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Euthanasia – Ethical Dilemmas

Eutanazja – dylemat etyczny

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Abstract

Euthanasia means “nice death”, and if we give this term a different meaning, “merciful death”, it means the killing of a person by others, causing intentional death as a result of feelings of mercy towards a suffering person. This act is in contradiction to criminal law, in which it is considered an act of murder, and this is the source of most of the ethical dilemmas concerning euthanasia. This paper deals with the issue of a person’s right to decide what will happen to his body, honoring the individual’s wishes in his last moments when there is no hope of recovery and when death is only a question of time. The following are the main dilemmas which I have chosen to discuss: 1) Is society entitled to make decisions concerning euthanasia? 2) Can nursing and medical staff decide to commit euthanasia when treating terminally ill patients suffering from intense pain? 3) Who should be the one to determine whether the family of a terminally ill patient in a coma is entitled to make decisions about euthanasia? The world around us is becoming more scientific and sophisticated and we, as human beings, must maintain the connection to our moral values and when we try to answer the question of euthanasia, we must discern the true motive of our acts. When are we directed by the needs of the suffering individual? Do we distinguish between the interests of the individual, the family, and society? Courageous answers to these questions, and to many others, are a necessary precondition when deciding on the weighty subject of euthanasia as a medical, ethical and philosophical issue (*Adv Clin Exp Med 2007, 16, 1, 75–83*).

Key words: aging, chronic disease, euthanasia, Israel.

Streszczenie

Eutanazja znaczy dosłownie „łagodna śmierć”; o ile nadamy temu wyrażeniu inne znaczenie, jak „śmierć litościwa”, znaczy to zabicie celowe, z litości dla osoby cierpiącej. Czyn ten sprzeciwia się prawu kryminalnemu, które uważa to za popełnienie morderstwa i czyni go źródłem większości dylematów etycznych dotyczących eutanazji. W pracy omówiono uprawnienie osoby chorej do zdecydowania, co stanie się z jej ciałem, uwzględniając jej życzenia w ostatnich jej chwilach, gdy nie ma już nadziei na wyzdrowienie, a śmierć jest tylko kwestią czasu. Główne dylematy, które omówił autor to: 1) Czy społeczeństwo uprawnione jest do pobierania postanowień w sprawie eutanazji? 2) Czy wolno personelowi pielęgniarskiemu i lekarskiemu decydować o popełnieniu eutanazji, jeśli zajmuje się on leczeniem osób krańcowo chorych, cierpiących z powodu silnego bólu? 3) Kto powinien oceniać, czy rodzina krańcowo chorej i pozbawionej przytomności jednostki jest uprawniona do decydowania w sprawach eutanazji? Świat wokół staje się coraz bardziej naukowy i skomplikowany, a ludzie muszą zachowywać skojarzenie z wartościami moralnymi. Gdy próbuje się odpowiadać na pytania związane z eutanazją, trzeba wyjaśnić, jakie są prawdziwe motywy działań. Czy zawsze kierujemy się potrzebami cierpiącej jednostki? Czy umiemy rozróżnić dobro chorego, jego rodziny lub społeczeństwa? Odważne odpowiedzi na te pytania i na wiele innych są koniecznym warunkiem do dyskusji o eutanazji jako istotnym problemie o medycznym, etycznym i filozoficznym (*Adv Clin Exp Med 2007, 16, 1, 75–83*).

Słowa kluczowe: starzenie, choroba przewlekła, eutanazja, Izrael.

Theoretical Discussion

The term euthanasia stems from two Greek words – *eu* – good or easy, *thanotos* – death, or in other words a good and easy death [1, 2]. The term

itself, nice or easy death, is not problematic and even express respect towards mankind. People live nicely and should die similarly. The question is whether it is morally and legally imperative to endeavor to help them leave this world nicely. The

term euthanasia includes the word death and does not mention release. It explicitly mentions the wish that death should be easy, good and not difficult. In modern terminology the customary term for euthanasia is “mercy killing”.

