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I. Introduction

The term *euthanasia* stems from the ancient Greek words *eu* ("good") and *thanatos* ("death"), literally meaning a *good death*, a *gentle death*, or, more precisely, a *good dying*. In Antiquity and in the Early Church, this term did not involve the action of shortening or taking a life, but it was rather concerned with the mental or spiritual state of a person at the

moment before death – a state of peace or reconciliation with the self and God [1] (p. 210). Euthanasia was a way of dying, not an intentional act of causing death, so it was not identified with taking a life [1] (p. 163). However, the practice which we would today call assisted suicide was widespread in that period [2]. It consisted of administering means by which death was speeded.

In modern terms, the Oxford English Dictionary offers three definitions for the word *euthanasia*: (1) "a gentle and easy death"; (2) "the means of bringing" this, and (3) "the action of inducing a gentle and easy death" [3] (p. 325). As Philippa Foot said, a curious fact is that none of these explanations is an adequate definition for *euthanasia* as it is understood in modern thinking because it means something more than *gentle and easy death* or even *the means* or *the action of inducing it* [4] (p. 85). A murderer can drug his victim to death and may later claim it to have been an act of euthanasia, so it is ridiculous to consider euthanasia only as a way of dying to which people use though an act of goodness [4] (p. 85). Additionally, the *euthanasia program* developed in Hitler's Germany, through which approximately 275,000 people with physical or mental disabilities, children and adults were systematically killed – *euthanized* by gas [5] (p. 158), cannot be considered a *gentle and easy death*.

As a conclusion from a multitude of definitions or interpretations, euthanasia[1] could be, with small differences, defined as the medical procedure by means of which a physician intentionally ends the life of another person suffering from an incurable disease in its terminal phase by directly administering a lethal agent, in accord with this person's explicit, voluntary, and informed request, in order to free him/her from a state of physical or mental degradation considered to be unbearable. Euthanasia can be: *voluntary* (with the patient's consent), *non-voluntary* (when the patient's will is not known), or *involuntary* (against the patient's will). Physician-assisted suicide (PAS) consists of the help offered by a qualified person (not necessarily a physician) to a terminally ill patient suffering from an incurable disease to commit suicide, which also involves the delivering of the means to achieve this purpose. Throughout this study one may notice how much relevance these definitions contained in the laws supporting assisted dying practices still have.

[1] In this essay, I refer to *euthanasia* in its active form.

Bioethicists have identified the factors that trigger the demand for euthanasia and its *surrogates* in four different contexts [6] (p. 628–629): (1) *medical* – some people choose euthanasia because of suffering and pain caused by a disease [7] (p. 730); (2) *psycho-social* – the poor condition of health accompanied by a weakened mental state greatly influences the social status of the person [8]; (3) *psycho-emotional* – patients under the burden of severe suffering develop suicidal thoughts due to underestimated factors such as depression, feelings of worthlessness, condemnation and guilt, isolation or loneliness, unbearable pain, or other forms of psychological disturbance that profoundly compromise deliberate choice [9, 10], but once treated and with improved health, suicidal intention disappears [11], and (4) *existential* – the experience of life which includes pleasant events until the disease occurs becomes the existential *burden* of the patient, caused by futility, the lack of hope for recovery, the bad intentions of relatives for inheritance, the costs of treatments, the insurers' pressures, etc. [12].

II. Pro-Euthanasia Society

A. Pro-euthanasia attitudes – a characteristic of a secularized culture

The consequences of Enlightenment, Modernism, and Postmodernism seem to raise *homo hedonicus* on a privileged pedestal in which his own person and his autonomy are the most important goals [13], which even Renascentist humanism had failed to achieve, although it covered many more areas of development and emancipation in this sense. This spectrum of consequences has amounted to the secularization of the *homo hedonicus'* society. This phenomenon has encompassed the entire society, whereby the implications of secularization are observed in many fields: medical, economic, social, cultural, religious etc. Assisted dying has gained its place, next to other controversial practices, in a space of complete openness and permissiveness. Can secularization be construed as the main factor of the openness towards assisted dying and of its acceptance in contemporary society? Is there a pattern of the society in which euthanasia and its *surrogates* were legally recognized? Can we talk about a new way of life and thinking, about a new paradigm, about a moral of an anthropology centred on the self where the *individual* dismantled himself/herself of his/her own *personhood*, rejects his/her primordial origin and purpose, lives as long as his/her

life endures and then passes away into non-being when he/she dies? Why has *homo hedonicus freed himself* of the moral precepts that had respected his/her freedom until they became too strict and outdated for him/her?

