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The International Social Acceptance of Euthanasia Practice

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Abstract

Euthanasia is a highly controversial topic in the 21st century, not only being debated on philosophical and moral grounds but also being debated in the medical community. Throughout the 20th and 21st century, there have been multiple attempts at legalizing Euthanasia in different countries around the world; in some instances, it has been possible to find ways to legalize it entirely or partially, while in other instances the road to legalization is still ongoing. Much of the controversy from Euthanasia stems from moral or ethical dilemmas, especially when involving religious beliefs and established social norms in different parts of the world. In order to fully understand and grasp such a controversial topic, it is of utmost importance to evaluate what Euthanasia consists of, and how religion and society play a role in affecting people's perception of this topic. It is also essential to see the benefits of Euthanasia through the donation of organs and how medical professionals must maintain and balance their role as physicians while upholding and respecting the patient's dignity and autonomy. When considering all these aspects and combining them, people will be able to have a complete view of what Euthanasia is and how it is implemented around the world.

Keywords

Euthanasia,
social norms,
society play.

Introduction

A recent venture of medicine and technology has pushed back the age at death with insistent drugs, refined surgical techniques, among other factors. However, the patient's quality of life is not always right, which under critical circumstances, some contemplate the possibility of euthanasia. The word euthanasia in Greece means good death. It is derived from the Greek word "Thanatos," which means "well death," referring to intentional mercy killing.[1]

Currently, it is defined by the 8th edition of the Black's Law Dictionary as the act or practice of killing or bringing about the death of a person who suffers from an incurable disease or condition, especially a painful one, for reasons of mercy.

Euthanasia, a debated subject, is being considered as an application by many countries among the increasing level of legalization; nonetheless, it is

difficult because all the definitions and terms are very diverse in all the countries. In present times, euthanasia can be classified under the following categories: active, passive, voluntary, involuntary, and non-voluntary euthanasia. For active euthanasia, a person, usually a physician, actively and intentionally ends a patient's life by some medical means such as an injection of a neuromuscular relaxant. The term passive euthanasia should be avoided because it refers to terminating potentially life-sustaining treatments, not an administration of a medical intervention to end a terminally ill or a persistent vegetative state patient.[2] Voluntary euthanasia happens when a patient asks for death by either active or passive euthanasia and is associated with the right to choice, serving in the best interest of the patient and everyone involved. Involuntary euthanasia occurs when a patient is killed against his stated will, meaning that the patient has not agreed to it, when mentally capable of consenting to their death.[1] Nonvoluntary euthanasia refers to cases when the patient is not mentally competent and could not request euthanasia.[2]

Although there is still no unified consensus, the main factor associated with opposition to euthanasia and Physician-Assisted Suicide (PAS) was the strength of religious views. Furthermore, over the last 30 years in most developed countries, there have been high levels of public support for euthanasia and PAS, but more limited support among physicians.[2] As a primary argument in favor of PAS, the autonomy of the will and the right to the patient's own will shows compassion, mercy and ensures release from more suffering.[3] In order to distinguish the act of death to mitigate pain by a terminally ill person from suicide, some in the US medical community has moved away from the term ''physician-assisted suicide'' to ''physician-assisted death''.[4]

Legally, euthanasia is practiced in the Netherlands, Belgium, Luxembourg, Colombia, Canada, and a few states in the USA. In Western Europe, an increasing and strong public support for euthanasia and physician-assisted suicide has been reported; however, in Central and Eastern Europe, the support is decreasing. In the United States, less than 20% of physicians received requests for euthanasia or physician-assisted suicide, and 5% or less have complied.[2] Noteworthy, out of all these requests for physician-assisted death, studies report that the typical patient has been diagnosed with cancer. [5]

In order to evaluate a topic as controversial as euthanasia, it is essential to analyze how society perceives and accepts to an extent the implications of such practice. Several common factors have to be mentioned when approaching this topic, expanding from the individual until finally reaching how society feels as a whole.

Programmed death, the right to die with dignity and patient's autonomy are topics that directly involve the patient and their decision to continue or suspend medical treatment when facing certain critical illnesses or medical conditions. Expanding from the patient outwards, terminal medical conditions and diseases, protocols and medications, and how these affect the quality of life of the patient must be addressed. By considering these factors, physicians and health care professionals included in the decision making of how each medical case will be handled are involved.

Focusing now in more broad topics, affecting both the patient and society, we begin by analyzing organ donation, the legalization of euthanasia, and how professional responsibility may have a role in patient care. A topic that is directly intertwined between the factors above is religious beliefs. These directly affect the behavior of the patient and their decisions regarding their care. Furthermore, they change how society will perceive and react when facing the choice of applying this option in medical care, and even when the opportunity arises to make this medical procedure legal.

In Canada, the Supreme Court has ruled for restricted access to euthanasia and assisted-death interventions to competent adults, where an adult is typically understood as any person who has reached the age of 18 years old.[6] In 1997, the United States Supreme Court rejected the notion that a constitutional right exists to either PAS or euthanasia and, as a result of this decision, relegated the issue of PAS and euthanasia to individual state legislatures. In the US, Physician-assisted suicide is legal in 5 states: Oregon, Washington, Montana, Vermont, and California. [2]

In India, the Constitution Bench (CB) of the Supreme Court of India (SCI) granted legal recognition to "advanced medical directives" or "living wills," and reiterates the legal recognition of the right to passive euthanasia, as by Article 21 (the Right to Life) of the Constitution of India should also include the "right to die with dignity." However, it reemphasized that active euthanasia is not permitted by Section 309 of

India's Penal Code (IPC) which recognize attempted suicide to be a punishable act. [7]

Since there is sufficient data to use as variables of study concerning euthanasia or PAS, data shows that death by PAS typically accounts for less than 0.4% of all deaths. Additionally, there has been a consistent increase in the number of requests for PAS, and about 75% of patients using PAS are dying of cancer. It is important to note that the typical patient using PAS are elderly, white, and well-educated patients.[2]

Internationally, there is an increasing debate among attitudes of acceptance regarding euthanasia and PAS, but especially in most developed countries in which over the last 30 years there have been high levels of public support for euthanasia and PAS, although more limited support among physicians. Many studies show that the primary concern of the patient for requesting such services is loss of independence and sovereignty when facing a terminal illness. As euthanasia and physician-assisted suicide are increasingly being legalized, these remain relatively rare and primarily involve patients with cancer. Existing data do not indicate widespread abuse of these practices. [2]

Legalization of Euthanasia & Physician-Assisted Suicide by countries and states

In the comparative theory, there is a difference between assisted suicide and physician-assisted suicide to further qualify the aid in committing the act of suicide [4], in which both procedures are related to the deprivation of life of the patient due to a severe health condition. In the first procedure, we have a perpetrator who is a third party and helps a patient to terminate their life (assisted suicide), while in the second case a physician (physician-assisted suicide) appears as an assistant. [1]

Unlike euthanasia, in which a physician deprives the patient's life by active engagement, at physician-assisted suicide, a doctor prescribes a medication that a patient will take when he decides to die. Therefore, PAS is an act by which a physician facilitates a patient's death by providing the necessary information and means to act. PAS is somewhere in the middle between euthanasia and suicide, and for some patients, it is only a way to avoid suffering and more significant, loss of control over their own body. [8]

Figure 1: Timeline of the year in which countries and states legalized euthanasia or physician-assisted suicide.