If we analyze the term, we see that it presents the merciful deed that is performed by killing. In other words, this is seen as a positive act performed as a result of the kindness of its enactor, perhaps a type of gift to the person killed. When we discuss the need to ease the process of death, it is important to clarify that we are dealing with an incurable patient, who is dying and has no chance of recovery [3]. In fact, the idea of reducing suffering motivates those who demand legal recognition of euthanasia. We may ask: Whose suffering? Merciful towards whom? By whom?

Historical Background

Sacks [4] wrote that euthanasia was usual among primitive tribes and nations. It was customary to take an ill or elderly person wishing to die out of the settlement or to allow the individual to die peacefully instead of continuing to sustain his life through means considered artificial.

One of the first people to defend euthanasia and to support it as a method was Plato, who claimed that the invalid should not be kept alive. This did not stem from compassion towards the disabled, but rather from concern towards their becoming a burden on society. The custom of euthanasia is also alluded to in the Hippocratic Oath: “I will give no deadly medicine to any one if asked, nor suggest any such counsel”. Russell [5] stated that euthanasia was apparently customary, but Hippocrates (460–377 BCE) objected to it (as can be understood from the Oath). During the Middle Ages, Sir Thomas More (1478–1535) in his book “Utopia” (1516) suggested that the state enact a law in favor of merciful murder on behalf of mortally-ill patients, which should supervised by the state and the church. He was one of the first to coin the term euthanasia in its present interpretation.

In the United Kingdom in 1798 the economist Thomas Malthus published his theory on poverty and called for population control, in the 1850s the philosopher Herbert Spencer published “Social Statics” where he coined the term “survival of the fittest”, in 1859 Charles Darwin published “the Origin of Species”, which all were a prelude to bring Francis J Galton on the scene and introduce the term “Eugenics” (Greek for well born) [6]. These ideas were exported to the United States, where Charles B Davenport and Harry H Laughlin

with money from the Carnegie Institution established the Station for Experimental Evolution at Cold Spring Harbor in 1904 and the grounds for eugenocide were laid and partly carried out in the United States, but later on a much larger scale by Nazi Germany in the 1940s [6]. In fact the idea of a lethal chamber for mass murder came from British eugenicists, like George Bernard Shaw, who in 1910 lectured on the subject and it featured also in the landmark book “Textbook on mental deficiency” by Arthur F Tredgold [7] first published in 1908, but later published in several editions, where it was concluded that for about 80,000 persons in Britain with intellectual disability “it would be an economical and humane procedure were their existence to be painlessly terminated... The time has come when euthanasia should be permitted...” [6].

The book “Permitting the destruction of life not worthy of life” was published in Germany in 1920 by Karl Binding, a professor of law from the University of Leipzig, and Alfred Hoche, MD, a professor of psychiatry at the University of Freiburg, where they argued that patients who asked for “death assistance” should, under very carefully controlled conditions, be able to obtain it from a physician. This book, together with the work by British and American eugenicists, eventually helped support involuntary euthanasia and mass murder by Nazi Germany [4, 6].

In 1998 the state of Oregon legalized assisted suicide, in 1999 Jack Kevorkian, MD, was sentenced to a 10–25 year prison term for giving a lethal injection to Thomas Youk whose death was shown on the “60 Minutes” television program, in 2001 the Netherlands legalized euthanasia and in 2002 Belgium legalized euthanasia [2, 3].

Religion and Euthanasia

Most Christian dominations are against euthanasia, because of the belief that life is given by God and that human beings are made in God’s image. Some churches also emphasise the importance of not interfering with the natural process of death. Life is seen as a gift from God with birth and death as part of the life processes which God has created, so we should respect them and therefore no human being has the authority to take the life of any innocent person, even if that person wants to die. The process of dying is spiritually important and should not be disrupted with many churches believing that the period just before death is a profoundly spiritual time. Christians believe that the intrinsic dignity and value of human lives means that the value of each

human life is identical. They do not think that human dignity and value are measured by mobility, intelligence or any achievements in life. Patients in a persistent vegetative state, although seriously damaged, remain living human beings, and so their intrinsic value remains the same, so it would be wrong to treat their lives as worthless. Patients who are old or sick and near the end and people who have mental or physical handicaps have the same value as any other human being. Therefore the Christian church object to euthanasia [5].

