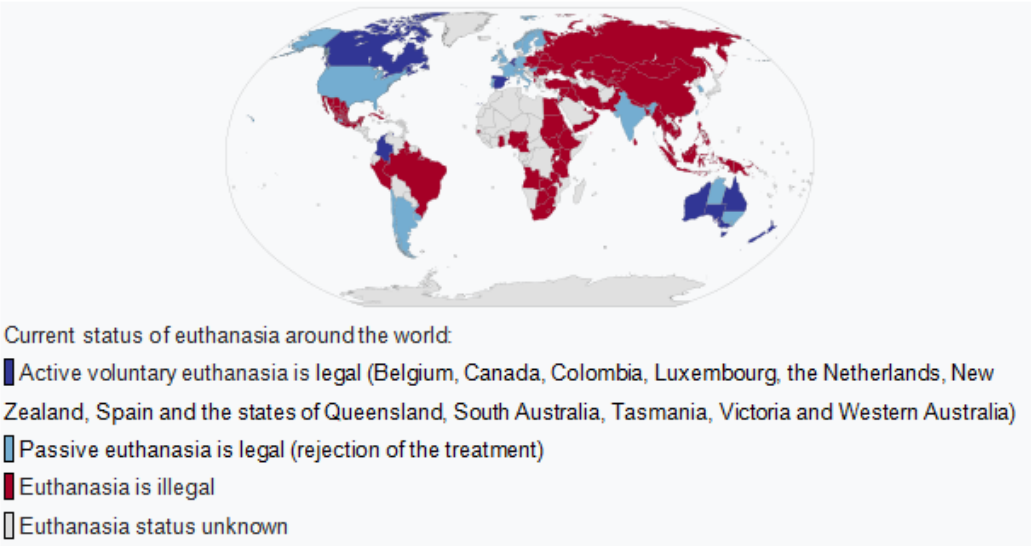
It starts with midazolam – a benzodiazepine often used for anaesthesia, sedation and anxiety. Patients are then given lignocaine (lidocaine) as a local anaesthetic, as some injections can be painful to the vein. Patients are then administered a large dosage of propofol, used to induce and maintain general anaesthesia in surgery to render a patient unconscious. This large quantity of propofol ensures the person is in a very deep medical coma, before an injection of the paralytic drug rocuronium is given, which stops the person's breathing.

How Long Does It Take?

People fall asleep within three and seven minutes after drinking the liquid. Twenty to thirty minutes after falling asleep, the person stops breathing and their heart stops. The vast majority of patients will die within an hour, and almost everyone within two hours.

In essence, from the time they fall asleep, the person goes into a profoundly deeper and deeper state of medically-induced coma until they die.

LEGAL STATUS OF EUTHANASIA



Different countries have different euthanasia laws. The British House of Lords select committee on medical ethics defines euthanasia as "a deliberate intervention undertaken with the express intention of ending a life, to relieve intractable suffering". In the Netherlands and Belgium, euthanasia is understood as "termination of life by a doctor at the request of a patient". The Dutch law, however, does not use the term 'euthanasia' but includes the concept under the broader definition of "assisted suicide and termination of life on request".

The Netherlands (2001), Belgium (2002), and Luxembourg (2009) have legalized euthanasia (Cohen, Van Landeghem, Carpentier, & Deliens, 2014), and Canada (2016) has introduced a federal law allowing medical aid in dying (Chochinov & Frazee, 2016; Upshur, 2016). In these four countries, euthanasia/assisted dying is legal provided those involved follow certain procedures involving an informed and competent request.

In the United States, some individual states have legalized physician assisted suicide (PAS) (Varadarajan, Freeman, & Parmar, 2016). This process involves a doctor prescribing lethal drugs to a person who, following defined procedures, wishes to die by taking the drugs, and then does so. Oregon legalized PAS in 1997 and subsequently so did Washington State, Montana, Vermont and California (Gostin & Roberts, 2016).

In the United States, PAS is legal in:

- Washington
- Oregon
- California
- Colorado
- Montana
- Vermont
- Washington, D.C.
- Hawaii (beginning in 2019)

Outside the United States, PAS is legal in:

- Switzerland
- Germany
- Japan

Euthanasia, including PAS is legal in several countries, including:

The Netherlands
Belgium
Luxembourg
Colombia
Canada

Each of these states and Washington, D.C. have different legal requirements. Not every case of PAS is legal. In addition, many states currently have PAS measures on legislative ballots, so this list may grow.