Euthanasia and its *surrogates* are found in the society of the "liberal cosmopolitan ethos" [14] (p. 129, 143, 162, 311). There is a modern and postmodern way of social thinking which (in the name of unrestrained freedom, pure autonomy, hedonism, and self-interest) sacrifices the respect for life and death with great ease [15]. The progress of civilization and the laboratory pilot programmes transform the entire human perception on life and death. The perception of the *omnipotent* human being on everything that surrounds him/her has brought him/her to believe, without a real basis, that he/she is the absolute sovereign and can decide over life and death. In this *mirage of omnipotence*, the field of biomedical sciences covers the period with the most impressive discoveries and achievements. Unfortunately, some of them generate problems, challenges, and questions that require specific answers and guidelines in order to achieve a profound understanding of the specific realities involved. New scientific and technological discoveries have led from the attempt to decipher the mystery of life to "the medicalized dehumanization of the end of life" [16] (p. 177).

The moral codes established by the Church are no longer a standard for *homo hedonicus* [17]. The Christian Church's recommended rules become too strict for *homo hedonicus* because they do not live up to his lifestyle, and this produces frustration and irritation. That is why he gives up, and then challenges moral religious values. It is, in fact, a struggle with his own weaknesses. Hence, religious values have been replaced by man's desire to have his full autonomy respected: "Autonomy and personal liberty attain an almost sacrosanct status, and 'values', for many, are perceived as 'subjective' and 'personal'" [18] (p. 195). This "dominant secular culture functions as a meta-normative perspective that seeks to relocate, re-interpret, and transform large areas of traditional moralities so as to downgrade the force of claims about a wide range of issues rendering them into life- and death-style choices" [19] (p. 8). We are confronted with an individualist moral, where moral authority has shifted from religious traditions to secular traditions of the self [20, 21]; and the self is the moral authority [18] (p. 195) in a

culture of morals without God's-eye perspective, moral standard or canonical moral perspective [19] (p. 6–7).

In the first place, the increasing permissiveness of contemporary society has led to specific means used to speed intentional death, this being also related to the decreasing importance that religiosity has come to have in the moral life of each person. Through an indissoluble connection to people's lives, (1) religiosity or religious orientation and (2) culture/education influence people's behaviours and attitudes with regard to the complicated problems of life. Religious traditions can contribute to the moral improvement of their adherents in cases where their message is properly understood by them, as some sociologists have indicated [22]. For example, Jews and Christians seem to be more motivated in dealing with moral and ethical challenges due to the salvation that God has performed for them [23]. Thus,

> they are no longer turned in on themselves and confined inside the constraining frontiers of their ego; in contrast to this limiting attitude, their relational self opens up to the broad horizon of the Kingdom that God has initiated – a horizon which is much larger than anything their natural mind could imagine [24](p. 618).

Along with it, the religious orientation of people can be influenced by their experiences, educational history and their fields of study. Several studies have brought up convincing evidence in this regard. On the one hand, religious guidance was significantly different for medical students and students in the humanities, whereas the higher a population's religious orientation levels were, the more they opposed euthanasia [25]. In the same context, a study made in 33 European countries showed that adults with higher academic degrees who declare themselves as less religious were open to euthanasia [26]. On the other hand, a series of recent studies demonstrates to what extent the teachings of the Church are decisive in these life-and-death decisions. Accordingly, with respect to euthanasia, one may claim that: (1) the adoption of religious views leads to non-acceptance of euthanasia [27]; (2) religious people have proved more firm in opposing euthanasia [28, 29], especially Roman Catholics whose points of view are the most restrictive [29, 30]; (3) religiosity, religious values, and the frequency of Church attendance form a vision that constantly undermines the

support for euthanasia or personal justifications for suicide [31] (p. 94); (4) the main increase in openness to euthanasia is manifested in those with minimal religious dependence [28]; (5) the choice and subsequent legislation on PAS in Oregon originated, according to researchers in the field, largely in the non-religiousness of the citizens of Oregon, the state with the lowest rate of religiosity and frequency of church attendance in the nation [32](p. 30), and (6) the French have had a more positive attitude towards euthanasia than Italians and Americans, which reflects the lower religiosity of France compared to that of Italy and the USA [33]. What concerns suicide, the same studies point out that: (1) religion and spirituality reduce the risk of suicide [34], though only among conservative Christians [35]; (2) several religious factors can contribute to strengthening moral obligations against suicide [36, 37]; (3) religious views lead to non-acceptance of suicide [38, 39] and (4) in the United States alone, suicide was the tenth leading cause of death in 2016, with 44,965 people having died by suicide, and 19,362 people by homicide because of putting people before religious principles or considering the self as unique judge [40](p. 35). In this sense, one can notice how the decrease of the religiosity level has serious consequences for the moral order within society, which is to say that Church goers are probably more receptive to its moral standards and are willing to observe the traditional moral rules, whereas the people who do not go to Church "may reject the 'menu' of church beliefs, instead recomposing a religion *à la carte* – constructing their own religious patchwork" [41] (p. 115). Furthermore, it is evident that a pious believer is less permissive in his/her morality than non-religious people who are less devoted to a particular moral system [42].