The basic Jewish law directly related to this subject is the Sixth Commandment: "Thou shalt not kill". 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 physicians to make dying last longer than it naturally would. Jewish law and tradition regard human life as sacred and find it wrong for anyone to shorten a human life, because our lives are not ours to dispose of as we feel like. All life is of infinite value, regardless of its duration or quality, because all human beings are made in the image of God. Saving someone from pain is not a reason to kill them, nor is it lawful to kill oneself to save oneself from pain, but there is a limit to the duty to keep people alive. If a life is ending and there is serious pain the physician has 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 wants to die. It is wrong to shorten a life even if it would end very soon, because every moment of human life is considered equal in value to many years of life. So even if a person is a "goses" (this word means someone who has started to die and will die within 72 hours), any action that might hasten their death – for example closing the eyes or moving a limb – is prohibited. Although a physician cannot do anything to hasten death, "if there is something which is preventing the soul from departing" a physician can remove whatever is preventing the soul from departing, or in other words 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 thing. So if a patient is certain to die and only being kept alive by a ventilator, it is permissible to switch off the ventilator since it is impeding the natural process of death [8]. Rabbi Moshe Feinstein and Rabbi Shlomo Zalman Auerbach have ruled that a dying patient should not be kept alive by artificial means, where the treatment does not cure the illness, but merely pro-

longs life temporarily and the patient is suffering great pain. Pain relief medicine can be given even though it may hasten death, as long as the dose is not certain to kill and the intention is not to kill, but to relieve pain.

From the above we understand that Jewish law is unequivocally opposed to the active facilitation of a patient's death, however it permits the removal of obstacles that prevent easy death and thus enables passive euthanasia in certain cases.

Muslims are against euthanasia. They believe that all human life is sacred, because it is given by Allah, who chooses how long each person will live. Human beings should not interfere in this. Euthanasia and suicide are not included among the reasons allowed for killing in Islam. "Do not take life, which Allah made sacred, other than in the course of justice" (Quran 17.33) and "If anyone kills a person – unless it be for murder or spreading mischief in the land – it would be as if he killed the whole people" (Quran 5.32). Allah decides how long each of us will live: "When their time comes they cannot delay it for a single hour nor can they bring it forward by a single hour" (Quran 16.61) and "no person can ever die except by Allah's leave and at an appointed term" (Quran 3.145). Suicide and euthanasia are explicitly forbidden: "Destroy not yourselves. Surely Allah is ever merciful to you" (Quran 4.29).

Buddhists are not unanimous in their view of euthanasia and the teachings of the Buddha do not explicitly deal with it. Most Buddhists are against involuntary euthanasia, but the position on voluntary euthanasia is less clear. The most common position is that voluntary euthanasia is wrong, because it demonstrates that one's mind is in a bad state and that one has allowed physical suffering to cause mental suffering, instead meditation and the proper use of pain killing drugs should enable a person to attain a state where they are not in mental pain, and so no longer contemplate euthanasia or suicide. Buddhism places great stress on non-harm, and on avoiding the ending of life. The reference is to life – any life – so the intentional ending of life seems against Buddhist teaching and voluntary euthanasia should be forbidden. Certain codes of Buddhist monastic law explicitly forbid it. 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.

Most Hindus would say that a physician should not accept a request for euthanasia since this will cause the soul and body to be separated at an unnatural time and it will damage the karma of both physician and patient. Other Hindus believe that euthanasia cannot be allowed because it breaches the teaching of ahimsa (doing no harm),

however some say that by helping to end a painful life a person is performing a good deed and so fulfilling their moral obligations.

Sikhs derive their ethics largely from the teachings of their scripture, Guru Granth Sahib and the Sikh Code of Conduct (the Rehat Maryada) with guidelines over the past 500 years set by the examples of the gurus. Sikhs have a high respect for life which they see as a gift from God. Most Sikhs are against euthanasia due to the belief that the timing of birth and death should be left in God's hands with suicide and euthanasia an interference in God's plan. Suffering, they said, was part of the operation of karma, and human beings should not only accept it without complaint but act so as to make the best of the situation that karma has given them.