What's The Difference Between Assisted Suicide And Euthanasia?

Assisted dying can take two forms: euthanasia or assisted suicide. Broadly, euthanasia describes the situation where the person who is asking for assistance to die has someone else take the action that leads to their unnatural death (commonly injections), and assisted suicide is when the person is prescribed drugs that they must take themselves in order to die.

More technically, euthanasia is when the attending medical or nurse practitioner, takes an action with the singular intention of causing a patient's death.[1] Generally, this is in the form of a lethal injection.

Assisted suicide is when a suicide is intentionally aided by the attending medical or nurse practitioner and the person self-administers the medication.[2] That is, the medical practitioner will prescribe a lethal drug which the patient will usually take orally.

The Netherlands became the first country to legalize euthanasia, albeit under strict regulations. The law specifies that the person must be enduring “unbearable and endless suffering” before undergoing euthanasia. While euthanasia is the only legal form of PAD in Colombia and Belgium. Physician-assisted suicide is the legal form in Switzerland and five regions of the United States (Oregon, Vermont, Washington, California, and Montana). Both are legally permitted in Australia, Victoria, Canada, Luxemburg, and the Netherlands. However, among middle-income countries, there is still controversy regarding its implication.

The Netherlands:

It became the first country in the world to formulate an extensive framework for the implementation of euthanasia. In 2016, the Dutch also proposed the guidelines to carry out euthanasia in advanced dementia patients under strict conditions with a written request

In the Netherlands voluntary euthanasia and assisted suicide are still criminal offences, but doctors are exempt from criminal liability in certain circumstances. The Netherlands Criminal Code Article 293, paragraph two, stipulates that the doctor:

- must be convinced that the patient has made a voluntary and well-considered request to die
- must be convinced that the patient is facing interminable and unendurable suffering
- has informed the patient about his situation and his prospects
- together with the patient, must be convinced that there is no other reasonable solution
- has consulted at least one other independent doctor who has seen the patient
- and given his written assessment of the due care requirements as referred to in the points above
- has helped the patient to die with due medical care

The Dutch law also permits euthanasia for non-adults. Children of 16 and 17 can make their own decision, but their parents must be involved in the decision-making process

regarding the ending of their life. For children aged 12 to 16, the approval of parents or guardians is required. If a patient can no longer express their wishes, but made a written statement containing a request for termination of life before they became incompetent, a doctor is allowed to carry out their request providing the other conditions are met.

United States:

On October 27th, 1997, Oregon became the first legalized state in the United States to enact the "Death with Dignity act" for assisted dying (23). Oregon was then followed by Washington in 2008, Vermont in 2013, and subsequent legalization was done in the states of California, Colorado, Hawaii, Maine, and New Jersey. All these states passed the "Death with dignity act" except Montana which allowed PAD but didn't explicitly enact the act. Litigation is in the process in other states also. In 2009, passive euthanasia was also declared legal in New Mexico.

The Oregon approach

The US state of Oregon legalised physician-assisted suicide in 1998. During the first three years, only around 2 people a month used this to end their lives. This was partly due to the severe conditions that had to be satisfied before a request for euthanasia could be granted:

- patient must be a resident of Oregon
- patient must be over the age of 18
- patient must make 2 oral and 1 written request for euthanasia
- there must be at least 15 days between the first and the last request
- patient must be terminally ill with a life expectancy of less than 6 months
- the prognosis must be confirmed by a second consultant physician
- both doctors must confirm that the patient is capable of making this decision
- both doctors must confirm that the patient does not have medical condition that impairs their judgment
- patient must self-administer the lethal medication

Luxembourg:

In 2009, Luxembourg legalized euthanasia as well. However, the law excludes minors and applies to anyone who is in a “hopeless medical condition.”

Belgium:

The physician should convey the decision to perform euthanasia or PAS to a review committee, which assesses the report and may ask for verbal or written testimony. In 2014, Belgium also formulated a special law for euthanasia of terminally ill children. However, the child must ask for the procedure and verify that they understand what will happen.

Switzerland:

Switzerland allows physician-assisted suicide without a minimum age requirement, diagnosis or symptom state. This country allows for assisted suicide by patients themselves. This has led to the curious phenomenon of “suicide tourism” wherein people come from other countries to carry out the act of suicide. In 2018, 221 people travelled to the Swiss clinic Dignitas for assisted suicide. This is also the only country where there is the formulation of a protocol for assisted suicide in individuals who suffer from some psychiatric illness. About 1.5% of Swiss deaths are the result of assisted suicide.