Secondly, referring to the present-day European area one can speak of a bimoral Europe. On the one side, the Christian faith and especially its practice in the West have been *eroded* by other religious or pseudo-religious and secularist culture with many effects such as self-sufficiency, indifference, or selfishness encountered in various shapes: utilitarian, hedonistic, etc. Also, secularization has forced religious decline so that moral guidance coming from the Christian Church is no longer popular nowadays and participation at religious services has declined. A recent study focused on the four major themes of homosexuality, divorce, abortion, and euthanasia illustrates that in Western Europe: (1) the presence of the Church in society has clearly

decreased in the last decades and (2) the reduced attendance in Church is in perfect harmony with the increased acceptance of the four mentioned themes. On the other side, in Central and Eastern Europe, as also shown by this study, the population is much more conservative than in the West [43] (p. 624–625). However, given the ongoing political, social, and religious changes taking place in these parts of Europe [44], one may ask: how long will this conservatism persist?

A comparative analysis of the European countries indicates that any form of assistance in suicide is strictly prohibited and incriminated by law in most of these states [45]. Nevertheless, a recent study regarding the approval rate of euthanasia in Europe showed a growing tendency for approval as well as a wide permissiveness of the practice, but at the same time an East-West polarization as well [46]. The predictions of researchers in this field are summed up in a quotation by the Oxford professor Julian Săvulescu when he says "Eventually all civilised countries will legalise euthanasia and assisted suicide – it is really just a matter of time." This is because the concerns of some that people might feel pressured to commit suicide were not substantiated in the aftermath of the legalization of the practices in the Netherlands and Belgium. "People want to have control over their death, and there is no reason for the state to intervene in the liberty of one individual to access assisted suicide or euthanasia when another individual is prepared to provide it," the professor adds [47] (p. 433). 67,786 citizens from 47 European countries were interviewed in the survey. The acceptance of euthanasia varied substantially, with the highest approval percentages registered in Denmark, followed closely by Belgium, France, the Netherlands, and Sweden [46] (p. 145). The lowest percentages were registered in Kosovo, Cyprus, Turkey, Georgia, and Armenia. A significant increase in the acceptance of euthanasia was recorded in Spain, Portugal, Great Britain, Germany, and Italy, while the most dramatic decrease was observed in the Russian Federation, Ukraine, Greece, Slovakia, and Belarus [46] (p. 145).

The antagonistic position between the Western and Eastern countries is, according to researchers, based on the inhabitants' positions with regard to religious values and the influence of faith among them. Two groups can be distinguished, with the first including the extremely religious countries that strongly reject euthanasia. These are Turkey, Kosovo, Malta, Georgia, and Cyprus. The second group,

with an equal number of countries but with the opposite views includes the Netherlands, Belgium, Denmark, France, and Sweden [46] (p. 145). Religious characteristics are highly important descriptive factors, both on an individual and global level. On the one hand, greater acceptance of euthanasia among non-religious people is probably rooted in the influence of secular culture that puts a relatively high value on the freedom of choice and pure autonomy in issues of life and death [48]. Grounded in this secular culture, an "after God" culture emerges: "after Metaphysics" – "a culture that articulates its concerns fully within the horizon of the finite and the immanent" – and post-traditional European culture – "a culture that is no longer structured by the traditional Christian norms" [19] (p. 5), that

> re-locates traditional moral norms of sexuality, reproduction, marriage, and end-of-life decision-making within a moral perspective that would transform traditional moral norms into quasi-aesthetic norms shaping alternative life-style or death-style choices. The dominant secular morality of the West invites the demoralization and deflation of traditional Western morality, Bioethics, and palliative care ethics [19] (p. 8).

The continuous secularization process, present also in religious areas, has influenced some religions to take a more liberal path [49], even towards a religious acceptance of euthanasia [50]. In general, Protestants seem to support euthanasia more than Roman Catholics, Orthodox and Muslims. In Protestantism there exists a variety of opinions about euthanasia [51] (p. 424). Some Protestant communities seem to argue that when a person is suffering from an end-stage disease, he/she can appeal to this way of dying [52]. Additionally, Roman Catholics from Spain and France are more permissive regarding euthanasia than those in Hungary and Poland. On the other hand, one can argue that the dominant culture in a country can play a more decisive role in determining opinions on euthanasia than the religious positions of the denomination with which a particular country is commonly associated [53], a present phenomenon, as one may see below, in the Netherlands and Belgium as well.

B. The Necessity of Directives from the Church

Firstly, the current practices of hastening death draw attention to a complex set of fundamental questions which have become irrelevant for *homo hedonicus*: What is life? Where do we have it/where does it come from? To whom does it belong? What about death? For Christians, man is the image of God in the world. He receives life as a gift from God, hence his responsibility towards the gift and the Giver as a testimony of the Christian ethos [54] (p. 445). Man's life is the supreme gift of God; the beginning and the end of it depend entirely on Him [55]: "In His hand is the life of every creature" [56]. God respects us as persons with free will, which is why He knows that some can accept the gift and some can reject it. God respects each of our decisions due to the freedom that He gave us. He does not compel us to live [57]. If someone decides to commit suicide, He does not prevent him/her, which shows that He respects every person's freedom [58] (p. 138). God does not prevent us from choosing, but this does not mean that man will not be responsible for his choices [59]. Life as a gift is not simply to be disposed of at the whim of the recipient, for "this is a gift that is not a property to possess" but rather "a task to live out, a task where freedom follows upon responsibility" [54] (p. 446). Life as a gift is the gift of immortality; accordingly, man's life is the supreme gift of God. He created man immortal by grace, and immortality is the natural state of man. Death, suffering, and pain came to the world through sin: death was allowed by God so that evil did not become immortal.[2] On the one side, the Church recognizes the weaknesses of the man, embraces those in pain and suffering, prays for the release of these burdens and for life to end in peace. At the same time, the Church claims that behind every suffering there is a blessing of God. It is the

