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## **Social views about assisted suicide, euthanasia, physician-assisted suicide, and positions of various organizations and countries**

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### **Abstract**

Euthanasia and assisted suicide in their various forms remain a heated and polarising debate. There is global variance in the legalization of forms of assisted dying; with it being legalized in some form in some countries, and staunchly prohibited in others. As legal status varies from country to country, so do religious and social views; within some countries, there is entrenched opposition to the premise of assisted dying, whereas in others it has become increasingly socially acceptable; and in some countries generalized acceptance of euthanasia is the majority viewpoint. Religious and historical perspectives can be used as a lens to explain and understand these varying social views. This chapter provides the religious, historical, legal, and ethical perspectives related to assisted dying.

### **Keywords:**

Assisted Suicide, Euthanasia, Law, Physician-Assisted Suicide, Religion, Society

## **1. Introduction**

Throughout the course of human history, and more intensely in the last few decades, assisted dying in its various forms has been a tempestuous and polarising topic. Within the medical community, the topic is becoming increasingly relevant as medical advances

continue, and our attitudes towards the rights of those at the end of their life evolve. Today, euthanasia, or physician-assisted dying (EPAS) is legalized in some form in certain countries; in others, it remains illegal and resolutely taboo for various cultural and religious reasons. Enduring concerns regarding EPAS remain, both regarding the theoretical process mandated in legislation, and how EPAS would be practically carried out.

This chapter will explore the distinct three variances: assisted suicide, euthanasia, and physician-assisted suicide, mainly focusing on EPAS. A commentary on the historical and religious understandings of EPAS within different societies will be discussed; to provide an understanding of the varying social views across cultures and how they have formed; and the various legal and ethical challenges that exist.

### 1.1. Definitions

There are various related terms and it is prudent to describe them in the beginning (Table 1). Within the literature, there is often a distinction between ‘active’, and ‘passive’ euthanasia; the difference being that passive euthanasia may involve a person not intervening to prevent another person’s death, and active euthanasia involves the direct hastening of a person’s death through a lethal dose of medication or other means (Fontalis et al., 2018). This chapter will primarily focus on physician-assisted suicide.

Table 1. Description of various terms related to EPAS

Euthanasia	Voluntary active euthanasia is the act of intentionally ending another person’s life, at their capacitous and voluntary request. This is usually done through a doctor administering medication (Mroz et al., 2021).
Non-voluntary euthanasia	Non-voluntary euthanasia involves the facilitating of someone’s death without their consent; in situations where informed and purposeful consent is not possible, such as the patient being in a comatose state. Involuntary euthanasia would represent the facilitation of death against a patient’s will (Mroz et al., 2021).
Assisted Suicide	When a person intentionally aids another person’s death, by providing them with the means to do so, or assisting them in the process in a manner that the suicide would not have been possible without the external person’s involvement (Fontalis et al., 2018).
Physician-Assisted Suicide	Physician-assisted suicide is defined as a physician intentionally facilitating a person's death by providing the means to do so, such as issuing a prescription for lethal medication, at the person's voluntary and capacitous request. In this case, the action of ending life is done by the patient, who is given the medication by the physician (Fontalis et al., 2018).

## 2. Religious views

There are variances across the major religions in theological perspectives that may explain how EPAS may be accepted or rejected by followers of each religion. The prominence of

ideas linked to EPAS across religious texts is discussed; with a view to understanding how prevailing religious beliefs may have informed social views and explain the position of various countries' differing legal approach.

Within Christianity, although EPAS is not mentioned within the Bible, there are several core themes throughout scripture that relevant theological arguments derive from and can be used as a lens to understand religious approaches to EPAS. Within several passages of the Bible, God issues direct, clear instructions that the taking of life is prohibited; and mandates punishment for doing so. Humans are described as being made in God's image; and so, there is a unique sanctity ascribed to human life which adamantly opposes the ending of it (Stempsey, 1997). The very framework of the Bible ascribes God as the creator, and sustainer of life – and to end life should happen only at God's command. Suffering on earth is viewed as temporary and inevitable; and occurs along the path to a suffering-free eternal life in Heaven after death (Grove et al., 2022). Keeping this core idea in mind, although EPAS is not directly referenced, there is strong implied theological opposition throughout the entirety of the Bible. In consistence with these views, the main branches of Christianity – Catholic, Protestant, Eastern Orthodox – are united in opposing EPAS. This then serves to form the majority views of Christianity's constituent followers.