China:

According to article 232 and 233 of Criminal Law of the People's Republic of China, PAD is illegal in china. Ethicists both oppose and defend it. Currently, the National People's Congress has not made any definitive decision regarding euthanasia.

France:

Palliative sedation, in which someone can ask to be deeply sedated until they die, is permitted in France, but assisted dying is not. In April 2021, a proposal to legalize assisted dying for people with incurable diseases was blocked in the French parliament.

Japan:

Japan has no official definition and legal framework for euthanasia cases. The term "songenshi" is equivalent to death with dignity in Japan. The first case was noted in 1949, after that, there were six cases of mercy killing, with two prominent cases that received special attention: Yokohama court (1995) and the Kyoto court (1996) .

In the case of passive euthanasia, three conditions must be met:

1. the patient must be suffering from an incurable disease, and in the final stages of the disease from which he/she is unlikely to make a recovery;
2. the patient must give express consent to stopping treatment, and this consent must be obtained and preserved prior to death. If the patient is not able to give clear consent, their consent may be determined from a pre-written document such as a living will or the testimony of the family;
3. the patient may be passively euthanized by stopping medical treatment, chemotherapy, dialysis, artificial respiration, blood transfusion, IV drip, etc.

For active euthanasia, four conditions must be met:

1. the patient must be suffering from unbearable physical pain;
2. death must be inevitable and drawing near;
3. the patient must give consent. (Unlike passive euthanasia, living wills and family consent will not suffice.)
4. the physician must have (ineffectively) exhausted all other measures of pain relief.

Spain :

In March 2021, Spain made it legal for people to end their own life in some circumstances. The law allows adults with "serious and incurable" diseases that cause "unbearable suffering" to choose to end their lives. The adult must be a Spanish national or legal resident and be "fully aware and conscious" when they make the request, which has to be submitted twice in writing. Before the law was passed, assisting someone to die in Spain was punishable with up to ten years in jail.

Canada:

In Canada, the bill was passed on 17th June 2016 and titled MAID (Medical Assistance in Dying). PAD was legalized throughout the country and in special cases; patients with advanced-stage dementia were also considered to be eligible. Medically assisted deaths counted for 1.89% of all deaths in Canada in 2019. In Quebec, only euthanasia is allowed.

Colombia:

Colombia was the first Latin American country to decriminalise euthanasia, in 1997, and the first such death happened in 2015. In July 2021, the Constitutional Court of Colombia extended the law on euthanasia or assisted death to include cases of non-terminal illnesses "provided that the patient is in intense physical or psychological suffering, resulting from bodily injury or serious and incurable illness"

Australia:

The Australian state of Victoria was the country's first to pass voluntary euthanasia laws, which happened in November 2017 after 20 years and 50 failed attempts. The Australian Senate had previously repealed the law in 1997 owing to a public backlash against the 1995 law that allowed it. To qualify for legal approval, you have to be an adult with decision-making capacity, you must be a resident of Victoria, and have intolerable suffering due to an illness that gives you a life expectancy of less than six months, or 12 months if suffering from a neurodegenerative illness. A doctor cannot bring up the idea of assisted dying; the patient must raise it first. You have to make three requests to the scheme, including one in writing. You must then be assessed by two experienced doctors, one of whom is a specialist, to determine your eligibility. Western Australia, South Australia and Tasmania have since joined Victoria in legalizing voluntary assisted dying. And, in September 2021, Queensland became the fifth Australian jurisdiction to allow voluntary euthanasia.

New Zealand:

In October 2020, New Zealand voted to legalise euthanasia in what campaigners have called "a victory for compassion and kindness", The law will allow terminally ill people

with less than six months to live the opportunity to choose assisted dying if approved by two doctors. It is expected to come into effect in November 2021.

Ireland:

Euthanasia is illegal in Ireland, and the Irish Medical Council's Ethical Guidelines state, "You must not take part in the deliberate killing of a patient" (Medical Council). The Irish government began to consider the topic, and this culminated in a 2018 (Oireachtas, 2018) report strongly in favour of legalising assisted suicide. In 2020 a private member's bill (the "Dying With Dignity Bill, 2020" (Dying With Dignity Bill)) garnered support from members of all parties. The bill did not progress, however, because a Dail committee found it to have serious technical flaws in several sections, and to have possible unintended policy consequences – particularly regarding the lack of sufficient safeguards to protect against undue pressure being put on vulnerable people to avail of assisted dying. These defects could potentially render it vulnerable to challenge before the courts (Oireachtas, 2021).