[2] According to the biblical creation narrative, the primordial humans were not submitted to dying. The Church Fathers confess that the man in the adamic state did not experience physical or emotional pain. Death appeared after man opposed the word of God wishing to be like Him. Man's main loss was the cessation of the paradisiacal existence and happiness. This resulted in serious perturbations of man's life who had become estranged from his authentic nature. Negative events, conditions, and drawbacks began to emerge, the first of which was death – an unatural event in man's life. As the first humans acquired death through their resistance, so assisted dying is the expression of the second resistance through *homo hedonicus* and thus of a second death.

limit of salvation, the dynamic boundary of the limits of existence, and the means or occasion for the preparation of eternal life. On the other side, the Church has always thought that biological life does not determine the entire existence of man. God created man with body and soul, in a unit temporarily interrupted only by death. Though the body disintegrates by death, the soul persists and continues its existence until the union with the risen body. Death is overcome through Christ, He who defeated death by His death and resurrection. Death is edifying in the process of salvation because the way someone lives and dies sets out the outline of eternal existence.

Secondly, the end-of-life decisions simultaneously constitute a social, cultural and political problem, a relational and personal moral problem with a strong religious substratum. Christian theology has approached the themes of life and death since its inception, these being grouped today under the field of medical ethics. Since the Early Church, theologians have developed moral arguments about sexuality, procreation, and the end of life [16] (p. 122, 123, 167). Because of the present-day Church's involvement in ethical education, some bioethicists have categorized believers who oppose euthanasia as *fundamentalists* [31] (p. 91). Clear directives on the part of the Church and its theologians are still necessary today as a response to the contemporary challenges. The teachings contained in these directives are fully comprehended in the light of the revelation of the Saviour Jesus Christ entrusted to His Church. Based on this revelation, the Church acquired the understanding of human nature and the responsibility to defend its dignity. The purpose of the ethical and religious directives is on this evidence double: (1) the reaffirmation of the fact that the ethical standards in the medical care field originate in the Church teaching about the dignity of the human person, and (2) the presence of an authoritative guidance in delicate moral-medical situations [60] (p. 4). These directives are addressed to both directly and indirectly involved persons: medical personnel, patients, hospital managers, administrators, sponsors, volunteers, students, or priests. The Church's point of view expressed by the clergy is vital in understanding end-of-life situations. Many people in distress call for the support of clergy, thus it plays an important role in the personal decisions of patients [61]. This also includes the shaping of the cultural viewpoint on situations related to and decisions at the end of life [62,

63]. A recent exploratory study, in which 15 clerics were interviewed on end-of-life moral deliberations, including suicide, cessation of unnecessary medical treatment, PAS, and euthanasia, testifies to support this argument of the vitality of belonging to the Church. This study resulted in a set of eight themes that summed up the moral deliberations of the clergy in the presence of those on their deathbeds: (1) *sanctity of life*; (2) *preservation of the natural course of life*; (3) *pastoral care*; (4) *support of the faith community*; (5) *referral to professional services*; (6) *end-of-life decision in community*; (7) *consultation with medical professionals*, and (8) *a shift to a hopeful narrative* [64].

Thirdly, today more than even before, one can speak of a three-step alternative for euthanasia and its *surrogates*: (1) the prevention of the disease – as a constant preoccupation throughout one's lifetime, understood as an attitude of gratitude and respect for the life received as a gift, not as an obsessive purpose;[3] (2) the support for research fields dedicated to medical technologies and pain relief – as a constant preoccupation in the service of developing solutions for the alleviation of pain other than lethal injection, and (3) palliative care – the alternative for euthanasia and its *surrogates* covering the factors that trigger the demand for assisted dying. That is a merciful alternative that truly respects the dignity of the person.[4] Palliative care emphasizes the person as a whole and the worth of life of a patient on his/her deathbed rather than the aggressive treatment against illness or death [65] (p. 2750–2751) because this new medical practice accepts the inevitability of death. The emphasis is on care rather than healing.

[3] Beside (1) each person's own care for the prevention of diseases, it is nesessary that in the near future (2) more doctors specialize in preventive medicine, as prevention impedes the occurance of diseases, whereby the work of physicians will be reduced considerably, and that (3) as many states as possible establish clear strategies for preventing diseases, as epitomized by the Swiss model.