The right to die with dignity, Physician-assisted suicide, Programmed Death

Living and dying by the person's own beliefs and desires are considered to be one of the most significant human freedoms. One of the most common wishes of patients who are in the terminal stage of the disease is to end their lives with a certain amount of dignity.[3] Regardless, the opinions about Physician-Assisted Suicide (PAS) can also vary between different professional fields. For example, four core ethical topics regarding Physician-Assisted Suicide (PAS) and Euthanasia (E) in the Intensive Care Unit have been discussed, and the results from this discussion have been collected and compared. The topics were: (1) the benefit or harm of death itself, (2) the relationship between PAS/E and withholding or withdrawing life support, (3) the morality of a physician deliberately causing death, and (4) the management of conscientious objection related to PAS/E in the critical care setting. [9]

Regarding the benefit or harm of death itself for a patient's euthanasia, physicians argued that some patients could benefit from death since the quality of life could be improved by sacrificing the quantity of life and that for some patients, suffering ended with the death of that patient. On the other hand, ethicists argued that because of the lack of knowledge of

physicians and of the patients about the benefits of death and how death itself could be more beneficial than remaining alive, ends any opportunities available for relational and spiritual healing at the end of their lives.[10]

Regarding a relationship between PAS/E and withholding or withdrawing life support treatment (WWLST), physicians explained that in both situations the values of the patient were taken in consideration when a decision was made and that in both cases the goal was to provide comfort to the patient. Ethicists argued that death was a direct result of WWLST, even if death was not deliberately done, and that the goal of providing comfort or relief to the patient, could also be achieved by natural death. Regarding the morality of a physician deliberately causing death, doctors argued that when there were consent and compassion behind the decision, it was morally acceptable, that PAS/E could be defended as a way to reduce harm, and that there was no reason to allow passive treatment to shorten life, when the same goal could be achieved via active treatment.[10]

Another argument made by ethicist regardless of the motive, causing death intentionally was not morally acceptable, that the value of that patient as a human being is incalculable, and that it transcends any circumstance or preference. Both physicians and ethicists expressed profound differences in their views regarding the first three aspects, but there was an agreement regarding the management of conscientious objection related to PAS/E in the critical care setting. Both parties agreed that physicians must discuss with their patients, all the available options to treat the suffering of a critical illness and recognize the distinction between restricting their actions and obstructing the patient's right to access. Also that special constraints upon conscientious objection apply in the ICU because hospitalized patients often have little or no ability to choose their attending physician, and that in the ICU context, "transferring care to an alternate attending physician upon the patient's request because of conscientious objection does not constitute a referral for PAS/E and does not imply moral culpability if the patient subsequently undergoes PAS/E.[9]

In the case of countries that have legalized euthanasia, current regulations for euthanasia or physician-assisted death (PAD) can vary. For example, Canada's policies for euthanasia or physician-assisted death follow well-structured processes, to safeguard vulnerable populations against potential abuse or exploitation of euthanasia, and laws have specific requirements to engage death with dignity. The initial physician consulted by the patient for euthanasia or physician-assisted death must seek a second opinion to confirm that the patient meets the requirements outlined in the state law. These requirements include that the patient is capable of deciding to request assistance in dying, making an informed decision and that the physician informs the patient that they have an opportunity to withdraw the request at any time and in any manner.[6]

A cohort of terminally ill patients endorses the legalization of euthanasia or PAS. This figure is comparable with the rates of support that are found in surveys of the Canadian general public. The study concluded that their general attitudes toward the social policy question of legalization might not be very different from those of the public at large. The pain was reported as a problem of at least moderate severity by 9 (40.9%) of the participants who desired a hastened death. Therefore, the pain was a contributing factor for some individuals, even though its overall prevalence was not elevated in this group in comparison to other participants. More generally, however, the physical symptoms that were more frequent were not acutely desperate crises with pain or dyspnea but rather the more protracted features of advanced disease, such as general malaise, weakness, and drowsiness—some of which may have been caused by medications used to treat other symptoms.[11]

Also, from a psychological perspective, prominent concerns with isolation and communication difficulties, existential issues regarding the loss of resilience and control, and symptoms of depression and hopelessness were more common among participants with a desire for hastened death, although in each case they were reported by only a minority. There is evidence that depression can be treated in palliative care, so the significance of this finding lies in reaffirming the importance of screening for potentially treatable mental health problems. [11]

Similarly, under Article 21 of the Constitution of India, it has been argued that the right to life and liberty encompasses individual dignity, hence the right to live with dignity. The CB of the SCI recognizes the right to privacy as a fundamental right under Art. 21 and presented the principle of self-determination with a higher value.[1]

Concerning California and Hawaii, older participants were more supportive of PAD compared to their younger counterparts in both states. People who reported that spirituality was less important to them were more likely to support PAD in both states. All ethnic groups in both California and Hawaii were overall in support of PAD. In California, 75.6% of non-Hispanic whites, 74.3% of Asians, and 71.6% of Hispanics were in favor of PAD compared to 59.6% of African Americans. In Hawaii, 77.9% of non-Hispanic whites, 77.5% of Asians, 75.3% of Native Hawaiian / Pacific Islanders, and 63.6% of Hispanics were in support of PAD. Within Asian Americans, Chinese were most favorably disposed toward PAD (82.7% in California and 85.5% in Hawaii), followed by Japanese (74.6% in California and 76.5% in Hawaii) and the Filipino Americans (67.7% in California and 76.5% in Hawaii).[4]

Terminal medical conditions, terminal illnesses and quality of life

Euthanasia, as understood by the Canadian Medical Association, refers to the practice of knowingly and intentionally performing an act, with or without consent, that is explicitly intended to end another person's life from an incurable illness. Moreover, the caregiver must know about the person's condition, hence, commits the act with the primary intention of ending the life of that person, with empathy and compassion and without personal gain. The Supreme Court of Canada has ruled for restricted access to euthanasia and physician-assisted-death interventions to competent adults, or any competent person who has reached the age of 18.[6]

In broader terms, this ruling it is defined as "The Act" and treatment is described as anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purposes, and includes a course and a plan of the treatment or a community treatment plan. [6]

Certainly, patients must meet a standardized capacity, which requires that they be able to understand the information relevant to deciding on the treatment while being able to simultaneously appreciate the reasonably foreseeable consequences of a decision or lack of decision. Specific to Ontario legislation, consent to treatment is considered informed if before giving it, the patient received information that another reasonable patient in the same circumstances would be required to decide and which complied upon the procedure. This requires that they can understand the presented information and appreciate the future consequences of consenting or refusing to comply with the intervention.[6]

In the Netherlands, physicians have more reservations about less common reasons such as a psychiatric or psychological condition, like dementia, or being tired of living.[5] However, in 80% of cases, the main reason for euthanasia is the patient's wish or that there is no prospect of improvement on the patient's condition. This percentage is higher than those for pain or other symptoms.[12]This possibly points an increasing demand for patients to control their end-of-life.[13] In South Asia, Indian cases in which a terminal condition has become overwhelming for a patient, and pain management is inadequate, leave death as the only capable thing to bring relief. In these situations, passive or active euthanasia can be thought as a way to uphold the 'right to life' by honoring the 'right to die with dignity.' Besides, an argument against the mentioned above is that with advancing medical technology, it is possible that patients ill today may be cured tomorrow. Re-Emphasizing that society has no right to kill any person with an incurable sickness, consequently denying them a chance of a future recovery.[7]