Israel:

The Israeli Penal Law forbids causing the death of another and specifically forbids shortening the life of another. Active euthanasia has been accepted in some cases under Israeli law. In 2005, proposals were put forward to allow passive euthanasia to be administered using a switch mechanism similar to Sabbath clocks. In 2006, the Steinberg Commission was set up to look into whether life and death issues could be rethought in the context of Jewish law, which suggested that hospitals could set up committees to determine whether patients would be given passive euthanasia.

Other countries:

Over the years, there have been landmark cases concerning PAD in other countries where it is still illegal, which, nevertheless, resulted in the heated debate by a variety of scholars, ethicists, lawyers, and doctors. These include the cases of Marie Fleming in Ireland and Lucio Magri in Italy.

Is It Against Hippocratic Oath?

The original oath included, among other things, the following words: “I will neither give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect.”

As the world has changed since the time of Hippocrates, some feel that the original oath is outdated. In some countries, an updated version is used, while in others, for example, Pakistan, doctors still adhere to the original.

In the updated version it goes as: “If it is given to me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty.”

THE RELATIONSHIP BETWEEN EUTHANASIA AND ORGAN DONATION

Potential organ donors after euthanasia involve patients whose request to undergo euthanasia has been granted and who voluntarily want to donate their organs after death. It requires patients to undergo euthanasia in the hospital, and organ donation is performed after circulatory death. The practice is controversial and currently only allowed in Belgium and the Netherlands.

Donation after euthanasia could potentially help ease the shortage of organs for transplantation. It is unknown how many of these patients would be medically suitable to donate organs.

What's The Difference Between Assisted Suicide And Euthanasia?

Assisted dying can take two forms: euthanasia or assisted suicide. Broadly, euthanasia describes the situation where the person who is asking for assistance to die has someone else take the action that leads to their unnatural death (like injecting a lethal drug), and assisted suicide is when the person is prescribed drugs that they must take themselves in order to die.

More technically, euthanasia is when the attending medical or nurse practitioner, takes an action with the singular intention of causing a patient’s death.[1] Generally, this is in the form of a lethal injection.

Assisted suicide is when a suicide is intentionally aided by the attending medical or nurse practitioner and the person self-administers the medication.[2] That is, the medical practitioner will prescribe a lethal drug which the patient will usually take orally.

RELATIONSHIP BETWEEN AGE, SEX AND EUTHANASIA

Between 1984 and 1993, 1707 cases of EAS were reported to the Public Prosecutor in North Holland. The average age of the female patients to whom EAS was administered was 65 years; for men, the average age was 62. For both men and women, EAS was most frequently performed in the age categories of 60–69 years and 70–79 years. Cancer and cerebrovascular accidents were positively related to age, while AIDS and multiple sclerosis (MS) were negatively related to age. In all physician reports the number of cases of EAS increased until the age category of 70–79 years, after which EAS was less frequently performed by general practitioners, but more frequently by nursing-home physicians. In the age groups of 70–79 years and 80 years and over the number of cases of EAS increased over the years. There were differences in the distribution of age between the patients to whom EAS was administered and all deaths, with the younger age groups EAS was performed relatively more frequently, while the lowest percentage was found in the group aged 85 years and over.

EUTHANASIA IN MODERN SOCIETY

Human life is recognized as the highest social value, and the right to life is the most important among personal non property rights, which is determined by the very being of man and is on top of a galaxy of social values. At the same time, there is the right of an individual to dispose of his/her life, which, in the context of the right to life, is interpreted by scientists as an opportunity to expose it to considerable risk and to decide on the question of ending life. It is with the possibility of exercising the right to dispose of one's own life that a problem arises that worries not only lawyers but also doctors, and the society as a whole - the problem of euthanasia.

During the 20th century, passive euthanasia was used in most countries. According to the results of sociological research in the late 1990s, 40% of deaths of seriously ill patients accounted for the facts of the use of passive euthanasia. Patients died "by prior

arrangement" with the doctors either as a result of official refusal of treatment, or accelerated the lethal outcome with the help of medications Active euthanasia has a slightly different history of its development.