In Islam, although the Quran does not directly discuss EPAS, there are several consistent themes that contribute to formulating an interpretation that strongly opposes EPAS, considering it to be a form of murder (Sobotková, 2019). As within Christianity, Allah is the sole creator and sustainer of life; he determines everything, including the timing of a person's death (Madadin, 2020) – and so the philosophy of Islam is focused towards saving and prolonging life. EPAS is therefore almost universally condemned as a form of murder by Islamic scholars; and opposition tends to form the majority viewpoint of the religion's followers. As such, it is not legalised in any Muslim-majority countries (Grove et al., 2022).

In the Hindu view, the soul along with the influence of karma continues after death, to the next life, in multiple cycles of birth and death. Suicide is considered as bad karma that affects the soul's spiritual progress, and is generally prohibited in Hinduism. Within the polytheistic, pantheistic or monistic belief and cultural systems of Hinduism, there is no distinct dominant view on EPAS; and Hindu philosophies both for and against EPAS exist. Ideas that may oppose EPAS are that Hinduism has, universally, maintained a resolute philosophy of respect for all living things, with strong opposition against the act of killing and violence – a principle of paramount importance known as *ahimsa* (Grove et al., 2022). However, considering the diversity of Hindu philosophies specific discussion or studies related to EPAS among Hindus in general population is rather scarce (Chakraborty et al, 2017). Hindu belief systems leave space for more nuanced and diverse reflection regarding EPAS.

EPAS is a complex topic within Judaism. A central tenant of *halakha*, Jewish Law, is the sanctity of human life. There is a widespread perception that *halakha* instructs that a dying

person's life should be extended at all costs, a duty that is held by those who can offer aid to the suffering person, such as a doctor. There is, however, no clear consensus throughout the theological and spiritual discourse as to whether this is a universal, unrelenting principle. In addition to a duty to preserve life, there is also a recognized duty to alleviate suffering; and within The Talmud, there is an assertion that extreme suffering can often be worse than death. The balance of the obligation to alleviate suffering, while prolonging life, has formed the basis of the decision of some authorities to rule that while withholding life-prolonging treatment can be permitted; removing treatment that would imminently cause a patient's death is forbidden. In this way, 'passive' euthanasia is widely accepted (Linzer, 2013). This is reflected within Israeli law; in which passive euthanasia is accepted through the Terminally Ill Patient Law of 2005 (Jotkowitz & Glick, 2020).

Karma and rebirth are central to the Buddhist philosophy and suffering is part of the life; such as the death in the cycle of rebirths. Buddhism aims to find liberation from suffering, but not through death; in that regard EPAS will not be able to alleviate suffering and will merely delay it to a subsequent life (Grove et al, 2022). Buddhism advocates towards attaining peaceful deaths (Upasen et al., 2022). Within cultural Buddhism, there is a qualified acceptance of certain forms of self-harm; certain motivations for suicide such as altruism, and self-immolation as a form of political protest (Kelly, 2011). Buddhist philosophy condemns harm to living things and mandates compassion as an important virtue. In healthcare, this manifests as aiming to obtain a peaceful death – a goal that influences decision-making (McCormick, 2013).

Although various theological perspectives on EPAS have been discussed based on religious texts, it must be acknowledged that religious affiliations do not necessarily determine a person's individual moral stance (Dorji et al., 2020). However, across the major worldwide religions, there are recurring themes that form the basis of moral views that may oppose EPAS, such as suffering on Earth being part of the journey to a better future after death. It is important that legislation considers and represents the views of those who hold religious-based objections to EPAS.

### **3. Historical accounts**

The origins of the word 'euthanasia' has initially been credited to the Roman historian Suetonius, who in his writings described how Emperor Augustus died 'quickly and without suffering' in the arms of his wife, Livia (Letellier, 2003), and 'experienced the euthanasia he had wished for'. The word was interpreted to mean a 'good' death – one without the terminal suffering often evoked when considering a person's death. The term euthanasia was later used in a medical context by Francis Bacon, a philosopher, to describe a situation in which a physician held a responsibility to 'alleviate the physical sufferings of the body' to facilitate a pain-free, happy death for their patient. Karl Marx further developed on Bacon's ideas and theorised that a doctor had an inextricable moral duty to ease the suffering of death, bringing this duty within the medical realm of responsibility (Nyman et al., 1996).