Palliative Care

Palliative care includes supportive care provided by the medical team, such as alleviating symptoms of pain and stress. Research has shown that among patients receiving palliative care for cancer, their willingness to accept euthanasia or PAS as a form of treatment, is associated with religious beliefs, functional status, physical, social, and psychological symptoms and concerns. Moreover, researchers found among patients in palliative care that if euthanasia had been legally available in the country, 5.8% of these participants would have taken direct action to end their lives. In jurisdictions that allow euthanasia or physician-assisted suicide, patients with cancer comprise the largest group to die by these methods, and many patients with advanced cancer were in favor of policies that would allow them access to both euthanasia and physician-assisted suicide if pain and physical symptoms became intolerable.[11]

However, advances in pain management and palliative care and their implementation hinges on adequate training in pain management and palliative care.

Trusted primary care providers are best positioned to mitigate their patient's symptoms and help them navigate complex end-of-life decisions. With a combination of excellent symptom management and skillful communication from the time of the diagnosis of a severe illness, suffering could be prevented. A careful assessment of the patient's mental health status is essential, as it is also the assessment of social support systems and family structure. Aggressive and prophylactic management of distressing symptoms is critical to preventing patients from reaching a depth of suffering at which they feel that PAD would be their only recourse.[4]

On the other hand, in the case of India, although passive euthanasia has been granted legal recognition, the judgment failed to contextualize the debate of the "right to die" since there is little organization in the healthcare system and an existing inequity in access to healthcare. Currently, in India, the only universal healthcare coverage is the National Health Protection Scheme (NHPS), which has been criticized for its overall lackadaisical conceptual framework and unviability in terms of availability of public funds. Many people in India are forced to embrace undignifying deaths because of a lack of resources to access the necessary healthcare.[1]

The practice of analgesic care counters would provide relief from distressing symptoms and pain, giving support to the patient as well as the caregivers.[7] Regardless, the patient may refuse palliative care or treatments, which does not always have to stand in the way of granting the euthanasia request. An alternative solution may not be considered reasonable if the patient rejects it, even though in medical terms, it may well have provided benefit. This way, the code of practice gives room for a shift towards a practice of euthanasia that is predominantly based on the patient's autonomous choice.[13]

Protocols and Medications

In Canada, when given the distribution of patient conditions and their desire for an ongoing physician-patient relationship when assisted death or euthanasia are pursued, assistance in dying would be best performed by a general practitioner or family physician. However, it may be able to be performed through a trained specialist if requirements are met. Additionally, before providing a patient with assistance in death, the process requires that potentially vulnerable populations are being protected and that a second opinion should be implemented to ensure that patients are meeting the required eligibility criteria.[6] Protocols to legally apply PAS include a review of the following: demographic and social characteristics, religious practices, attitudes toward euthanasia and PAS, a diagnostic assessment of depression and anxiety disorders, an inquiry into a range of common physical, social, and existential symptoms and concerns.[11]

Concerning assisted suicide, the latter is performed most often by drinking a barbiturate derivative, which causes low blood pressure and oxygen saturation drop with unpredictable duration. Even though this approach has been proposed by others, it is unknown whether organ donation is still medically possible. Euthanasia implies the intravenous admission of a coma inducer and a muscle relaxant, causing the patient to die quickly, often without severe ischemia to the organs.[12]

Notwithstanding, a terminally ill adult California resident with intact decisional capacity has the right to request their attending physician for an 'aid-in-dying' drug prescription. Two physicians must confirm that the patient has an incurable and irreversible disease and will likely die within six months. The terminally ill patient must make three requests to a physician: two verbal requests 15 days apart and a written request attested by two witnesses. If the patient cannot verbalize their request due to the inability to speak, it is not clear that they will be eligible for PAD. Patients with cognitive impairment will not be eligible to request a lethal prescription.[4]

If patients have portable orders for end-of-life care, such as Physician Orders for Life-Sustaining Treatment (POLST) or portable Do Not Resuscitate (DNR) orders, Emergency Physicians (EP) and EMS directors should advise EMS responders to respect these portable orders regarding interventions ranging from invasive life-prolonging measures, to non-invasive respiratory support, to palliative interventions only. EMS should generally transport patients in this circumstance to facilities to optimize palliative interventions unless arrangements for available and sufficient hospice care are already in place. To patients arriving in the ED after ingesting a prescribed lethal medication, EPs should be cautioned against ongoing assistance in completing the suicide by providing additional lethal medication in this circumstance. EPs should provide only comfort care if they have reliable evidence that the patient intends to complete the dying

process but should take active measures to preserve life if they have reliable evidence that patients have changed their minds and no longer desire to end their lives. Orders for limited interventions and palliative interventions only remain subject to rescission by patients with decision-making capacity or their legally authorized surrogates.[14] In India, training should be given to doctors about the use of modern medical science and technology which could determine to a great extent the course of the decision while meeting with terminally ill patients.[7]

Psychiatrists might be involved for mental capacity assessment, mental health assessment, and to check the eligibility of the person for PAS if, in the future, the courts of law decide to legalize it in India. Social services, palliative care specialists, and psychologists may also be involved when making such decisions.[15]

Religious Beliefs

Different religions across the world come from different cultural systems that help shape civilizations, countries, and governments. Most religions do not support the act of deliberately hastening death. Understandably, religious beliefs play a fundamental part in social acceptance as well as decision making regarding PAS-E. Most commonly, patients with any religious affiliation have a significantly higher likelihood of opposing euthanasia compared to those not affiliated with any particular religion. Catholic nurses have lower rates of acceptance of euthanasia compared to nonreligious nurses. Similarly, Catholic physicians have significantly higher rates of disagreement with non-Catholic physicians regarding the legalization of and active participation in euthanasia/PAS.[16]

Canada has studies showing that desired death was associated with lower religiosity, reduced functional status, a diagnosis of major depression, and more considerable distress. Specifically, among patients receiving palliative care for cancer, the desire to accept euthanasia or PAS is associated with religious beliefs, functional status, and physical, social, and psychological symptoms and concerns. Although this desire is sometimes transitory, once firmly established, it can be enduring. In a conducted study participants who acknowledged no religious affiliation were most likely to be in favor of legalization (55 of 62; 88.7%), followed by members of Protestant faiths (95 of 147; 64.6%), by those who indicated other religious affiliations (19 of 34, 55.9%), and finally by Roman Catholics (69 of 136, 50.7%). Notably, the most frequently cited concern in this dimension was a fear of intolerable pain. Finally, some participants believed that hastening one's death could be a generous act serving to reduce the stress and burden on strained family members or health care resources. For one, they had lower religiosity and were less likely to be of the Roman Catholic faith. Therefore, they had no fundamental moral objections to euthanasia or PAS that were grounded in religious tenets. [11]