Reasons for the Current Significance of the Issue of Euthanasia

Medical Development

With the assistance of innovative medical technology, modern medicine can today revive sick people, who were once considered as good as dead. Technology has developed and continues to do so, however the ethical world has not advanced at the same pace. Complex treatments sometimes cause pain and suffering. Postponing death prolongs life, but does not always improve its quality [9].

Medication

Pharmacological developments enable various treatments of difficult diseases. In addition, analgesic medications have been developed, helping people to cope with their suffering, but at the same time destroying body cells and sometimes hastening their end. The question is therefore whether to use painkilling medication, when it is known to hasten the end [9].

Increase in Life Expectancy

Modern medicine has almost doubled human life expectancy. As a result of this increase, there has been a rise in the number of elderly people, who create an economic/social/sociological burden worldwide. This reality will constitute as a problem, when these people reach complete senility and exist only from a biological point of view. Then we will have to decide whether to do all possible to prolong their lives or to find other

ways, such as organ transplants. Transplants require the extraction of body parts from people who have recently died or people defined as brain-dead whose body parts are operated by various machines, and here there is a double bind: Are we entitled to keep a person alive artificially in order to utilize his body and try to save another human being? Can we interrupt the operation of life-sustaining machines and at what stage may this be done?

The Economic Problem

Enormous financial resources are invested in the maintenance of instruments for terminally ill patients and a large staff is required for their operation. Thus, sustaining a terminally ill person with the help of technology can be seen as economically problematic [9].

Types of Euthanasia

It is customary to divide the concept of euthanasia into four main types [1]: **active euthanasia** (performance of a direct act leading to the termination of a life), **passive euthanasia** (death caused as a result of avoiding life-prolonging activity, such as not giving food, fluid or providing medical care), **voluntary euthanasia** (the patient himself performs the act, requests or agrees that it be performed, after his health condition has been explained to him and he makes the decision while fully conscious), **involuntary euthanasia** (the patient does not express his opinion or cannot express his opinion since he is unconscious, or when the patient is a baby and those surrounding him wish to make the decision in his place based on various considerations).

Active euthanasia is taking specific steps to cause, such as injecting the patient with poison. In practice, this is usually an overdose of pain-killers or sleeping pills. Passive euthanasia is usually defined as withdrawing medical treatment with the deliberate intention of causing death. For example, if a patient requires kidney dialysis to survive, but the dialysis machine disconnected, the patient will presumably die fairly soon. The classic example of passive euthanasia is the "do not resuscitate order". If a patient has a heart attack or similar sudden interruption in life functions, medical staff will attempt to revive them, but if they make no effort but simply stand and watch as the patient dies, this is passive euthanasia.

In other words, the difference between "active" and "passive" is that in active euthanasia, something is done to end life, while in passive

euthanasia something is not done, which would have preserved life. An important idea behind this distinction is that in “passive euthanasia” the physicians are not actively killing anyone, they are simply not saving him.

Voluntary euthanasia is when the patient requests that action be taken to end his life, or that life-saving treatment be stopped with full knowledge that this will lead to his death. Involuntary euthanasia is when a life is ended without the patient’s knowledge and consent, usually when the patient is unconscious, unable to communicate, or is too sick and weak to be aware of what is happening or to take any action on his own behalf.

Euthanasia and the Law in Various Countries

Euthanasia has not been recognized by Israeli law. According to the Criminal Code Ordinance of 1936 based on English law, the motivation for performing an act of killing or murder is irrelevant. Even when a person is killed according to his own wish or request and even if his motives were mercy killing, this law is still upheld. Many sections deal with euthanasia, but in section 214 it is stated that any person who has caused the death of another is guilty of murder. According to section 216 of the Penal Code, euthanasia fits the category of “premeditated murder”, because the following conditions exist: A) there was no provocation by the other side; B) it was preceded by planning; C) it was performed in cold blood. A person accused of premeditated murder is liable to be sentenced to life imprisonment without pardon. Section 231 places professional responsibility on the physician, who must be properly trained and behave with reasonable responsibility, while engaged in his work.