HOW MUCH DOES EUTHANASIA COST?

The cost of euthanasia depends on the country that you are going to pursue the action in. But in general, it costs between 6000 euros to 15000 euros. Although euthanasia is not legal in a lot of countries, in the countries where it is legal there is some economic barrier since the general payment a person gets is a lot lower than the cost of euthanasia.

Does Euthanasia Impact A Person's Life Insurance?

In Canada nearly all life insurers treat physician-assisted death/euthanasia in a similar way. If there is a clear case of MAID (medical assistance in dying) where both health preconditions (terminal disease/palliative condition) and legal requirements are met, life insurance companies will pay claims in full – it does not matter how long the policy was in place.

In New Zealand the End of Life Choice Act (2019) makes it clear that assisted dying will not void an insurance contract and prevent a payment or other benefit being made to the estate of the person. The Act does not significantly impact the insurance industry. Most insurance policies already include cover for terminal illnesses under which insurers can pay a claim 'early' once an insured is eligible under the policy. Many insurance policies define a terminal illness as an illness that results in death within 12 months. Under the Act, to be eligible for assisted dying the terminal illness must be likely to end your life within six months. Therefore, some insureds may be paid out some months before facing a choice about assisted dying.

In USA life insurance policies (unlike most medical insurance policies that won't cover costs associated with self-inflicted harm) issue a benefit to beneficiaries even when the insured has taken her own life. Whether the policy owner committed suicide or had a physician-assisted death wouldn't affect the policy's pay out, provided the policy was in place for at least two years.

With both permanent life and term life insurance, the first two years of coverage are known as a "contestability" or "exclusionary" period. If you die within that period, the

life insurance company will investigate your death to make sure you hadn't committed fraud by providing inaccurate or incomplete information on your insurance application (like hiding a terminal diagnosis, severe depression, smoking, etc.).

EUTHANASIA DEBATE

Historically, the euthanasia debate has tended to focus on a number of key concerns.

Proponents of euthanasia have presented four main arguments:

1. that people have the right to self-determination, and thus should be allowed to choose their own fate;
2. assisting a subject to die might be a better choice than requiring that they continue to suffer;
3. the distinction between passive euthanasia, which is often permitted, and active euthanasia, which is not substantive (or that the underlying principle–the doctrine of double effect–is unreasonable or unsound);
4. permitting euthanasia will not necessarily lead to unacceptable consequences.

There are four major arguments presented by opponents of euthanasia:

1. Not all deaths are painful;
2. Alternatives, such as cessation of active treatment, combined with the use of effective pain relief, are available;
3. The distinction between active and passive euthanasia is morally significant;
4. Legalising euthanasia will place society on a slippery slope, which will lead to unacceptable consequences.

An alternative approach to the question is seen in the hospice movement which promotes palliative care for the dying and terminally ill. This has pioneered the use of pain-relieving drugs in a holistic atmosphere in which the patient's spiritual care ranks alongside physical care. It 'intends neither to hasten nor postpone death'.

One concern is that euthanasia might undermine filial responsibility. In some countries, adult children of impoverished parents are legally entitled to support payments under filial responsibility laws. Thirty out of the fifty United States as well as France, Germany, Singapore, and Taiwan have filial responsibility laws.

Arguments For

Freedom of choice: Advocates argue that the patient should be able to make their own choice.

Quality of life: Only the patient really knows how they feel, and how the physical and emotional pain of illness and prolonged death impacts their quality of life.

Dignity: Every individual should be able to die with dignity.

Resources: It makes more sense to channel the resources of highly-skilled staff, equipment, hospital beds, and medications towards life-saving treatments for those who wish to live, rather than those who do not.

Contradictions

The doctor's role: Health care professionals may be unwilling to compromise their professional roles, especially in the light of the Hippocratic Oath.

Moral and religious arguments: Several faiths see euthanasia as a form of murder and morally unacceptable. Suicide, too, is "illegal" in some religions. Morally, there is an argument that euthanasia will weaken society's respect for the sanctity of life.

Patient competence: Euthanasia is only voluntary if the patient is mentally competent, with a lucid understanding of available options and consequences and the ability to express that understanding and their wish to terminate their own life. Determining or defining competence is not straightforward.