In South America, different aspects persuade the opinion of the population; in this case, is religion and spirituality. In the Mexican population, those who are not religious have a more favorable view of euthanasia. In this group, passive euthanasia is favored by 63.8%, while 60.8% favors active euthanasia. Those who are religious, on the other hand, have shown a predominantly negative posture towards all forms of euthanasia. However, there is a more favorable improvement towards the use of euthanasia from the religious sector, only if there is a previous written statement from the patient itself requesting its use.[10]

In Europe, atheists in Italy were more likely to be in favor of euthanasia (44.6%) than non-practicing Catholics or practicing Catholics. Nonpracticing Catholics (42.5%) were more likely to be in favor of assisted suicide than practicing Catholics (16.5%), and atheists (38.4%) ($P < 0.001$). Years of experience, gender, and the geographic macro area did not influence the choice of assisted suicide (P ¼ 0.374, P ¼ 0.587, and P ¼ 0.770, respectively, Fisher exact test) [5]. In another study showed that only 15% of Catholic Italian primary care physicians had been shown to favor euthanasia/PAS, whereas 33% agree with withdrawing/withholding treatment in appropriate situations. However, more than 80% of the Catholic healthcare systems in Belgium permit euthanasia for competent terminally ill patients.[16]
In Great Britain, religious denominations also seem to impact on the attitudes towards PAS. Those who attend church regularly, or at least once a week, are less likely to be supportive of a change in the law regarding euthanasia than those who never attended. Non-Christians, whose numbers grew in recent years, are about four times less likely to support the legalization of euthanasia than those with no religion. Roman Catholics are more than twice as likely to oppose the legislation, although this relation is at the verge of significance in some of the years. For both religion and religiosity, there does not appear to be

any definite trend in the magnitude of the effects over time. None of the other covariates demonstrated a consistent effect on the attitudes towards euthanasia across the six years of the study. Analysis of the study suggests an increase in support for legalization of euthanasia in Britain over time from 75.8% in 1984 to 83.8% in 2012. While the change of 8% points may not seem dramatic, it remains statistically significant.[17]

It should be remembered too that the high initial support might have limited the potential for further increases over time. The increase in support coincides with an increase in the degree of secularization recorded in the survey as measured by the percentage reporting no religious affiliation and the percentage reporting non and infrequent attendance at religious services. The most substantial changes in the support for euthanasia legalization over time happened among the least religious groups, while in the group of most religious people, little change in attitudes is evident. Further analyses have shown that consistently the most significant observable determinant of opposition to the legalization of euthanasia is religious beliefs and the strength of those beliefs as evidenced by the frequency of religious service attendance. It is unsurprising therefore that support for legalization of euthanasia has increased in Britain over the past 30 years coinciding with an increase in secularization.[17]

The probability of agreement with the practice of euthanasia was found to be inversely related to the degree of intrinsic religiosity among physicians who practice Judaism. Among elderly Jewish women in Belgium, an overwhelming majority of Orthodox Hasidic and non-Hasidic women rejected euthanasia/PAS; a positive outlook was in secularized respondents.[16] The Exodus 20:13 is cited in Jewish and Christian tradition as the basis of condemning suicide. However, one study notes that suicide per se is neither condemn nor approved in the Bible.[4]

In Buddhism, more than half of elderly Chinese subjects in Singapore agreed that euthanasia should be allowed under appropriate circumstances, although a third of these respondents disagreed about pursuing euthanasia even in the case of futile circumstances. In Iran, nurses which the majority of whom were Muslims, were found to have negative attitudes toward euthanasia in about 60% of respondents. In Pakistan, a patient survey found only 9% advocated PAS, and those who did were likely to be female, married, elderly, and educated. Also, elderly Muslim immigrant women in Belgium have been shown to have a predominantly negative attitude toward euthanasia.[16] The Islamic jurisprudence in India does not recognize a person's right to die voluntarily since according to Islamic teachings, life is a divine trust and cannot be terminated by any form of active or passive voluntary intervention. In Islam, "life is sacred, and euthanasia and suicide are not included among the reasons permitted for killing, and Allah decide how long each of us will live".[7] Supporting this reason are two verses of the Holy Quran:

"Moreover, do not take any human being's life, which Allah has made sacred save with right/justice, and do not kill yourselves: for verily Allah is to you most merciful".[7]

"The moment of death is under the control of Allah, and humans have no say in this matter; the human cannot and should not attempt to hasten or delay the death".[7]

Religious doctors felt that PAS must not be considered, and it would be against their belief system irrespective of whether they were Christians or Muslims. In contrast, Jainism is one religion that permits suicide but with restrictions. Jain scriptures talk about ending life in a dignified way in Sutra krtraanga and say, 'When a wise man, in whatever way, comes to know that the apportioned space of his life draws towards its end, he should in the meantime quickly learn the method of dying a religious death.' [15] The scriptures of Sutra krtraanga identifies a holy fast unto death and brings about with dignity and dispassion (sallekhana). However, within the Jain religion and traditions, this method of ending life is not regarded as an act of suicide. According to Hinduism, if a person commits suicide, they neither go to hell nor heaven but remains in the earth as a bad spirit and wanders until he or she completes the allotted lifespan. Committing suicide is considered a violation of the code of Ahimsa (non-violence) and is therefore as sinful as committing murder. Sikhism, Buddhism, Christianity, and Judaism reject or forbid the assisted killing of another person and suicide.[15]

The legalization of euthanasia

On the 6th of February 2015, the Supreme Court of Canada (SCC) invalidated the Criminal Code provisions that prohibit 'Physician-Assisted Death.' Although the government made euthanasia in Canada legal in Quebec since 2014, this ruling was suspended until June 2016, in order to provide the federal

government and stakeholders with the opportunity to develop legislation, policies, and protocols for PAD, which made euthanasia legal nationwide since 2016.[11]

In their decision, the SCC did not attempt to define either physician-assisted death or euthanasia explicitly but presupposed the Canadian Medical Association definitions. Nonetheless, the SCC declared both Section 14 and part 'b' of Section 241 as an unjustifiable infringement on a competent individual's Section 7 rights. It can be reasonably inferred that both physician-assisted death and euthanasia, as commonly understood, ought to be considered permissible. As defined in the act, medical assistance in dying refers to care consisting in the administration, by a physician, of medications or substances to end the life of the patient, at their request to relieve their suffering by hastening death.[11]

Regarding the eligibility criteria, the act lays out some requirements. The patient must be of full age, insured, capable of providing consent, at their end of life, suffering from an incurable illness or from an advanced state of irreversible decline in their physical capability, and suffering from constant and unbearable physical or psychological pain, which cannot be relieved in a manner that the person deems tolerable.[11] Also, the patient must present themselves a request aid in dying through a standardized form, although a third party may sign the form if the patient is physically incapable of doing so. Notwithstanding, the act does not allow for medical aid in dying when it is requested through an advance directive.[6]

In the case of Mexico, euthanasia is only permitted in three regions (Aguascalientes, Michoacán, and Mexico City) and only the passive form is legal, while the active form remains illegal. In Colombia, euthanasia was legalized in 1997, and it was the last country in Latin America to legalize euthanasia across the country, to allow a patient who suffered from a terminal illness to take his life. The Constitutional Court of Colombia established 3 elements for the application of euthanasia in terminally ill patients: "(I) The passive subject suffers from a terminal illness; (II) A doctor must be the active subject who performs the act or omission to end the patient's pain and; (III) It must be produced by specific request, reiterated and informed of the patients". [18]