[4] The real alternative does not imply the direct intervention by hastening death, but it allows the patient reconciliation with himself, with his neighbours and with God; in other words, a good, light death, authentically dignified. It is the loving and competent care through the management of pain and suffering for the person on the deathbed. The light/easy death is best exemplified through palliative care, not through euthanasia and its *surrogates*, nor through palliative sedation or the voluntary cessation of nutrition and hydration.

Palliative care means alleviating, reducing, and diminishing pain as well as the consideration of three main aspects [16] (p. 193): (1) focus on managing pain and suffering [66]; (2) concern, both for the medical condition and for the patient's inner/spiritual life [67], and (3) decision-making that respects the patient's freedom of choice [68]. Regarding the previous statements concerning pro-euthanasia attitudes, characteristic of a secularized culture, we move forward to approach the current legal status of assisted dying practices in the states where euthanasia and its *surrogates* have been legally recognized.[5]

III. America

A. The United States of America

The Supreme Court of the United States of America has recognized the quality of citizens to have legitimate concerns about death, and in 1997 decided that death is not a constitutionally protected right, leaving the possibility of regulations on PAS to each individual state [69]. In the USA, the number of states that allow PAS in different forms is steadily increasing. In 1994, following a referendum, the citizens of Oregon voted for the *Death with Dignity Act* (DWDA), a law that would eliminate the difference between the right of a patient in the terminal stage of a disease to refuse treatment and the right to quicken death with a lethal substance [70] (p. 154). The result was, three years after the referendum, the 1997 legalization of PAS (but not of euthanasia) in Oregon through the *Oregon Death with Dignity Act*, "a pioneering law" from the viewpoint of the other states. Some other states like Washington (2008), Montana (2009), Vermont (2013), California (approved in 2015/in effect from 2016), Colorado (2016), District of Columbia (2016/2017), and Hawaii (2018/2019) followed the same legislative process, all of them legalizing PAS, while the debate continues in several other American states, which proves that the legalization of assisted dying practices "in the United States is a train that has left the station. It will eventually reach most of the other [...]

[5] Some aspects related to the assisted dying laws in several countries were addressed in the study S.G. Vulcănescu, "The Legal States of Euthanasia and Its Surrogates around the World," *Apulia Theologica*, vol. 4, no. 1, p. 195-209, Jun. 2018.

U.S. jurisdictions where it is not yet legal" [71] (p. 301). As indicated below, the case of Montana shows some peculiarities.

1) In *Oregon*, patients who suffer from an incurable disease have the right by law to request lethal medication. The requirements that the adult patient has to fulfil in order to receive assistance are: (1) he/she has to be a resident of the State of Oregon; (2) to be in the terminal phase of an incurable disease (6 months or less until the natural death), but still capable of self-administering the lethal substances prescribed by the physician; (3) to be informed as to his/her decision and the options of PAS as well as to be able to justify his/her decision; (4) two physicians have to agree on the diagnostic, the prognosis of the disease, and the patient's capacity for decisions, and (5) the patient has to submit an oral request and after at least 15 days a written request in the presence of two witnesses who must not be his/her relatives [72].

The provisions of the Oregon Act are well known, since the controversies surrounding it are notorious, thus making this Act a model of inspiration for neighbouring American states as well as for European ones. In Oregon, unbearable suffering is not a prerequisite for PAS, and that is why the critics of this law have expressed concern and asked for more safety measures to be adopted. Another cause for concern is related to the difficulty in detecting and diagnosing depression in patients with advanced cancer [73] (p. 178). Between 15% and 50% of patients show symptoms of depression, but only between 5% and 20% of them are diagnosed [74] (p. 101). What we know about the connection between depression and the wish to hasten death is that it causes variability, inconsequence, and instability in the wish to die [75]. From 1997 until the end of 2017, when the law was adopted, a total of 1,967 people had prescriptions written under the DWDA, and 1,275 patients died from ingesting the medications [76] (p. 6). The PAS process starts with the patient ingesting the lethal agent. After taking the lethal substances secobarbital or pentobarbital, the patients become unconscious. Death generally occurs after 25 minutes. In the cases referred to, the complications were attributed to: incomplete substance consumption, medical tolerance, or vomiting. There were patients who regained consciousness after ingesting the substances, which led to a minimum level of awareness, followed by death taking place after a few days, and there was also one person who woke up 3 days after ingestion and lived for another 3 months [77] (p. 9).

2) *Washington* is the second state, after Oregon, to legalize PAS, by adopting the *Washington Death With Dignity* (WDWD) *Act* in 2008. The Washington Act is similar to the one in Oregon: (1) the resident patient must submit two oral requests and a written one at an interval of at least 15 days respectively; (2) he/she has to be of full age, and (3) to suffer from a disease in terminal phase with a life expectancy of 6 months or less [78]. Here one can also note the ongoing growth in the number of people who request and receive medical assistance to commit suicide. Immediately following the legalization in 2009 there were 64 registered deaths, while in 2017 there were 212 requests, out of which 196 persons are known to have died [79] (p. 1).