Recently (December 2005) a new government bill was passed by the Israel Knesset (parliament) after six years of discussions and deliberations, which will allow the terminally ill to die in dignity without being forced to be kept alive by artificial means. A delayed response timer build into the respirator (ventilator) will be the solution to the problem of how to let terminally ill patients end their lives, if they have so indicated in a living will and over the age of 17 years [10].

United States and Canada

There has been a lot of debate in the United States among physicians, religious leaders, lawyers and the general public over the question of what constitutes actively causing death and what

constitutes merely allowing death to occur naturally. The physician is faced with deciding whether measures used to keep patients alive are extraordinary in individual situations, e.g., whether a respirator or artificial kidney machine should be withdrawn from a terminally ill patient. The Supreme Court’s decision in *Cruzan v. Director* [11], Missouri Dept. of Health set a precedent for the removal of life-support equipment from terminal cases. In 1983, Nancy Beth Cruzan was involved in an automobile accident, which left her in a “persistent vegetative state”. She was sustained for several weeks by artificial feedings through an implanted gastronomy tube, but when her parents attempted to terminate the life-support system, state hospital officials refused to do so without court approval. The Missouri Supreme Court ruled in favor of the state’s policy over Cruzan’s right to refuse treatment. In a 5-to-4 decision, the Court held that while individuals enjoyed the right to refuse medical treatment under the Due Process Clause, incompetent persons were not able to exercise such rights. Absent “clear and convincing” evidence that Cruzan desired treatment to be withdrawn, the Court found the State of Missouri’s actions designed to preserve human life to be constitutional. Because there was no guarantee family members would always act in the best interests of incompetent patients, and because erroneous decisions to withdraw treatment were irreversible, the Court upheld the state’s heightened evidentiary requirements.

The public have supported the legalization of living will or a statement by a mentally alert patient that can be used to express a wish to forgo artificial means to sustain life during terminal illness, where in 1977 California passed a state law to this effect, known as the death-with-dignity statute. The absence of a written living will complicated the case of Terri Schiavo, a Florida woman who was in a persistent vegetative state from 1990 until 2005, when she died after having her feeding tube removed. In 2000 her husband, who was her legal guardian, won the right to remove it based upon what he stated were her orally expressed wishes, but legal challenges from her parents and Florida governor Jeb Bush and attempted government interventions through Florida and federal legislation delayed the tube’s removal for five years [12].

Societies advancing the cause of positive euthanasia were founded in 1935 in England and 1938 in the United States [6] with End-of-Life Choices (formerly the Hemlock Society) as one group that has pressed for right-to-die legislation, but positive euthanasia is for the most part illegal in the United States. In the late 1970s the pro-euthanasia movement gained significant momen-

tum after a highly publicized incident in the United States, when in 1975 a 21 year old woman named Karen Ann Quinlan suffered a respiratory arrest that resulted in severe and irreversible brain damage and left her in a coma with recovery extremely unlikely. Her parents requested that artificial means of life support be removed, but the hospital refused this request. In 1976 the parents obtained a court order from the New Jersey Supreme Court allowing them to remove the artificial respirator that was thought to be keeping their daughter alive, so that she could die with dignity, but although the respirator was removed in 1976, she began to breathe on her own and lived until 1985 without ever regaining consciousness [13].

In the early 1990s, Jack Kevorkian, a physician who gained notoriety by assisting a number of people to commit suicide and became the object of a state law (1992) forbidding such activity. Kevorkian tried and acquitted repeatedly in the assisted deaths of seriously ill people was convicted of murder in Michigan in 1999 for an assisted suicide that was shown on national television [3]. In 1997 the Supreme Court upheld state laws banning assisted suicide (in most U.S. states assisting in a suicide is a crime). Voters in Oregon in 1994 approved physician-assisted suicide for the terminal ill and the law went into effect in 1997 after a long court challenge. In 2001 the Bush administration sought to undermine the law with a directive issued under the federal Controlled Substances Act, but Oregon sued to prohibit the enforcement of it, and the Supreme Court ruled that the federal government had exceeded its authority [14].