Still, it was legal to proceed with euthanasia and had the approval from the government, specific laws in the Colombian constitution, that were mainly enacted from a robust Catholic point of view, made difficult the implementation of the legalization of euthanasia. The Congress at that moment in time did nothing to alter these previous laws that made difficult the implementation and usage of euthanasia. For that reason, the law was reviewed in 2014 and the appropriate amendments were made. The Colombian Ministry of Health was ordered to educate health providers about the legality of applying euthanasia, and the right of the patient to request this method to end their lives because of a terminal illness.[18]

In India, only passive euthanasia is legal but restricted. On March of 2018 for the first time and after approximately 15 years the Constitution Bench (CB) of the Supreme Court of India (SCI) granted legal recognition to "advanced medical directives" or "living wills", and reiterates the legal recognition of the right to "passive euthanasia", as by the Art. 21 (the right to life) of the Constitution of India also should include the "right to die with dignity." The judgment has sustained legal permissibility of advance directives concerning the withholding or withdrawing of life-sustaining treatment, which leads to implications for the draft Medical Treatment of Terminally Ill Patients Bill (which is still pending before parliament), a safeguard for patients and medical practitioners. Clause 11 of this bill considers advance directives or medical power of attorney to be annulled and not binding on any medical practitioner.[1] In India, it was not until 1994 that Section 309 of the Indian Penal Code was defied, which made both supporting suicide and attempting a suicide illegal, under Article 21.[7]

The Supreme Court of India in a path-breaking judgment allowed "passive euthanasia" o retreating life support to patients in Persistent Vegetative State (PVS) but did not permit active euthanasia of terminating a patient's life through the administration of a lethal injection. The SCI maintained their position that the right to die was not permitted under Art. 21, but causing the death if a PVS patient, with no chance of recovery, by withdrawing artificial life support is not a 'positive act of killing.'[7] After this, on March 7th 2011, the Supreme Court decided to legalize 'passive euthanasia' on the case of Aruna Shanbaug ("a nurse who is living in a vegetative state for the past 37 years after being brutally assaulted by a hospital worker"), after a review of medical experts, while leaving 'active euthanasia' illegal. Every citizen residing in Indian territory shall have the right to live with dignity and should not be forced to die.[2] According to Penal Code 1860, active euthanasia is an offense under Section

302 (punishment for murder) or at least under Section 304 (sentence for culpable homicide not amounting to death).[15]

In Europe, euthanasia and assisted suicide have been legal in the Netherlands and Belgium since 2002. In Switzerland, assisted suicide is allowed, although no specific legislation exists on the subject. When both practices are legally permitted, euthanasia occurs more frequently than assisted suicide. In Italy, these procedures are illegal but highly debated in special clinics.[5] In Serbia, there are strong efforts for the legalization of euthanasia and PAS in relation to it. Nonetheless, assisted suicide in Serbia is considered a criminal offense by the Article 199 of the Criminal Code, entitled 'Inducement to suicide and assisted suicide.' Thus, the same article regulates the parameters of assisting and inducing a person to commit suicide. [3]

Among the provisions that regulate offenses against public health, there is no difference between a criminal act and that of PAS, as in some other legislation, leading to the crime of assisted suicide. Therefore, the perpetrator of this criminal act may be any person, making it irrelevant whether it is performed by a physician. The basic form of the felony consists of encouraging or aiding someone to commit suicide, and if the act itself is attempted or committed. If someone assists in suicide to a juvenile or to a person who is in a state of considerably diminished mental capacity, he or she will commit a more severe form of this felony, which is punishable by imprisonment from two to ten years. If someone assists in suicide to a child or mentally incompetent person, it can be punishable by imprisonment from at least ten years and up to 30 to 40 years. [3]

Furthermore, assisted suicide has been legalized in Luxembourg, the Netherlands, Germany, and Switzerland. In Belgium, the Netherlands and Luxembourg euthanasia has been legalized although not mentioned explicitly in legislation.[19] Despite its legalization in several jurisdictions, the hastening of death remains the subject of intense debate in these and other jurisdictions. In the UK, there is an ongoing debate on the issue of legalizing assisted suicide, though less attention is devoted to euthanasia. In England, Wales, and Northern Ireland, individuals who assist in the death or suicide of another could face prosecution under the 1961 Suicide Act. However, in 2010 the Director of Public Prosecutions issued guidelines for England and Wales detailing provisions under which a prosecution would not be pursued (Crown Prosecution, Service, 2010).[17]

Assisted suicide has been legalized in seven states of the USA; Vermont, California, Hawaii, Washington, Oregon, Colorado, Washington D.C., and Montana. In the state of Vermont, male physicians were significantly more likely to favor legalization of PAS (42% males vs. 34% females), whereas female physicians were more likely to be ''undecided'' on the matter (23% females vs. 14% males). Retired physicians, in comparison to their practicing counterparts, were more likely to favor legalization of PAS (54% vs. 37%, respectively). Doctors who did not care for patients through the end-of-life, held the position that PAS should be legalized (48%), whereas those who did care for patients with a terminal illness (33%) opted out. Only 44% of doctors who had experienced previous requests for PAS support legalization, whereas only 36% of those who have not to experience patient requests for PAS. The higher percentage of physicians receiving PAS requests, mentioned above, could be attributed to the recent increase of public awareness and discussion surrounding this issue. Physicians who had received a specific patient request for PAS were more likely to support legalization, suggesting that patient's demand may prove to be a significant factor in changing the opinion of physician.[8]

In the state of California and Hawaii, older patients were more supportive of PAD. Individuals who reported that spirituality was less important to them were more likely to support PAD in both California and Hawaii. In both states, all ethnic groups were overall in support of PAD. Specifically, in California, non-Hispanic whites, Asians, and Hispanics were in support of PAD, compared to African Americans who did not support it. In Hawaii, non-Hispanic whites, Asians, Native Hawaiian/Pacific Islanders, and Hispanics were in support of PAD. Within Asian Americans, Chinese were most favorably disposed toward PAD (82.7% in California and 85.5% in Hawaii), followed by Japanese (74.6% in California and 76.5% in Hawaii) and the Filipino Americans (67.7% in California and 76.5% in Hawaii).[4]

In Europe, laws, and practice about PAD differs considerably from those in the United States, in where the legal requirements focus on the physician's assessment of a patient's unbearable suffering and illness, without prospects of improvement on their condition. PAD in the Netherlands and Belgium, have

expanded its access for adolescents, individuals who have not made an explicit request, and patients with a mental disability, but not necessarily with a physical illness. In Switzerland, the law specifies that for assisting a suicide, a physician-patient relationship is not required, and it is punishable only if done for "selfish reasons." Patients must be competent and have an incurable disease, though not necessarily terminal. Medications can be administered intravenously, but the administration must be under the patient's control. [20]

A Right-to-Die organization from the UK, called Dignitas, offers assisted suicide almost exclusively to nonresidents. Between 2008 and 2012, the organization helped 611 noncitizens, predominantly from the UK and Germany, to die. In contrast to the United States, the number of physician-assisted deaths is increasing rapidly in the European nations, where the practice is legal. In Oregon and Washington, every case of legal physician-assisted death must be reported to the state; if not reported, the physician is not eligible for the legal protections that the laws provide. [20]