3) In *Montana*, PAS is permitted according to a decision of the State Supreme Court. Nevertheless, there is no law that recognizes PAS. In December 2009, the Montana State Supreme Court ruled in the *Baxter v. Montana* case that there is no legal provision that prohibits a physician from honouring the request of a terminally ill, but mentally competent patient to be prescribed a lethal agent that can hasten his/her death [80].

4) *Vermont* joined the states which allow PAS in 2013, by adopting the *Patient Choice at the End of Life Act*. In order to be approved for PAS, the patient (1) has to be an adult resident of Vermont; (2) has to suffer from an incurable disease in terminal phase; (3) has to be able to submit his/her request, and (4) to administer himself/herself the lethal agent, and (5) the diagnosis and the prognosis have to be confirmed by a second physician from Vermont [81]. Between May 31, 2013 and June 30, 2017 there were 52 registered requests corresponding to the PAS law, while the disease was confirmed in 48 cases [82] (p. 4).

5) *California* legalized PAS through the *End of Life Option Act*, along the lines of Oregon, in 2015, and the law came into force in June 2016. The State of California recognizes the right (1) of adults suffering from a disease in terminal phase with a life expectancy of 6 months or less (2) to require and receive a medical prescription for the purchase and self-administration of the lethal substances [83]. This law remains in force for 10 years, unless the legislators renew it. Within the first 6 months after the law came into force, 191 persons received medical prescriptions according to the law, out of which 111 died after the ingestion of the prescribed lethal substances [84] (p. 3–4). In 2017, 374

of the 577 persons who received medical prescriptions died after the ingestion of the prescribed aid-in-dying drug(s) [85] (p. 3).

6) *Colorado* was the next American state to legalize PAS. On November 8, 2016, Colorado voters decided to pass the *Access to Medical Aid In Dying Act*. This law followed the Oregon example and came into force on December 16, 2016. This law allows (1) an adult person who suffers from an incurable disease in terminal phase with a life expectancy of 6 months or less (2) to receive a medical prescription for the lethal substances for self-administration, (3) authorizes a physician to prescribe the necessary medication, and (4) establishes criminal sanctions for the case in which one's request for medical assistance or medication is deliberately not honoured [86]. During the year 2017, 50 patients of those 69 who requested medical prescription for PAS died after taking the lethal substances [87] (p. 2–3). With an over 70-percent increase compared to 2017, 125 patients in 2018 received prescriptions for aid-in-dying medications under the provisions of the law [88] (p. 1).

7) *District of Columbia*

In 2017, the District of Columbia followed the other U.S. states which passed a law granting the patients with a terminal disease the right to end their lives through medical assistance. The law permits the request for the medical prescription for PAS to (1) an adult person (2) who is in the terminal phase of an incurable disease with a life expectancy of 6 months or less, and (3) who is capable of making this decision and of deliberately requesting the assistance for suicide [89].

8) *Hawaii*

Hawaii is the most recent US state to grant PAS legal status, doing so in 2018. The law *Our Care, Our Choice Act* became effective at the beginning of 2019 and grants (1) adult patients with a disease in terminal phase and (2) decision-making capacity the right to self-administer the lethal agent at the end of life [90]. Given the short period of time elapsed since the coming into force of these laws in the District of Columbia and Hawaii as well as the special status of PAS in Montana, there are no statistics available for these three US territories.

B. Canada

Canada's resistance to the idea of assisted dying crumbled at an unprecedented speed. In less than two years, Canada changed from the nation where PAS was considered a federal crime to the nation that

adopted one of the most radical systems of legalizing PAS in the world. In 2013, the National Assembly of Quebec, known to be the most liberal among the Canadian provinces, passed *Bill 52*, an Act that gives the right to receive *end-of-life care*. The novelty of this fast paradigm shift has become second to the one redefining the medical meaning of *receiving end-of-life care*. Prior to the passing of *Bill 52*, this process included hospice and palliative care provided to a terminally ill patient by qualified staff. After the law passed, these services came to include the act of administering a lethal injection or substances that expedite death. Offering medical care becomes a contradictory practice since it helps to accelerate death, an act viewed as *support*. Canadian patients must meet the following criteria to qualify for receiving *medical help* to die: (1) they must suffer from a serious and incurable disease in its terminal stage; (2) be medically insured; (3) be at the age of free and full consent; (4) be in an advanced state of irreversible decline in mental and physical capacities, and (5) have constant, unbearable physical or mental pain, from which they cannot be released in a way that they consider tolerable [91] (p. 11–12).

The Quebec law has been in effect since December 2015. After only one year, the mortality rate was three times higher than the Government had predicted. Alex Shadenberg, executive director for *Euthanasia Prevention Coalition*, remarked that euthanasia-related deaths are underreported, even though in Quebec reporting and monitoring requirements are among the strictest [92]. The Government of Quebec recently issued a report in which 262 deaths were registered in the first 7 months since legalizing this practice [93]. There are also 3 cases mentioned where the law was not observed, without any other information regarding the consequences of these transgressions. This made an enraged Aubert Martin, the executive director of the anti-euthanasia organization *Living with Dignity*, state: "We are talking about killing a human being. This is criminal" [92].