Euthanasia is first referenced in practice in ancient Greek and Roman texts, although the practice of taking human life was condemned by dominating Hippocratic principles. Throughout later human history, euthanasia continued to be practised within various forms with customs such as suffocation, removing people from their sick beds to be placed outside, and swiftly removing a pillow from a person's head - which was thought to hasten death (Stolberg, 2007). Despite the endurance of the practice through the centuries, in Judeo-Christian tradition EPAS has long been strongly opposed, and this view gained prominence as Christianity grew. Although within different cultures this resolute approach has not persisted through time; for example, in Japan, suicide is not traditionally viewed as a sin, and in some situations can be dignified, and even honourable (Otani, 2010).

Within Britain, amongst medical scholars in the early 1800s, morphine and chloroform were proposed as treatments to 'treat the pains of death' and widely used for this purpose; however, this was not with a goal of accelerating death, rather relieving the symptoms of dying. The contemporary euthanasia debate was ignited in 1870 by a proposal by Samuel Williams, a schoolteacher, who suggested the usage of chloroform to patients to hasten their death, with the goal of achieving a 'quick and painless death' (Brenna, 2021). This proposal achieved both widespread acclaim and opposition; however medical doctors largely did not participate in the discussion, which remained philosophical in nature (Brenna, 2021).

The first attempt to legalize EPAS within the United States came in 1906, when within the General Assembly of Ohio, a bill was proposed that proposed allowing the deliberate administration of anaesthetic to cause a patient's death – if they were of sound mind, and suffering from either a fatal injury, an irrevocable illness, or great physical pain (Appel, 2004). This bill was inspired by Anna Sophina Hall; a leading figure in the euthanasia movement who had dedicated herself to the cause after watching her mother suffer a prolonged death from liver cancer. The bill was rejected; however, it represented a shift in societal views (Appel, 2004).

The debate surrounding EPAS intensified in Britain in the 1930s; when the Voluntary Euthanasia Legalisation Society was founded – later renamed, and today known as Dignity in Dying. The society called for the legalization of EPAS which resulted in proposed legislation reaching the House of Lords, although it did not progress further. In 1936, King George V died; although at the time kept a secret, his death was caused by a fatal dose of morphine, deliberately given by his physician, to hasten his death as he suffered from cardiorespiratory failure (Ramsay, 1994).

There are some countries that have a challenging historical past with euthanasia, where widespread discomfort around the practice remains pervasive. For example, in Germany during the period of the Nazi government, euthanasia programmes with eugenic ideals were created. In 1933, many doctors had an active role in these euthanasia programmes. It was reported that, an estimated 200,000 to 300,000 people were killed under the guise of

'mercy killing' – deemed to be 'unfit' due to physical or mental disability. The atrocities in this period to some are sobering examples of the importance of ensuring any EPAS legislation protects the patient and reinforces their right to make the decision (Grodin et al., 2018). This period created an unfortunate public association of euthanasia with eugenics and Nazi ideology, which marred public debate for several years.

#### **4. Current Status in Different Countries**

Within this section, the legality of EPAS across different countries will be discussed, with notable examples being highlighted. As of writing, EPAS (*active* euthanasia) is legal in the Netherlands, Belgium, Luxembourg, Columbia, Canada, Switzerland, Spain, New Zealand, some territories of Australia, and within eleven American states Emanuel 2016(. Passive euthanasia – that is to say, the refusal or withdrawal of life-saving treatment, is either legislated for or not explicitly banned in most countries. An example of this is India, in which the Supreme Court legalized passive euthanasia in 2011 in a landmark judgement (Sinha et al., 2012), although this specific judgement gave no specific instruction and was not practically applicable. A further judgement in 2018 and 2023 helped to develop the criteria for passive euthanasia: that the patient must be able to consent (via a living will) and must be terminally ill or in a vegetative state (Shekhawat et al., 2023). The decision to allow passive euthanasia, in individual cases, would be scrutinised by an independent medical board, consisting of doctors with more than five years of experience. Despite the development of the law's clarity, in 2023 there had been no reported case of passive euthanasia in India (Supreme Court of India & Delhi High Court, 2024).