The divergence in the rate and growth of Physician-Assisted Death between the United States and Europe defies a natural explanation. On the surface, the differences in the process of care are extraordinary. For example, in Oregon, 18% of those who made an explicit request for PAD received a prescription for a lethal medication; however, 77% of applications for euthanasia were granted in Belgium. Palliative care clinicians are considered to have the expertise required to help patients find other alternatives to PAD, but disparities in access to palliative care services do not account for the differences in rates. Palliative care services preceded euthanasia in 74% of cases of physician-assisted death in Belgium. 90% of people in Oregon who received physician-assisted death were enrolled in hospice. [20]

Overall, in the United States, much of the clinical work has been done by a small number of physicians. In Oregon and Washington, nonprofit advocacy organizations provide counselors to enable patients to navigate the process. This counseling system relies on volunteers. This is important because some medical policies and hospices with religious affiliations prohibit their staff from participating, and even ask patients not to discuss their interest in physician-assisted death with their employees.[20]

Patients considering physician-assisted death should have access to palliative care services and hospice before, but the current shortage of palliative care physicians and nurses may limit the involvement of expert clinicians. A call to action to ensure high-quality care by expanding access to palliative care, especially earlier in the trajectory of illness before interest in physician-assisted death is expressed. Providing high-quality training to physicians and other clinicians in the communication skills needed to sort out a patient's fears, wishes, and values as well as advocating for continued and comprehensive public reporting systems about physician-assisted death. Physician-assisted death should remain an end-of-life practice of last resort for those who have made an informed choice and meet the legal criteria. [20]

Ethics vs. Moral

Among the many topics that can be considered when pursuing a balanced and neutral analysis of euthanasia, the opinions of physicians, patients, and society regarding euthanasia can be controversial. Personal opinion can vary depending on the country, and how euthanasia is seen both socially and religiously. In the case of physicians, it can also be influenced by the different conditions that may arise, such as a terminal illness, where the conventional approach and procedures can change, and euthanasia could be involved as an alternative.

For example, Mexicans opinion regarding the use of euthanasia is tightly attached to spirituality and religion. A survey was conducted to access the public opinion of Mexicans regarding euthanasia, asking a series of questions that covered every possible aspect: The administration of the drug, the level of freedom physicians should have for administering the drug, and even if the person asking for the treatment should have the freedom to go forward with the administration of euthanasia. From a general standpoint, it had low acceptance in the population as only 30% of that surveyed favored passive euthanasia, and just 18% supported the active form. [10]

However, compared with a more recent survey of the population at the time (2008), an increase was seen in the acceptance of the use of euthanasia among the population as 40% of those interviewed this time favoring both forms. In the case of the professionals in the medical field, a survey was conducted on medical students from Nuevo Leon Mexico, also being asked their opinion regarding the implementation of

euthanasia on terminally ill patients. A 44.4% of those surveyed, favored active euthanasia, 52.1% favored the use of passive euthanasia, and a 44.8% had positive thought regarding its use, at a personal level.[10]

In Canada, research determined that physical suffering, emotional distress, and loss of independence are the most common factors that prompt patients with ALS to request PAD. Concerning ALS disease, most of society's opinion agreed that a patient with moderate stage ALS and severe stage ALS should be eligible for physician-assisted suicide. A lower proportion of respondents agreed with the option for physician-administered lethal injection (voluntary active euthanasia). Nonetheless, there is dissent from physicians on accepting PAD eligibility for a patient with mild stage ALS. Only a minority of physicians who agreed with PAD eligibility in each scenario were willing to actively participate by providing a prescription for a lethal dose of oral medication in the moderate and severe stage ALS scenarios, or administration of an IV lethal injection for active euthanasia in the critical stage ALS scenario.[19]

The majority of respondents in their study believed a second opinion by a clinician with ALS expertise was required to confirm PAD eligibility. Additionally, palliative care experts who agreed with PAD in each scenario were less willing to provide lethal prescriptions and administer lethal injections to requesting patients. Overall, the majority of respondents agreed with the SCC ruling on PAD. The support was higher among AHP than physicians. Despite high levels of support for PAD, the survey revealed a small number of respondents who remain staunchly opposed. The right of conscientious objection is well-recognized in biomedical ethics, and there remains a struggle to find a balance between a physician's right to not participate in PAD and the patients' right for equal access to legal, medical services. These opposing interests will continue to challenge society for controversial medical issues such as PAD and abortion, which is still disputed despite legalization in Canada for almost three decades.[19]

Only a minority of ALS health care providers believe PAD should be available to patients with ALS at all disease stages. Most ALS clinicians and AHP thought that a second opinion from an ALS expert to confirm eligibility and a psychiatric evaluation to assess for reversible mood disorders should be required for PAD eligibility. A prior study has shown that depression is rare in patients with ALS who receive PAD, but patients were not uniformly assessed by psychiatry.[19]

In the case of Puerto Rico, a questionnaire was handed to a group of medical students, residents, interns, and faculty members of various hospitals, in different regions of the island, to know the level of acceptance of euthanasia among the medical field professionals on the island. Topics covered in the questionnaire included: Support of active euthanasia, physician-assisted suicide, withholding or withdrawing life-sustaining treatment with informed consent, how ethical was to prescribe full doses of drugs needed to alleviate pain even if they accelerated the death process, or agree to limit or restrict resources for the terminally ill were asked about in the questionnaire. [21]

Results showed that 40% of the students and 20% of the faculty supported the use of euthanasia, and if the use of euthanasia was legalized, the percentage of students favoring its use increased to 50% of students and increased to 45% among faculty members. Also, 68% of the students and 88% of faculty members supported withholding or withdrawing life-sustaining treatment for dying patients, only if there was a previous informed consent from the patient. However, when it came to prescribing full doses of drugs to alleviate pain in dying patients, only 54% of medical students, compared to 80% of the faculty members, supported the initiative, and 36% of residents, compared to only 16% of medical students, would agree to limit the use of medical resources for the terminally ill. [21]

In Italy, 31.9% of physicians working in hospice or home care were more likely to be in favor of euthanasia. Younger physicians, on the other hand, were more likely to be in favor of euthanasia [5]. In the case of the Netherlands (2018), the Dutch Right to Die Society (NVVE) in 2012, founded the 'End-of-Life Clinic.' The clinic aimed to offer euthanasia, within the limits of the law, to people whose treating physician rejected their request for euthanasia or assisted suicide. The End-of-Life Clinic seems to support and enhance the emphasis on the autonomous wish of the patient in euthanasia practice because it is essential to aim is to grant a euthanasia request in case of unbearable suffering without the prospect of improvement, just as the euthanasia law permits. [13]

Also, in the Netherlands, a 2010 study from the Dutch KOPPEL showed that most Dutch physicians, and the public, support Netherlands legislation at the time regarding the application of euthanasia. However, both groups seemed reluctant regarding the use of euthanasia, when the patients' suffering was of a psychological origin or nature. Six years later, a third evaluation of the euthanasia law was made (2016), and it showed a similar picture as far as the opinions of physicians regarding its use was concerned, but in the case of its citizens regarding the use of euthanasia, there was an even more favorable view for situations of non-somatic suffering.[13]