In the early 1990s the decision of *Nancy B. v. Hotel-Dieu de Quebec* in Canada played a role in promoting public awareness of the issues surrounding euthanasia. In this case, a young woman paralyzed as a result of Guillain-Barré syndrome (incurable neurological disease) wished to have the respirator disconnected. In January 1992 a Québec superior court judge authorized the physician to remove the respirator [15].

Laws in both the United States and Canada maintain the distinction between passive and active euthanasia. While active euthanasia is prohibited, courts in both countries have ruled that physicians should not be legally punished, if they withhold or withdraw a life-sustaining treatment at the request of a patient or the authorized representative. These decisions are based on increasing public acceptance that patients possess a right to refuse treatment. Until the late 1970s, whether or not patients possessed a legal right of refusal was highly disputed. One factor that may have contributed to growing acceptance of this right is the

ability to keep individuals alive for long periods of time, even when they are permanently unconscious or severely brain-damaged. Every US state has adopted laws that authorize legally competent individuals to make living wills. Such documents allow individuals to control some features of the time and manner of their deaths. In particular, these directives empower and instruct physicians to withhold life-support systems, if the individuals become terminally ill. Furthermore, the federal Patient Self-Determination Act, which became effective in 1991, requires federally certified health-care facilities to notify competent adult patients of their right to accept or refuse medical treatment. The facilities must also inform such patients of their rights under the applicable state law to formulate an advanced directive. Patients in Canada have similar rights to refuse life-sustaining treatments and formulate advanced directives [16].

Europe

According to Swiss law since 1937, "Whoever, from selfish motives, induces another to commit suicide or assists him therein shall be punished, if the suicide was successful or attempted, by confinement in a penitentiary for not more than five years or by imprisonment." The key words are "from selfish motives" and in essence there is no prosecution, if the person assisting in suicide claims he acted unselfishly. While this results in de facto legalization, assisted suicide is not legal, only unpunishable, unless a selfish motive is proven [17].

In 1936 the Voluntary Euthanasia Act was proposed in England, but it was rejected by a majority of 35 to 14. In England euthanasia is considered a criminal act, however there is an alternative via hospices commonly found in England, who support: relief of pain and suffering with respect and attention towards the dying person. The patient participates in choosing proper care, but there is no legislation supporting the use of a living will or the cessation of life-sustaining care of vegetative patients [18].

Euthanasia and assisted suicide have been widely practiced in the Netherlands since 1973 although they were against the law until 2002. The Dutch situation between 1973 and 2002 was a result of several court decisions and medical association guidelines, beginning with a 1973 District Court case in which Geertruida Postma, a physician, was convicted of the crime of euthanasia after she ended the life of her seriously ill mother. While finding her guilty (mercy killing punishable by imprisonment for a maximum of 12 years) the court imposed a one-week suspended

sentence and a week probation. The Dutch court relied heavily on expert testimony by the District's medical inspector who set forth certain conditions under which the average physician thought euthanasia should be considered acceptable. Inclusion of those conditions formed the basis for subsequent acceptance of euthanasia and assisted suicide in the Netherlands [2, 17]. Under the guidelines in effect for ending a life on request, euthanasia and assisted suicide continued to be punishable, but were not prosecuted if the guidelines were followed.

In 1991 a new procedure for reporting physician-assisted deaths was introduced in the Netherlands, which led to a tripling in the number of reported cases. In 1995, a nationwide study of euthanasia and other medical practices concerning the end of life began, which was identical to a study conducted in 1990. This study involved interviews with 405 physicians (general practitioners, nursing home physicians, and clinical specialists) and questionnaires mailed to physicians, who attended to 6,060 deaths identified from death certificates. 2.3% of those in the interview study and 2.4% of those in the death-certificate study were estimated to have resulted from euthanasia and 0.4% and 0.2% resulted from physician-assisted suicide. In 0.7% of cases, life was ended without the explicit, concurrent request of the patient. Pain and symptoms were alleviated with opioids that may have shortened life in 14.7 to 19.1% of cases, while decisions to withdraw life-prolonging treatment were made in 20.2% [19].