Only a handful of countries, Russia being an example, outlaw even passive euthanasia (Shestak & Dyachenko, 2020). In general, Western Europe is experiencing a surge of support for legislation of EPAS; whereas within Eastern and Central Europe, support is decreasing (Emanuel et al., 2016). EPAS laws, and support, vary across Asia. In Japan, there is a developing legal framework for implementing EPAS, which is not currently ratified in law. China similarly has a legal 'grey area' in which there is no clear law explicitly dictating the legality of passive euthanasia (active euthanasia remains equivalent to homicide in Chinese law), and so there is ambiguity and uncertainty in situations where passive euthanasia may be considered (Weng et al., 2011). There is, as of the time of writing, no Asian country with EPAS legislation. In countries with theocratic governments and populations of a majority practicing religious background, EPAS is explicitly banned; rather unsurprisingly when considering the prominent religious arguments that have previously been discussed. Opposition to EPAS is often deeply entrenched within religious societies; again, because of the vast theological perspectives that condemn the practice. In Ireland, EPAS is illegal – a reflection of the largely Catholic population - and staunchly forbidden under the guidelines of the Irish Medical Council. EPAS is however, the subject of debate more recently, due to the proposal of a bill in the Irish parliament, which may indicate a slow transition of society to harbour more favourable views (Clarke et al., 2021).

As wider society becomes more versed in understanding their own health, and interactions with doctors become less paternalistic and more mutualistic, there is a greater emphasis on patient choice, across all societies. Shared care is supported across all branches of medicine; the patient coming to a decision jointly with their medical team, as opposed to the past days of absolute medical authority. A patient's right to self-determination has formed some of the more prominent supportive arguments for EPAS in more recent times; replacing the 'intolerable suffering argument' - that patients with incurable diagnoses are often described as experiencing 'intolerable suffering' as their disease progresses; and as the cause of their suffering is their illness, the only effective proposed way to end their suffering is death. The 'intolerable suffering' supportive argument has, in some ways, faded; replaced by the 'control' argument, that a person should have the ability to control the end of their life (Randall & Downie, 2010).

In the UK, assisting a person's suicide is a prosecutable offence under the 1961 Suicide Act; however, this law is rarely enacted, and arrests are vanishingly rare. In 2021, an Assisted Dying Bill was introduced into the House of Lords; that proposes that terminally ill patients with a prognosis of less than six months should be given the ability to opt for a medically assisted death (UK Parliament, 2021). The bill is awaiting its second reading, after which it is largely expected to progress. The potential of the introduction of EPAS is therefore hotly anticipated in the UK.

#### 4.1 The Netherlands

The system within the Netherlands has served as a 'model' for other countries. The Netherlands was the first country to legalise EPAS; beginning with official tolerance in 1985, then progressing to full legalisation in 2002 (der Heide et al., 2005). Since the law's conception, cases of EPAS have continually risen annually (Groenewoud et al., 2021). This law broadly allows EPAS in fixed circumstances: if the person is suffering 'unbearably without hope' from either a physical or mental condition (Roehr, 2021). They must also be competent to make the decision; and any request must involve two doctors to certify the appropriateness of the request. There are a certain number of criteria to be met: that the suffering of the patient has no realistic prospect of improvement, that their request for EPAS is enduring and not transient, and that the patient has been fully made aware of their options and possible alternative treatments (Janssen, 2002).

Despite the implementation of the law, it has been suggested within the literature that the legislation did not lead to an increase in EPAS cases in the Netherlands; it just provided a regulated and proper framework for them to happen (Onwuteaka-Philipsen et al., 2012). From this perspective, any increase in reported EPAS cases is not as a result of the legislation's implementation, but deaths that would have occurred without it. In 2016, 4% of all deaths in the Netherlands were recorded as being due to EPAS (Pascoe, 2017).

### 5. Bioethical Debate

*“Neither will I administer a poison to  
anybody when asked to do so, nor will  
I suggest such a course” -*

The Hippocratic Oath (Ahlzen, 2020)

The role of the doctor has been inextricably associated with Hippocrate’s mandate that a doctor should ‘first do no harm’; (although interestingly this phrase was not present within the original Hippocratic Oath but is widely misremembered and assumed to have been (Hajar, 2017). The Hippocratic Oath contains a deontology-based philosophy: that the doctor's duty to their patient must be to take care of the ill with selflessness, dedication, and enduring compassion – and their ultimate duty is to cause no harm (Tännsjö, 2005).

Deontology, as an ethical theory, defines a person’s action as right or wrong depending on the morality of the action itself, regardless of the consequences of the action. Using Hippocrate’s framework, we can take the duty of a doctor to be to cause no harm, and to treat their patient – regardless of the consequences of the action. The duty of a doctor to cause no harm is where the ambiguity and differing interpretations may lie. In the context of EPAS, active euthanasia would be prohibited using a deontological perspective (Tännsjö, 2005) if the death was the *intention* of the action. Deontological arguments therefore do not support active EPAS legislation, but there may be circumstances in which EPAS may be accepted if death was not the intended action, but a consequence – for example, prescribing a lethal dose of morphine with the ostensible intention of relieving intractable pain (Alexander & Moore, 2020).