In the fact of Serbia, only 51.1% of physicians consider PAS as an acceptable alternative patient who is in their terminal phase of the disease, and 48.9% see it as a detrimental alternative. Nonetheless, EMT's (Emergency Medical Technicians) were sharply divided. In a survey, 19 were asked about their opinion regarding the use of euthanasia, 10 answered YES while 9 answered NO. A similar study was conducted with emergency room physicians, and almost every physician was against PAS (89.47%), while in the third department (a combination of the Cardiology, Surgery and Transfusion departments), 66% of physicians were in favor of PAS in such cases, while 34% was against it. [3]

The majority of physicians were willing to prescribe a medication for PAS, in the case that the procedure was legal, and the patient was in the terminal phase of an incurable disease. In the third department, however (integration of the Cardiology, Surgery, and Transfusion departments), 56% of physicians were willing to prescribe medication, while 44% would not specify the drug. Regarding legalization, the main question was if those physicians were in favor or against PAS in all age groups, 52.3% of physicians were against PAS legalization (52.3%), while 47.7% were in favor. In the case of physicians of the emergency room, just two physicians were in favor of PAS legalization.[3]

In the United States, in the state of Vermont, physicians' attitudes toward PAS are sharply polarized. Prior research found that increased physician age was associated with an expanded agreement with legalizing PAS. Other study results found that hematologists and oncologists, physicians who often deal with patients with a terminal illness, tend to oppose the legalization of PAS. One possible explanation for this finding is that physicians more experienced with palliative care measures believe that specific legislation directing their practice is not required. Decreased support for euthanasia and PAS has been correlated with increased training and perceived knowledge in palliative care among hematologists and oncologists. [8]

Of the physicians supporting legalization, 92.9% cited patient autonomy as a factor in their decision, and 82% also cited intractable pain. Those who believe it should be illegal, moral and ethical beliefs were a factor for 84.3%, and potential for misuse was a factor for 62.8%. Physicians in favor of not legislating PAS were most likely to cite doctor-patient relationship (74.3%) and moral and ethical beliefs (75%). [8]

From the respondents, 50.1% said they would participate in PAS, while 37.7% said they would not participate. The retired physicians, 60% stated they would join in PAS if a law were passed compared with 47.6% of currently practicing physicians. 53.3% of physicians who do care for patients with terminal illness stated they would participate in PAS if it were legal. By contrast, 44.7% of physicians who do not routinely care for patients with a terminal illness said they would participate.[8]

In the past, although India legally recognized the Right to Privacy, passive euthanasia remained illegal. This was until the 'Puttaswamy judgment' pronounced that the Right to Privacy is protected as an intrinsic part of the Right to Life and Personal Liberty under Article 21, and as part of the freedoms guaranteed by Part III of the Constitution of India. This judgment is widely hailed as a landmark judgment on the privacy of individuals.[1]

However, the judgment of the legalization of "passive euthanasia" does not take awareness of the continuing debate regarding the ineffectiveness of the distinction between passive and active euthanasia. Decreasing human suffering and augmenting patients' autonomy "ought to be foundational to the notion of dying with dignity in specific situations. These two principles serve as the moral imperative of euthanasia". [1]

Since society has acknowledged a patient's right to passive euthanasia, by legally recognizing refusal of treatment to sustain life, active euthanasia should be permitted. However, it is argued that if 'the right to death with dignity' is embraced, "people with terminal and unbearable sickness will be cast off from society. [7] Current literature shows that cultural differences may

account for some inequalities related to assisted suicide.[15] Jain leaders, a powerful religious group in India, say the constitution protects the fasts and people have the right to decide to die with dignity. [1]

Organ donation

Euthanasia is legally possible in the Netherlands, Belgium, Luxembourg, and Colombia. Some other countries and states in the United States have legalized assisted suicide.[12]Some patients who undergo euthanasia wish to donate their organs. In this circulatory donation death (DCD) procedure, it is possible to donate the lungs, liver, kidneys, and pancreas, except the heart, due to concerns surrounding prolonged warm ischemia time. Although the majority of patients undergoing euthanasia suffer from malignancy, are too old or have other comorbidities that preclude them from organ donation, research has shown that up to 10% of all patients who undergo euthanasia may be suitable organ donors.[22]The patient's euthanasia request will often result from a process of increasing insight and knowledge during illness and after a constant dialogue between the treating physician and the patient. Different options will be discussed, like palliative sedation, pain relief, and going to a hospice. The combination of euthanasia and organ donation is not a common practice, often limited by the patient's underlying pathology, but has been performed >40 times in Belgium and the Netherlands since 2005. Before December 2015, organ donation after euthanasia was performed 15 times in the Netherlands and resulted in the donation of eight pairs of lungs, 13 livers, 13 pancreases, and 29 kidneys. [12]

Although directed donation after death is possible in the United States, allocation in the Netherlands is done by Eurotransplant, using a procedure that does not enable the donor to choose the recipient or recipients. In the past, donors have asked who would become the recipients of the different organs. It is not legally allowed to convey this information for reasons of privacy. The answer also might put additional pressure on the donor to continue the process, even if the donor is having thoughts about withdrawal from the donation process. It could also create additional stress if the patient is informed that there is no suitable recipient for an organ. [12]

This approach seemingly contradicts the principle of patient autonomy and could give rise to frustration in the patient as well as the eligible recipient, potentially even causing the patient to abandon the donation procedure. Some organ donors expressed the wish to donate all of their organs, including their heart, which is not currently common practice in DCD. A theoretical possibility would be to perform euthanasia by removing the heart, under general anesthesia.[12] "Organ donation euthanasia" (ODE), upon a request to be anesthetized with subsequent removal of organs—including the heart—in a "living organ donation" procedure and would maximally respect the patient's autonomy but may give others the impression that patients are killed for their organs".[22]

The dead-donor rule (DDR) is an internationally applied rule in organ donation stipulating that organ procurement itself must not cause the death of the donor. Donated organs in such manner would safeguard improved clinical outcomes and output concerning graft acceptance. [23] The "dead donor rule," as well as the current Dutch Euthanasia Act, currently does not allow such a "heart-beating" euthanasia–donation procedure.[12] "When living donation could lead to serious consequences for the donor, or when it concerns organs that do not regenerate, it only be carried out when the recipient is in a life-threatening situation".[22]

Controlled donation after cardiac death (cDCD) is a protocol undertaken in Canadian provinces. Specifically, cDCD most often occurs in cases where the patient has a severe neurological injury but does not meet all the criteria for brain death. Specifically, the patient is in an unconscious state and has a poor prognosis stated by the medical personnel. The potential organ donor is a patient who is dependent on LST such as a ventilator or hemodynamic support. The donation is after the decision to withdraw life-sustaining treatment (LST). In cases where patients are conscious before the withdrawal of LST, are unusual and have raised doubts as to the acceptability of removing organs from individuals who are not neurologically impaired and who have voluntarily chosen to die.[23]