PAS became legal across Canada on June 17, 2016. The bill known as *C-14* allows *Medical Assistance in Dying* (MAID) for (1) medically assessed adult patients (2) who experience intolerable suffering as an effect of an irreversible medical condition, and (3) who face imminent natural death [94]. According to the report from Health Canada, there were 1,982 medically-assisted deaths in the first year after it became legal (803 assisted deaths in the first 6 months and 1,179 in the

following 6 months) [95]. By December 31st, 2017, the number of persons who received MAID in Canada amounted to 3,714 [96]. The most common underlying medical condition was cancer, while other common reasons were neuro-degenerative disorders and circulatory or respiratory system failures [95]. An independent report on the status of *mature minors*, with focus on their potential eligibility for MAID, was required by the 2016 Act and is expected to be approved [97].

C. Colombia

Euthanasia was decriminalized in Colombia in 1997 when the Colombian Supreme Court pronounced a favourable sentence in a case where the right to euthanasia was requested. For over 15 years euthanasia was practiced in Colombia without legal regulations. The Supreme Court subsequently decided that this practice cannot be deemed criminal under certain circumstances. In a 2014 process the Court issued two orders to the Ministry of Health and Social Protection in order: (1) to offer support to the Interdisciplinary Scientific Committee which is the enabled institution to evaluate the requests submitted by patients and (2) to prepare a medical protocol that should serve as a guide for physicians and be applied as a reference for the assisted dying procedures, after it was discussed previously by a group of experts from different fields [98].

In July 2015, the Congress of the Republic of Colombia presented a bill that regulates the assisted dying practices in Colombia. This bill defines the necessary steps to be observed and establishes the monitoring and assessment mechanisms for correctly implementing the law, according to the guidelines proposed by the Ministry of Health. The preliminary conditions of the law are: (1) the patient must possess Colombian citizenship and be at least 18 years old; (2) must suffer from an incurable disease in its terminal stage; (3) must have the full capacity of mental faculties at the time of submitting the request; (4) the request must be written, voluntary, repeatedly submitted and signed in the presence of two witnesses or, in the case of the patient's inability to sign, by a person previously designated; (5) if the patient is unconscious and cannot express his/her will by any means, the family or (if he/she does not have a family) the physician can become the decision-maker; (6) the physician must be aware of the patient's serious medical condition which causes him/her great suffering, as well as the patient's

capacity for decision-making. Additionally, the physician must inform him/her of the alternatives to euthanasia, the process and its consequences, and (7) after the assessment of the patient and his/her decision-making capacity, the physician sends the request to the Interdisciplinary Scientific Committee for verification [99].

According to the resolution published in March, 2018, by the Ministry of Health and Social Protection in Colombia, minors are allowed to request euthanasia when they suffer from a severe affliction for which there is no reasonable hope for healing. Whereas children under 6 years old were excluded from the euthanasia procedure, minors between 6 and 12 years old can require it if one proves a "neurocognitive development and exceptional psychological that allows them to make a free, voluntary, informed and unequivocal decision in the medical field and their concept of death reaches the expected level for a child over 12 years old" and if they have the consent of both parents. When it comes to adolescents who are 12 to 14 years of age, if there is a discrepancy in the parents' decisions, the will of the patient prevails. Finally, beginning with the age of 14 the decision of the adolescent prevails [100].

IV. Europe

A. The Netherlands

In 2002, the Netherlands was the first country in the world to legalize both euthanasia and PAS [101] (p. 197). A long process of deliberation and tolerance preceded legalizing these two practices. In the mid 1980's, the Royal Dutch Medical Association and the Attorney General came to an agreement regarding euthanasia. If a series of strict conditions were met, the physician conducting the process of euthanasia could not be put under investigation and, consequently, convicted. The first step was to define euthanasia as the ending of the patient's life at his/her own request. The second step was to establish criteria that include: (1) the voluntary request of the informed patient; (2) unbearable suffering; (3) lack of alternatives and of an improvement in health perspective, and (4) consulting a second physician [102]. In the first phase, a prosecutor was the one who evaluated whether all the criteria were fulfilled. From 1998 onwards, the prosecutor's task was taken over by a commission composed of a lawyer, a physician, and an

ethicist. On January 1st, 2002, this practice became, with slight changes, formally legal.