Beneficence asserts that a doctor’s moral obligation is to act in a manner that does ‘good’, and that benefits the patient maximally. The concept of beneficence can be applied to EPAS in either supportive or critical arguments. Some would suggest that, using the ideas of beneficence, a doctor should be motivated towards preserving life above all else; with a focus on relieving the symptoms of a patient's suffering, rather than ending their life. Others would suggest that beneficence requires the doctor to support the autonomy of their patient, and that they must act to relieve their suffering. Promotion of a patient’s autonomy may also contradict beneficence; if a doctor is the arbiter of what action would benefit a patient the most, they may believe that ending a patient’s life would not be the action that benefitted them the most (Benedict et al., 1998) while the patient may disagree. An autonomy-based approach to EPAS would be morally justifiable if a person with full decision-making capacity has independently, autonomously made the decision to end their life – however, an autonomy-based approach would also mean that *any* person (who does not necessarily have an untreatable condition) should be able to request it, and that their motives would not be scrutinised or applied to an objective standard before approval (Braun, 2022). One benefit of an autonomy-based approach is that, firstly, the emphasis of

the decision and act is placed with the patient, rather than the doctor. Additionally, it avoids the expressivist objection: that, in EPAS systems, EPAS is often available to a specific group of patients. This may externally suggest that any person with these conditions has a life not worth living, which unquestionably is not a belief shared by everyone living with the conditions. The expressivist objection to EPAS has been a core argument against its legislation; representing the concerns of many disabled people that their lives would be judged not worth living (Braun, 2022).

Lastly, virtue ethics will be discussed in the context of euthanasia. Virtue ethics is a philosophy that asserts that an action is morally acceptable based on the intent, and moral character, of the actor. If their intent is virtuous, then regardless of the consequences of the action, their action was morally justifiable. In this context, EPAS may be acceptable if the intention of the doctor facilitating the death is to relieve the suffering of their patient and to honour their wishes. Of course, this argument would therefore ascribe strict protocol and processes to EPAS; in that, a doctor administering lethal medication or facilitating a patient's death was acting virtuously (Begley, 2008) and with no malintent or ulterior motives.

## **6. Position of Different Organisations**

There are various voluntary organisations that represent views across the spectrum of either support or criticism of EPAS. 'Dignity in Dying' is a prominent British organisation dedicated to campaigning for greater autonomy in end-of-life care, with the resolute belief that an option of a pain-free, peaceful death should be an option for everyone, with stringent legal safeguards and protective mechanisms in place. The organisation is resolutely secular; and not aligned with any political or cultural affiliations. The group was established in 1935; and its membership was reported to be formed of 25,000 active members by 2010 (Dignity in Dying, 2016). As British society becomes more secular, and religious values are less strongly associated with legislation, views towards EPAS have softened. Humanists UK is a further organisation that, while not solely advocating for the legalisation of EPAS, represents members who support secular humanism. As part of this ethos, EPAS is viewed through the frame of supporting an 'open society', a philosophical proposal of a society in which individual liberty and agencies are supported by government policy and the state healthcare system (Humanists UK, 2024).

The World Federation of Right-to-Die Societies represents an international federation of voluntary organisations that advocate for access to EPAS. It was founded in 1980 and represents 60 Right to Die Societies from across the world, representing 30 countries as of 2020 (World Federation of Right to Die Societies, 2020). As part of their campaigning, the 'World Right to Die Day' was established, which is annually celebrated on November the 2<sup>nd</sup>, ostensibly to raise awareness of the topic and promote further discussion.

From a global perspective, Exit International is an eminent not-for-profit organisation that supports EPAS. It has met controversy over the years; namely, through the publication of

the 'The Peaceful Pill Handbook', a book that provides information on euthanasia and assisted suicide (not physician-assisted suicide), targeted towards those who are considering ending their lives (Nitschke & Stewart, 2006). The book describes various methods, and rates them based on scales of peacefulness and reliability. It has been criticised for its recommendation of the internet as a source of purchasing lethal drugs, such as sodium nitrite (Stephenson et al., 2022).