Guilt: Patients may feel they are a burden on resources and are psychologically pressured into consenting. They may feel that the financial, emotional, and mental burden on their family is too great. Even if the costs of treatment are provided by the state, there is a risk that hospital personnel may have an economic incentive to encourage euthanasia consent.

Mental illness and dementia: A person with depression is more likely to ask for assisted suicide, and this can complicate the decision. Not only mental illnesses but also dementia should be a sensitive topic. Patients may be sure about ending their lives, but they will not remember it in the near future as well as the opposite is true too. So how can a doctor be sure about the decisions made by the people who have dementia or mental illnesses.

> For dementia, One way to address these problems is by carefully writing an "advanced euthanasia directive" beforehand when decision-making capacity is still intact and satisfies the criteria of voluntariness. This case highlighted the difficulty of applying euthanasia on persons suffering from dementia: at what point is it ethical for the "previous" self to make decisions for the "present" (demented) self? Moreover, the "previous" self might have underestimated the "present" self's ability to cope with the challenges—both physical and psychosocial—thrown by dementia, and so is it correct for the "previous" self to be making these decisions pre-emptively? In addition, evidence states that decision-making might be hampered even early in the course of the illness

Slippery slope: In general, slippery slope arguments are those where a premise, such as an action or a reform, must be rejected as bad (or accepted as good) on the basis of similar cases with further consequences that are much more negative (or positive) In the moral and social domains, these kinds of arguments are typically used to oppose a proposed reform by linking it to a chain of disastrous consequences alleged to inevitably follow the passage of a reform: "if we do A, at some point, the highly undesirable B will follow" (In particular, with regard to euthanasia, it is often feared that the acceptance of voluntary adult euthanasia for highly serious reasons will gradually extend to an acceptance of involuntary euthanasia, as well as euthanasia for less serious reasons, or even for eugenic motives. In conclusion, There is a risk that physician-assisted suicide will start with those who are terminally ill and wish to die because of intractable suffering, but then begin to include other individuals.

Possible recovery: Occasionally, a patient recovers, against all odds. The diagnosis might be wrong.

Regulation: Euthanasia cannot be properly regulated. Euthanasia opponents do not believe that it is possible to draft laws and guidelines that will prevent the abuse of euthanasia. Those in favour of euthanasia think that there is no reason why euthanasia cannot be controlled by proper regulation, but even they fear that regulations won't deal with people who want to implement euthanasia for bad motives.

In order to have a good and proper regulation they have to involve investigations of the patient's psyche, his family dynamics and the financial implications of his death, along with more obvious things such as the patient's medical condition and the likely course of the disease.

To ensure that requests are properly considered, by the patient, the family and the authorities, regulations need to be built in a time-period for reconsideration. Proper regulation must also make sure that a patient was receiving good palliative care before a request for euthanasia is considered.

WHAT IS AN ADVANCED DIRECTIVE

Advance directives, or living wills, are preferences that patients can put in writing to detail what medical actions should and should not be taken to maintain their life in the event of a medical emergency in which they would otherwise not be able to communicate their wishes.
For example, CPR is performed in the United States on anyone who does not have a written order, or advance directive, stating his or her code status
Advance directives usually come in two forms:

1. various health instructions in the event of a medical emergency,
2. designation of a durable power of attorney or someone who can serve as a health proxy in the event that they are not able to advocate their end-of-life preferences for themselves. Precipitated by high-profile cases of persons left partially alive in persistent vegetative states around the world, advance directives often emerged as a patient-led response to overtreatment at the end of life and in the context of public discussions about what constitutes ‘good’ or ‘bad’ forms of dying.

COMMUNITY PERSPECTIVE ON EUTHANASIA

A study in Finland to assess the attitude of the public in Finland toward active voluntary euthanasia, passive euthanasia and physician-assisted suicide reported that approximately half of the public supported euthanasia in a special situation, and around two-third population accepted passive euthanasia as a mode for the termination of life in dementia patients.

Contrasted with their European counterparts, the African communities are more opposed to euthanasia. Surprisingly, a study to assess the cultural perspective on euthanasia through ethnocultural profile among 120 participants (African, Coloreds, and Europeans) found no statistically significant difference in attitudes between the various groups. However, older participants were found to favour euthanasia.

Religion, which is a formal institution in the community, and spirituality, which is more elusive and personal in nature, help an individual cope with stressors. In Madrid and Spain, a survey of 128 dementia caregivers found that decreased anger in those who held stronger belief in religion and spirituality, possibly due to religion offering higher social support, and spirituality and religion both providing more individual meaning to these stressful situations, as a consequence of cognitive restructuring of these events.