By mentioning the possibility of organ donation after euthanasia, the physician appeals to the patient's right to self-determination and creates awareness and a mindset regarding this perhaps unknown possibility. It is possible that the option of organ donation is raised by the patient, even before the issue of euthanasia has been discussed. If the patient wishes to become an organ donor, the performing physician verifies whether the patient is registered as an organ donor or

has the patient sign an advance directive. It could be comforting to the patient to know that he or she can help people survive and to improve their quality of life. Alternatively, when a patient is suffering so severely that he or she asks to undergo euthanasia, it may be inappropriate to discuss organ donation.[12]

Current guidelines state that only the patient should pose the question of organ donation, and only after a positive response to the euthanasia question, thus keeping both procedures strictly separated.[22]The treating physician should investigate whether others, like a person in need of an organ, are persuading the patient to consider euthanasia to make organs available and whether the patient might be requesting euthanasia because he can donate organs. Nevertheless, it is important not to discourage the patient's altruistic intentions. As long as the patient meets the due diligence criteria for euthanasia, it is ethical to respect the patient's desire to donate organs.[12]

Nevertheless, organ donation after physician-assisted death will have an impact on patients' end-of-life experience. Patients who request such services do not usually die in hospital. If they want to donate their organs, their death would have to occur either in an operating room, intensive care unit, or a medical ward which affects the patient and family's last moments together. [23]

The evolution of deceased donation has, unfortunately, been inextricably linked to the development of an end-of-life care philosophy in intensive care.[24]On the 2004 Venkatesh case where the plaintiff requested permission to turn off his life support system before his organs "suffered irreparable damage, thus limiting donation of his organs in a non-heart-beating state." Despite the request, a two-judge Bench of the Andhra Pradesh High Court in Suchita Srivastava v. Chandigarh Administration refused the petition saying that would amount to euthanasia or mercy killing, which is illegal in India.[25]

The linking of organ donation with brain stem death in the Transplantation of Human Organs Act of 1994 has led to a bizarre situation: when families of brain dead patients give consent for organ donation, the organs are removed after which life support systems are withdrawn; but if the family does not consent to donation and asks for the ventilator to be disconnected, the request is turned down. These contributions point to the need for systematic empirical research that will inform policies, programs, and legislative reforms on palliative care, end-of-life care, and euthanasia. These inquiries should not only cover medico-legal aspects but also delve into sociocultural and religious perspectives, and the economic dimensions of the matter.[24]

Professional Responsibility and Patient Autonomy

The medical society has traditionally had an unfavorable position regarding physician-assisted suicide and euthanasia (PAS-E), but that opposition may be changing. For those who oppose the implementation of PAS/E, they mention four reasons why it should not be legalized.[26]

The first reason is the slippery slopes regarding the regulations established for PAS, since there is evidence that the safeguards for PAS are ineffective and violated, for example, the administration of lethal drugs without patient consent, absence of terminal illness, untreated psychiatric diagnoses, and nonreporting. The second reason mentioned is the lack of self-determination, in which both psychological and social motives, could characterize requests for PAS-E, instead of physical symptoms or rational choices. The argument is that these requests could disappear with improved symptom control and psychological support. The third reason is inadequate, palliative care. They say that with better palliative care, most patients would feel more physically comfortable. Also, they argue that many of these individuals who request PAS-E do not want to die but to escape their adequate suffering treatment for depression and pain decreases the desire for death. The fourth reason is medical professionalism. The medical society argues that PAS-E transgresses the inviolable rule that physicians heal and palliate suffering but never intentionally inflict death.[26]

Oncologists, when it comes to patients with advanced or terminal cancel to deal with extreme distress, must advise them against bad choices, to mobilize needed resources, to overcome barriers, and to provide dependable care with continuing support for patients and caregivers. In short, their obligation as professionals is "to cure sometimes, relieve often, and to console always." terminally ill patients with cancer need from their clinician's unwavering support for their psychosocial needs throughout the natural course of their terminal illness, rather than the option of PAS/PAD.[27]

In the case of India, India, the Constitution Bench of India recognizes the right to privacy as a fundamental right under Art. 21 and presented the principle of self-determination with a higher value.[1] Those who provide health services to patients with terminal illness have professional duties that forbid killing and maintain that it is contradictory to the rules of nursing, caregiving and healing. Terminally ill patients "should be given the freedom to choose between life and death instead of being forced to die".[7]

The importance of individual autonomy in Canada has traditionally been viewed in medical decision-making as the negative right to refuse treatment as opposed to the positive right to request or demand treatment and expect accommodation. In the provision of interventions aimed at ending the life of a patient, this will continue to be the case. Regarding patient autonomy, nonvoluntary assistance in death is therefore excluded, and decisions to access euthanasia or physician-assisted death ought to be guided by the doctrine of informed choice that is common across Canada. Thus, for patients who meet these requirements, the Supreme Court's commitment to autonomy "yields the prima facie right to choose the time and conditions of one's death, and thus, as a corollary, to request aid in dying from medical professionals." [6]

Provider autonomy relies on the basis that an obligation of physicians to provide interventions to terminate life would extremely difficult, if not impossible, to justify. It is, therefore, ethically appropriate to support the conscientious refusal of providers to engage in the direct provision of interventions that would terminate the life of a patient. What is less clear, however, is whether an appropriate justification can be provided, which would support the right of providers to refuse to refer their patients to another physician who may be willing to participate. Here, any right of physicians to refuse to apply would necessarily be weaker than in the previous consideration because of the proximity or degree of involvement to the proposed act. [6]

Translated to the practice of euthanasia, the physician's role could be viewed as entirely instrumental: the patient's right to self-determination should be the primary consideration. That would imply that a doctor should grant a euthanasia request whenever this is possible within the law. The duties of a competent healthcare professional are a supplement to the requirement of informed consent, to address the idea of positive autonomy adequately. This presupposes a good relationship between healthcare professionals and patients and requires commitment, trust, and excellent communication. Furthermore, complexities most often occur in the process towards granting a euthanasia request, and not during the actual performance of it. The course of that process is not only influenced by the patient, but also by the involved relatives.[13]

Excellent communication about expectations is of great importance in decision-making in end-of-life care. The previous analysis of the increased emphasis on patient autonomy 'as a right' and as the basis for euthanasia is relevant beyond Dutch borders. Physicians, especially GPs, in other countries, should be aware of the importance of their professional role in end-of-life decision-making. Pressure on this role can create a void in which the doctor's opportunity to offer and discuss alternatives to euthanasia is at risk of being lost. This may erode good end-of-life care.[13]

Conclusion

Euthanasia and Physician-Assisted Suicide (PAS) are currently in use in many countries around the world, more often than not for the benefit of people that are suffering from terminal illnesses and other crippling conditions. The responsible use of Euthanasia and PAS, especially respecting patient autonomy and while respecting their dignity and condition as human beings, is important to these patients because it allows them to end their suffering. Religious beliefs and societal norms still play a significant role today in how Euthanasia is seen and directly affect the legalization of these medical procedures. Organ Donation through Euthanasia or PAS, although an unorthodox way to reach this goal, still provides other people the opportunity to live their lives thanks to the sacrifice of others who wanted their own lives to have meaning by helping out people in need. By providing here a global snapshot of the international acceptance of Euthanasia and all its variants, people may be better informed and serve as beacons of information on such a controversial topic.

Conflict of Interest Statement

The authors declare that there is no conflict of interest regarding the publication of this paper.

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