There are voluntary organisations that campaign against the legalisation of EPAS; Care Not Killing is a prominent organisation based in the United Kingdom that opposes EPAS. Their goals are focused instead on improving palliative care and ensuring existing laws that prohibit EPAS are strengthened. Their rationale is based on several arguments; mainly that if EPAS was legalised, vulnerable people would be at risk of coercion and pressure to end their lives, and that if people are 'properly cared for' they would not request EPAS (Care Not Killing, 2009) – a suggestion that when patients receive adequate symptomatic treatment for their condition, they would not consider EPAS.

### **6.1. Professional Bodies**

It is important to appreciate the spectrum of opinions held by medical professionals, as within a system that legalises EPAS, they will be the enactors of the procedure. The views represented by medical practitioners are broad in nature; as they represent the ethics of the individual, there is no uniform opinion – however, the stance of professional bodies needs further discussion.

In a 2009 postal survey of 3733 medical practitioners practicing in England, it was found that the majority of the doctors surveyed displayed opposition to the legalisation of EPAS. Strikingly, palliative specialists were particularly noted to be opposed. Religious beliefs were cited as reasons for personal opposition to legalisation. Additionally, reservations were expressed regarding the practicality of implementing a system in a way that safeguards the most vulnerable in society (Seale, 2009), with a fear legislation would have inadequate safeguards. A 2012 systematic review that included 15 studies later again identified that the majority of UK doctors were opposed to EPAS. Major themes identified were, again, religious affiliations, but also scepticism about adequate safeguards, and the concern that the provision of palliative care may be affected (McCormack et al., 2011). Traditionally, palliative medicine doctors are unlikely to support EPAS. A 2019 Royal College of Physicians (RCP) put a vote to their members regarding their policy on EPAS – ultimately the vote resulted in the college moving to adopt a neutral stance. Most (80%) of palliative medicine doctors voted to maintain a position of opposition (BBC News, 2022)– a significant finding as this group of doctors would spend the most time with terminally ill patients, and likely be expected to be most involved in EPAS if it were legalised.

Although these studies reflect a greater hesitancy within the medical profession to support EPAS when compared to the public, this is not necessarily the same across all disciplines of

medicine. A study that utilised structured interviews with general practitioners (GPs) in the UK found that those who had not personally witnessed terminal suffering were against EPAS legalisation; however, those who had felt EPAS could be justified in certain situations. The prominent themes in this study were again apprehensions of the potential for harm; but also, a desire to respect a patient's autonomy and right to self-determination (Hussain & White, 2009). Having personal experience of witnessing terminal, intractable suffering has often been reported as a potential causative factor for having sympathetic views towards EPAS (Jewell, 2009).

It is clear there is no uniform consensus amongst medical practitioners, and the decision to either support or oppose EPAS appears inextricably associated with a person's personal experience and religious views. Amongst the wider public, however, there is evidence within the literature that there is a tendency for the public to support the legalisation of EPAS. A 2019 cross-sectional study that used questionnaires to assess the views and perceptions of the UK public regarding EPAS legislation found that 70% of respondents thought EPAS should be legalised; and a further 62% supported the involvement of doctors in cases of assisted dying (Pentaris & Jacobs, 2020). It is clear then, that there is a level of disconnect between the views of the doctors of the UK, and the UK public at large.

Good Medical Practice, a guideline by the UK regulatory body the General Medical Council (GMC), in its beginning statement, instructs a doctor that they must 'Make the care of your patient your first concern' and act in their 'best interests' when providing care (Breen et al., 2010); ultimately issuing guidance that defines the central role of a doctor as acting in their patient's best interests. This unwavering notion of aiming for a patient's best interests is where nuance can be found; what are a patient's best interests, and by which parameters can they be measured? The GMC instructs doctors that they should not aim for a 'serious adverse outcome' (of which death is included) in their treatment recommendations; a stance that implicitly opposes EPAS.

The British Medical Association (BMA) the foremost trade union representing doctors in the UK, in 2021 changed their policy regarding EPAS. While previously they had taken an opposing stance, their updated position is one of neutrality (BMA, 2021). Despite this change, however, they are resolute in advocating for doctors who voice their concerns regarding EPAS and the potential role of the doctor in implementing it. In terms of the guidance the BMA offers to its members, their stance is that a patient's 'best interests' must include 'clinical improvement'; that is to say, improvement in relation to their health circumstances and wellbeing (British Medical Association, 2009). This term, again, is open to interpretation: many would argue that ending terminal suffering would represent a clear improvement of a patient's well-being, and by extension represent their best interests.