PSYCHIATRIST'S PERSPECTIVE ON EUTHANASIA

For psychiatrists, this is a double-edged sword. Even though it is the moral and ethical obligation of psychiatrists to protect life, it is also equally imperative to maintain a state of psychological well-being, especially as the patient faces their end. The request for euthanasia in the presence of a psychiatric disorder or advanced dementia is an area of controversy.

In a cross-sectional study of 2,269 Dutch physicians where the majority of physicians reported that they can conceive of granting a request for assisted dying in patients with cancer (85%), or another physical illness (82%), but only around one-third of physicians found it conceivable to provide PAD in patients with a psychiatric diagnosis (34%), early dementia (40%) or advanced dementia (~30%). This finding also implies

that physicians are less likely to consider psychosocial suffering as intolerable as compared to physical suffering, and which might in part be due to not having complete insight into their suffering. Patients with depressive disorder or any treatment-resistant psychiatric disorder are found to be more likely to put forward the request for physician-assisted dying.

Psychiatrists have a potential role in exploring and understanding patient modifiable or non-modifiable psychosocial factors. Besides assessing the mental capacity of patients for decision-making, they can also provide brief psychological support to the primary physician, who deals with the moral dilemma of the right to decide whether to take life.

PATIENT'S PERSPECTIVE ON EUTHANASIA

When patients are at their life's end and suffering from terminal illnesses like dementia, they frequently express the desire to not live any further. Life is often viewed as meaningless, and they often express the opinion that they are held captive under their mental prisons. They frequently consider themselves to be a burden on their family members. As dementia progresses, all their daily living and instrumental activities get impaired. This loss of personal autonomy results in guilt and shame among patients.

This raises important ethical questions in mind: If people have the right to live, then why can they not also have the right to die, especially when they are suffering immensely under such unbearable and terminal conditions? Why can't we respect the right of the person to die at home with dignity, rather than prolong their suffering? Patients may prefer dying with dignity and in control of their end.

A study to explore the personal experience of terminally ill patients found that the majority were in support of assisted suicide, and the most commonly cited reasons were anticipated pain, fear of indignity, and a loss of control. In another study among palliative care patients reported that roughly a quarter (29%) were in favour of euthanasia, one-fifth against (20%), while the majority were ambivalent (51%). Those in favour argued that suffering so intensely made life meaningless on a personal level,

or had fears of frailty and loss of independence, and doubts regarding the provision of continuing help and communication.

THE MORAL DILEMMA OF PROFESSIONALS

Medical ethical guidelines commit each professional to four basic prima facie principles: beneficence, non-maleficence, autonomy, and justice when evaluating the merits and demerits of any medical procedure. Therefore, respecting the autonomy of patients for their decision of euthanasia should be equally balanced by the intent of doing good or at least doing no harm to the patients.

Significant impact on how the community perceives the physician's role can be achieved by engaging in ethical behaviour and “doing the right thing” for patients. General physicians and other healthcare professionals working with patients of severe dementia face another conundrum, with the prospect of permanent disability brought on by the disease toward the end of life.

Choosing between seeing patients endure endless suffering or giving them a prescription of lethal medication to end it draws heavily on the mental well-being of the doctor. Life is considered to be sacred, and each physician must protect human life, but concurrently, physicians should strive to preserve individual dignity and protect the patients from suffering by the end of life.

When physicians are no longer able to achieve the overall goals of care, it is more humane to adhere to the wishes of the patient or the proxy decision-maker rather than prolonging their misery further. Adherence to the dying's right to self-determination (autonomy) is central to ethical care at the end of life.

An online survey was conducted on a sample of 3,773 UK medical practitioners from various specialties -physicians, palliative medicine specialists, neurologists, specialists in geriatric medicine, and others (except those engaged in public health) – to assess their attitudes toward assisted dying. There was found to be lesser levels of support by doctors of all categories for assisted dying when compared with the general public. The opposition was found to be stronger among palliative medicine doctors and elderly care specialists.

THE VIEW OF RELIGIONS TOWARD EUTHANASIA

All faiths offer meaning and explanations for death and try to find a place for death within human experience. Most religions disapprove of euthanasia, some forbid it.