In 2001, the Dutch Parliament approved the "Termination of Life on Request and Assisted Suicide (Review Procedures) Act", which amended sections of the criminal code, specifically stating that the offenses of euthanasia and assisted suicide are not punishable if they have been "committed by a physician who has met the requirements of due care" that are described in the act and if they have informed the municipal "autopsist" in accordance with the Burial and Cremation Act [17]. The "due care" requirements transformed the crimes into medical treatments as physicians had advocated. Under the new law, minors between sixteen and eighteen may request that their lives be terminated. Although parents or guardians must be consulted, they have no authority to prevent the requested death. Children between the ages of twelve and sixteen may request euthanasia or assisted suicide, but a parent or guardian must agree with the decision [17]. The law recognizes the right of a physician to carry out euthanasia based on a written advance request for death of a currently incapacitated patient who is 16 years old or older.

Later the University Medical Center in Groningen acknowledged that it had been euthanizing infants, not only in the case of terminally ill newborns, but also in cases of children who had spina bifida and other disabilities [20].

Belgium followed suit in 2002 with an act legalizing euthanasia, which limits euthanasia to competent adults and emancipated minors. In 2005, a pharmaceutical company announced that home "euthanasia kits" would be available soon in Belgian pharmacies. Reports indicated that the kits will contain a barbiturate, a paralyzing agent, an anesthetic and instructions for use costing 45 Euro [17].

Discussion

In response to advances in medical technology, physicians and lawmakers are slowly developing new professional and legal definitions of death. Additionally, experts are formulating rules to implement these definitions in clinical situations, as for example when procuring organs for transplantation. The majority of countries have accepted a definition of brain death, the point when there is a complete and irreversible cessation of brain activity, as the time when it is legal to turn off life-support system with permission from the family.

Europe and especially the Netherlands seems to be the front runners, when in 2001 the Netherlands became the first country to legalize active euthanasia and assisted suicide and this way formalize a medical practice that the government had tolerated for many years. Under the Dutch law, euthanasia is justified, if the physician follows strict guidelines, which include: 1) the patient makes a voluntary, informed and stable request; 2) the patient is suffering unbearably with no prospect of improvement; 3) the physician consults with another physician, who in turn concurs with the decision to help the patient die and 4) the physician performing the euthanasia procedure carefully reviews the patient's condition. Today it is estimated that about 2% of all deaths in the Netherlands each year occur as a result of euthanasia.

In 2002 the parliament of Belgium also legalized active euthanasia, permitting physicians to perform euthanasia only for patients who are suffering unbearably with no hope of improvement. The patient must make a voluntary, well-considered and repeated request to die in writing. Other physicians must be consulted to confirm the condition of the patient and each act of euthanasia must be reported to a government commission for review.

A discussion of euthanasia concerns questions from the medical, social and ethical fields and it is no wonder that the approach to the subject differs from society to society and from country to country. When the view of passive euthanasia was examined, most of the studies leaned towards consent and acceptance. However if we discuss the clear definition of active euthanasia, most countries absolutely prohibit it. The studies quoted also discussed the effect of religion on these views.

The accelerated medical development in our generation enables us to prolong life artificially. This tendency will increase, and therefore the question presented in this paper will become more acute and require a clearer answer. The world around us is becoming more scientific and sophisticated and we, as human beings, must maintain the connection to our moral values and when we try to answer the question of euthanasia, we must discern the true motive of our acts. When are we directed by the needs of the suffering individual? Do we distinguish between the interests of the individual, the family, and society? Courageous answers to these questions, and to many others, are a necessary precondition when deciding on the weighty issue of euthanasia.