There are differing views in professional bodies abroad. In America, both the American Medical Association and the American College of Physicians are unanimous in vehement opposition to the legalisation of EPAS (Fontalis et al., 2018). This opposition within

professional bodies is also found within countries where EPAS is not only not legalised, but realistically not likely to be implemented in the next few years, such as those countries that have a high proportion of religious citizens. In the Netherlands, where EPAS is legalised, doctors are reminded by their professional body that they are not obligated to honour requests to perform euthanasia. However, when they do decide to accept a patient's request, there are strict criteria to be met (KNM, 2017). Passive euthanasia which is 'withholding or withdrawing treatment necessary to maintain life' has received legal sanction in India following a landmark ruling by the Supreme Court (Gupta and Bansal, 2023). Following this the Government of India has suggested the draft guidelines for passive euthanasia for doctors, to 'consider' for withdrawing life support in terminally ill patients; however the Indian Medical Association (IMA) has reservations; although the proportion of doctors favouring euthanasia is growing in India (Shekhawat et al 2023). There has been further work by The Indian Council of Medical Research in defining 'do not attempt CPR, withholding life-sustaining treatment, withdrawing life-sustaining treatment, euthanasia, active shortening of the dying process, physician-assisted suicide', etc. in the Indian sociocultural context (Salins et al 2018).

### **6.3 Dignitas and 'Suicide Tourism'**

Dignitas is a nonprofit organisation based in Sweden that provides EPAS services. The term Dignitas has become synonymous with the EPAS debate. By the end of 2020, Dignitas had helped 3,248 people to end their lives (Dignitas, 2020). Dignitas has the motto 'To live with dignity, to die with dignity', with a mission statement of improving choice in care at the end of one's life. Dignitas has proved to be a polarising organisation and has been the subject of much criticism. One of these is that Dignitas promotes 'suicide tourism'; in that people from countries in which EPAS is not legal, travel to Dignitas with the intention of ending their life. In 2023, it was reported that 40 UK citizens travelled to Dignitas to end their lives (Waple, 2024). Assisting a suicide remains a criminal offence in the UK; as such, anyone who travels with a person who goes to Dignitas to end their life is at risk of arrest and prosecution (Bird, 2022). Although in practice, those who are arrested rarely are prosecuted – there have been just four cases of prosecution of assisted suicide in the UK (CPS, 2019), the legal ramifications are still a threat for anyone who facilitated a person's death, be that through travelling with them, or supporting the travel plans. Proponents of EPAS point to 'suicide tourism' as evidence that the current law is failing patients in the UK; in that clearly, those who seek a physician-assisted death have the means to achieve it by travelling abroad, and a ban does not universally stop this from happening, as seen by the continued numbers of UK citizens who do make this decision.

## **7. Challenges**

To discuss some of the challenges an EPAS system would face, we can consider some of the challenges seen within the Netherlands. Although EPAS is strongly supported amongst Dutch society; it has not come without controversial cases. There have been cases reported

of young Dutch citizens who have been granted euthanasia on the grounds of intolerable suffering with no prospect of improvement (as is mandated by law), due to psychiatric conditions such as chronic depression, anxiety, and personality disorder that are thought to be refractory to treatment (Sherwood, 2024, Pressley 2018). These cases fuel debate, as to some, the ending of the life of physically healthy young individuals appeared irreconcilable with ideas of their best interest; while for others, the cases exhibit the right to self-determination and ultimate autonomy that EPAS campaigners promote. Psychiatric conditions meet the criteria for EPAS just as physical health conditions; as long as the approving doctor is satisfied the patient meets the strict criteria (van Veen et al., 2022).

It is clear that an EPAS system needs stringent safeguards and regulations. Many of the challenges in its implementation is ensuring that those who are most vulnerable in society are not harmed by an EPAS system, as has been the subject of debate in countries where EPAS is legalised. A group of patients with clear vulnerability is patients with a dementia diagnosis, who ultimately may lose their ability to have the mental capacity to consent to EPAS as their disease progresses. In patients with significant cognitive impairment, who lack the mental capacity to request significant medical procedures, there will always be complex debate – which intensifies when EPAS is the decision involved. In the Netherlands, only 30-40% of GPs would oblige a request for EPAS for a patient with dementia compared to 60% of the public (Brinkman-Stoppelenburg et al., 2020). This displays a level of discord between the attitudes of the public and the medical professionals in the Netherlands, and a clear uncertainty and reluctance in the medical profession. Many concerns focus on the ability of the doctor to ascertain that a patient is suffering unbearably in this instance, if a patient has lost the ability to meaningfully communicate. Even with the presence of a written advance directive, a doctor may question how they could determine the patient was competent and had the mental capacity at the time of writing the directive.