Buddhism

In Buddhism, the way life ends has a profound impact on the way the new life begins. So a person's state of mind at the time of death is significant - their thoughts should be selfless and enlightened, free of anger, hate or fear. Because Buddhists regard death as a transition. The deceased person will be reborn to a new life, whose quality will be the result of their karma. Buddhists argue that helping to end someone's life is likely to put the helper into a bad mental state, and this too should be avoided. This suggests that euthanasia is only approved for people who have achieved enlightenment.

Hindu

There are three Hindu views on euthanasia:

1. Euthanasia cannot be allowed as it breaches the teaching of ahimsa (doing no harm).
2. By helping to end a painful life, a person is performing a good deed and so fulfilling their moral obligations.
3. By helping to end a life, even one filled with suffering, a person is disturbing the timing of the cycle of death and rebirth, those involved in the euthanasia process will take on the remaining karma of the patient.

The same argument suggests that keeping a person artificially alive on a life-support machine would also be frowned upon.

Islam

The study observes that Allah gives life and has the absolute authority of taking it. In other words, the Qur'an prohibits consenting to one's own destruction which could be related to terminally ill patients who give consent to mercy killing. The study equally revealed that death is not the final destination of human beings but the hereafter; therefore, a believer should not lose hope when facing difficulties, suffering and

hardship but should instead keep hope alive. The study calls on Muslims to ensure that Islamic teachings on medical ethics are entrenched in all fabrics of human endeavour.

(taken from: https://journals.co.za/doi/pdf/10.7833/115-0-1175)

General Christian View

Christians are mostly against euthanasia. Some churches emphasize the importance of not interfering with the natural process of death.

All life is God-given. Birth and death are part of the life processes which God has created, so we should respect them. Therefore, no human being has the authority to take the life of any person, even if that person wants to die.

Many churches believe that the period just before death is a profoundly spiritual time, so it is wrong to interfere with the process of dying, as this would interrupt the process of the spirit moving towards God

Christians believe that the intrinsic dignity and value of human lives means that the value of each human life is identical. Valuing human beings as equal just because they are human beings has clear implications for thinking about euthanasia:

- patients in a persistent vegetative state, although seriously damaged, remain living human beings, and so their intrinsic value remains the same as anyone else's
- patients who are old or sick, and who are near the end of earthly life have the same value as any other human being
- people who have mental or physical handicaps have the same value as any other human being

The position of the Catholic Church is that nothing and no one can in any way permit the killing of an innocent human being, whether a fetus or an embryo, an infant or an adult, an old person, or one suffering from an incurable disease, or a person who is dying. Furthermore, no one is permitted to ask for this act of killing, either for himself or herself or for another person entrusted to his or her care, nor can he or she consent to it.

Judaism

The Jewish tradition regards the preservation of human life as one of its supreme moral values and forbids doing anything that might shorten life. However, it does not require doctors to make dying last longer than it naturally would. All life is of infinite value,

regardless of its duration or quality, because all human beings are made in the image of God, but there is a limit to the duty to keep people alive. If someone's life is ending, and they are in serious pain, doctors have no duty to make that person suffer more by artificially extending their dying moments

Jewish law forbids active euthanasia and regards it as murder. There are no exceptions to this rule, and it makes no difference if the person concerned wants to die.

Jewish law says that doctors (and patients) have a duty to preserve life, and a doctor must do everything he/she can to save a patient's life - even if the patient doesn't want them to.

But this isn't the end of it. There is some freedom for doctors in cases where a patient is terminally ill. If something is an impediment to the natural process of death and the patient only survives because of it, it is permitted under Jewish law to withdraw that impedance. So if a patient is certain to die, and is only being kept alive by a ventilator, it is permissible to switch off the ventilator since it is impeding the natural process of death.

POINTS TO BE ADDRESSED

1. What should be the proper definition of euthanasia?
2. What should be the correct way to practice euthanasia?
3. Can non-voluntary euthanasia be regarded as euthanasia?
4. What should be the steps while practicing euthanasia?
5. What kind of permissions should be obtained for euthanasia?
6. What should be the procedure for dementia patients and some other special groups?
7. How do we prevent slippery slope arguments from becoming real?
8. How can euthanasia be properly regulated, What to do if it is not possible to regulate?
9. What should be the procedure for advanced directives?

10. What should be done if doctors do not feel comfortable performing this procedure?
11. What happens if the patient changes their minds about the procedure after making the decision to perform it?
12. Should insurance cover this procedure?

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