A critical review of the euthanasia system in the Netherlands has been published by an Israeli researcher [2], who before visiting that country was a supporter of the way euthanasia was practised there, but came back with reservations about the practicality of its implementation. It is worth listening to his proposed guidelines: the physician

should not suggest assisted suicide to his patient, but instead the patient should have the option to ask for such assistance, the request for physician assisted suicide of an adult and competent patient who suffers from an intractable, incurable and irreversible disease must be voluntary, palliative care must be implemented so the patient will not ask or be influenced by severe pain, the patient must be informed of the situation and the prognosis for recovery or escalation of the disease and the suffering it may involve, it must be ensured that the decision is not the result of familial or environmental pressures, the decision making process must include a second opinion to verify diagnosis, a consultant must review requests for physician-assisted suicide, prior to the performance of physician assisted suicide a physician and a psychiatrist must visit and examine the patient, the patient can rescind at any time, physician assisted suicide must only be performed by a physician with another present, physician assisted suicide must be conducted in one of three options: oral medication, self-administered lethal intravenous infusion or self-administered lethal injection, physicians must not demand a special fee for physician assisted suicide, there must be extensive documentation in the patient medical file, pharmacists must be required to report all prescriptions for lethal medications, physicians must not be coerced into actions against their conscience, local medical association must monitor physician assisted suicide, sanctions must be in effect if physicians fail to follow these guidelines

References

- [1] **Darbyshire P:** Euthanasia. Whose life, whose decision. *Nurs Times* 1987, 83 (45), 26–29.
- [2] **Cohen-Almagor R:** Euthanasia in the Netherlands. The policy and practice of mercy killing. Dordrecht, Kluwer 2004.
- [3] **Cohen-Almagor R:** The right to die with dignity. An argument in ethics, medicine and law. New Brunswick, NJ, Rutgers Univ Press 2001.
- [4] **Sacks S. Aktion T:** Annihilation of disabled in the Third Reich. Tel-Aviv, Papyrus, 1985. [Hebrew].
- [5] **Russell O:** Freedom to die. Moral and legal aspects of euthanasia. New York, Human Sci 1977.
- [6] **Black E:** War against the weak. Eugenics and America's campaign to create a master race. New York, Thunder's Mouth Press, 2003.
- [7] **Tredgold AF:** Textbook on mental deficiency (Amentia). New York, William Wood, 1908.
- [8] **Jakobovits I:** Jewish medical ethics. A comparative and historical study of the Jewish religious attitude to medicine and its practice. New York, Bloch 1967.
- [9] **Turton P:** The death debate. *Nurs Times* 1987, 83 (45), 31.
- [10] **Siegel-Itzkovich J:** Israelis turn to timer device to facilitate passive euthanasia. *BMJ* 2005, 331, 1357.
- [11] **Cruzan V:** Director. Missouri Dept. of Health. 497 US 261, 1990, 88–1503.
- [12] **Schiavo T:** Website: http://en.wikipedia.org/wiki/Terri_Schiavo.
- [13] **Quinlan, KA:** Website: http://en.wikipedia.org/wiki/Karen_Ann_Quinlan
- [14] **Lavi SJ:** Euthanasia. The modern art of dying: A history of euthanasia in the United States. Princeton, NJ, Princeton Univ Press 2005.
- [15] Canada Quebec Superior Court. *Nancy B. v. Hotel-Dieu de Quebec*. *Dominion Law Reports* 86, 1992, 385–395.
- [16] Northern Territory Government. Rights of the terminally ill act 1995. Northern Territory of Australia, Darwin, Government Publisher, 1995.
- [17] International Task Force. Website: http://www.internationaltaskforce.org/rpt2005_3.htm#236
- [18] **Keown J:** Euthanasia in England: courts, committees and consistency. *Med Law* 1997, 16 (4), 805–811.

- [19] **van der Maas PJ, van der Wal G, Haverkate I, de Graaff CL, Kester JG, Onwuteaka-Philipsen BD, van der Heide A, Bosma JM, Willems DL:** Euthanasia, physician-assisted suicide, and other medical practices involving the end of life in the Netherlands, 1990–1995. *New Engl J Med* 1996, 335 (22), 1699–1705.
- [20] **Sheldon T:** Killing or caring? *BMJ* 2005, 330, 560.

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