## **8. EPAS and Suicide Prevention**

One suggestion of the opposing debate of legalising EPAS is that it may undermine suicide prevention efforts; and that the availability of EPAS may make it more acceptable to end one's life and increase the incidence of deaths caused by suicide. Concerns of turning EPAS as a method of dealing with suicidal intent associated with psychiatric illnesses are not new (Hendin, 1995). There is even a suggestion, and concern, that a patient may utilise the healthcare system as their method; and that their request for EPAS is the result of a symptom of psychiatric illness. This is a serious emerging issue world-wide (Sprung et al, 2018); and in spite of safeguards built into the legal and procedural framework there is a possibility of EPAS being inappropriately used.

Suicidality is a recognised symptom of psychiatric illness; and one that would be prominent in patients that have significantly severe disease, who may also fit the criteria for EPAS. Suicidal tendencies and behaviour can fluctuate over time; and there is ample empirical evidence to suggest that they can be treated successfully (Mehlum et al., 2020). Patients

with personality disorders are often likely to display suicidality and are at increased risk of suicide (Mehlum et al., 2020). In the Netherlands, psychiatric conditions that have no meaningful prospect of recovery qualify a person to be considered for EPAS (Sherwood, 2024). Considering the suffering of psychiatric illness could be as severe as the physical illnesses, the contrast of commitment of psychiatry to prevent suicide and the physician-assisted suicide creates a moral and philosophical dilemma, which needs further debate, and appropriate standards of evaluation of sufferings in physical and mental illnesses (Kious and Battin, 2019).

A 2021 systematic review suggested that the characteristics of patients who request EPAS for psychiatric conditions were very similar to those who die by suicide: with self-harm being a consistent trend (Calati et al., 2020). Alternatively, there have been claims that having accessible EPAS may reduce the incidence of self-initiated deaths – from both suicide and EPAS combined. However, a 2022 systematic review of six studies that examined deaths in areas that had legalised EPAS indicated that there were higher rates of self-initiated death (both EPAS and suicide) in countries that had legalised EPAS (Doherty et al., 2022), showing that deaths by suicide do not decrease if an EPAS pathway is available, as some would suggest. An explanation could be that a socially accepted, legalised system may lower the personal threshold of an individual to consider ending their own life, leading to a generalised increase in self-initiated deaths. Similar studies have also demonstrated that self-initiated deaths have shown an increase in cases amongst older women in countries with legalised EPAS, a population group who are epidemiologically more vulnerable to depression (Doherty et al., 2022). This indicates an unmet suicide prevention need within these populations and a suggestion that patients suffering suicidal ideation may be more vulnerable in a system where EPAS is legalised. As, clearly, certain psychiatric disorders will result in suicidality as a core symptom, and there is the possibility that the healthcare system could then be used as an instrument for those with suicidal ideation.

As the acceptance of EPAS grows in the countries and more countries legalize it, another concern that will affect psychiatrists. There will be requests for psychiatrists to assist medical, surgical and palliative colleagues in differentiating this end-of-life practice from suicide as many of these patients would have cognitions of hopelessness and possibly depressive and other psychiatric disorders. There is a suggestion to consider the change in terminology to medical aid in dying (MAID) from physician assisted suicide; with specific indicators to distinguish MAID from suicide (Bostwick et al 2024). However it still remains a complex issue which may affect suicide prevention efforts in specific group patients.

## **9. Conclusion**

There is a global discrepancy in the acceptance of EPAS. In some countries, it will likely remain prohibited and socially unacceptable for years to come; with the laws in these countries reflecting the entrenched social opposition that is often rooted in religious affiliation. In countries where EPAS has been legalised, support is often attributed to a

generalised increase in support for patient autonomy, and an increasing reluctance to encounter the ‘terminal suffering’ that has haunted the human experience of death for so long. The idea of a ‘good death’ that EPAS aims to achieve is certainly the intention; however, concerns remain from medical professionals, the disabled community, and voluntary organisations regarding its impact on those who are amongst the most vulnerable in our society. It is clear that, over the next few years, it is likely there will be even more countries adopting a permissive legal stance towards EPAS. With this, the need to ensure that the system has stringent criteria and appropriate regulation is of paramount importance. Future research needs may be focused on the intersection between psychiatric patients and EPAS requests, and how EPAS can be both safely implemented while maintaining stringent safeguards.

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