Despite all protests and critiques, Holland has endorsed the practice of euthanasia thus becoming an emblematic case for the states that had debates and similar bills on their public agenda. The Dutch professor Theo Boer, a former member of the Evaluation Commission, sees Holland as "a laboratory from which other countries may draw lessons when considering the option of legalizing euthanasia" [101] (p. 198). In the religious circles in Holland the reaction was inconsistent and equivocal at the beginning. While Protestant theologians like Willem Velema and Jochem Douma opposed euthanasia vehemently, the liberal theologians Harry Kuitert and Heleen Dupuis played a major role in promoting euthanasia both in the Christian and in the lay community [101] (p. 198). One emphasized the individual responsibility in the interpretation of the Holy Scripture as well as in the moral capacity to make decisions. What is not mentioned very often when discussing the role of religion in this controversy is the tradition of Dutch liberalism and pluralism. The Netherlands has developed into an important maritime centre and home to many people from different social, ideological, and religious backgrounds. The liberalism of some Dutch theologians influenced by these varied worldviews has been steadily reformulated resulting in the abandonment of the precepts of traditional morality altogether and the idea that a new ethic should not be grounded on the Holy Scripture.[6]

Since the institutionalization of euthanasia in the Netherlands, the majority of euthanasia cases have been performed for people who suffered from terminal stage cancer, a few days, or a few weeks before the occurrence of natural death; these cases were known under the term *traditional cases of euthanasia* [101] (p. 198). Lately, a new category of requests has emerged, not submitted by terminally ill patients as has

[6] "Leading Reformed theologians have stressed the corruption of reason and insisted on a close link between Scripture and morality. For religious and secularized debaters alike, the rejection of religious convictions was assumed to logically imply the rejection of a traditional morality. There have been media discussions in which Reformed Christians virtually prove their opponents right in abandoning a traditional morality and embracing a liberal one: once these opponents – tragically – have rejected the Bible as the basis for ethics, what else is there left?". [101] (p. 209–210).

been the case up to this point. These *new patients* register themselves on the waiting lists justifying their resolution with age-related problems, chronic diseases, exhaustion, the loss of social status, or even loneliness [101] (p. 205). For this new category of applicants who do not receive the approval of the authorities, while fulfilling some conditions of the law, the Clinic End-of-Life offers assistance in dying [103].

The laxity with respect to the initial obligations has also brought about abuses, considering that in Holland the number of persons euthanized or medically assisted in suicide grew from 1,923 in 2006 to 6,091 in 2016, a growth namely of 317% [104]. The evaluation commissions ascertained that there were many cases in which the law was not observed or the physician did not act in conformity with the law, while some patients seemed to have the chance of improvement [105]. Dutch prosecutors are investigating more and more cases that concern suspected abuses committed by Dutch physicians who euthanized ineligible persons [106]. For example, a Dutch physician is currently being tried for the violation of the euthanasia law after having euthanized a woman with dementia without her expressing the wish to be euthanized [107].

B. Belgium

On January 20th, 2001, a committee formed of representatives of the Belgian Senate voted in favour of a law regarding euthanasia. According to this law, neither this practice nor the medical staff who performed it could be prosecuted as long as the legal requirements were met. On May 16th, 2002, after two days of harsh debate, the lower house of the Belgian Parliament passed the law with 86 votes in favour, 51 against, and 10 abstentions [108] (p. 290–291). After euthanasia has taken place, the resulting death can be classified as a *natural* death according to Article 15 in the *Euthanasia Law*, eliminating the legal duty to inform the prosecutor or the coroner. This legal duty consists of writing the patient's death certificate and sending a report to the Federal Commission for Euthanasia Control and Evaluation (CFCEE) within 4 days, after which this authority has to determine whether the procedure was carried out correctly or not. The Belgian euthanasia law, in effect since September 23th, 2002, mentions in Article 3 that the physician who carries out euthanasia is not committing a crime as long as he/she ensures that: (1) the patient has reached the age of maturity or is an

emancipated minor and is conscious at the time of the submission of the request; (2) the request is voluntary, well considered, repeatedly submitted, and not the result of external pressure; (3) the patient has a serious medical condition as the result of an incurable disorder caused by disease or accident in which physical or mental suffering is unbearable and constant and can no longer be mitigated; (4) the patient has been informed in a proper manner about the available treatment options, and (5) a different independent physician was consulted [109]. This legislation took effect on September 23rd, 2002, and has since then been modified twice: on November 10th, 2005, in regard to the legal security of the pharmacist who offers the so-called *euthanatica* used by a physician who practices euthanasia, and on February 28th, 2014, in regard to euthanasia for *capable minors* [110] (p. 41). Statistical data show a constant annual increase of euthanasia cases so that their number grew with ca. 900% from 259 persons in the first year to 2,309 in 2017 [111].

In Holland, liberalism and pluralism are considered the ideological foundations on which the law of euthanasia was based. In Belgium, among many other controversial laws, the legal recognition by the Belgian Government of secular humanism alongside 6 other belief systems can be undoubtedly mentioned as the starting graft in the new legislative approach to life and death. Since 1981, the Belgian Government has paid humanitarian counselling services, the secular equivalent of clergy, to provide moral guidance to those in the army, hospitals, and prisons, and human values (autonomy, ethics based on reason and science etc.) are taught in Belgian schools as part of the non-confessional ethics curriculum. This includes the subject of euthanasia which is "part of a philosophy of taking control of one's own existence and improving the objective conditions for happiness. There is an arrow of evolution that goes toward ever more reducing of suffering and maximizing of enjoyment", says Jan Bernheim, professor emeritus of Medicine at the Free University of Brussels [69].

While being the second country in Europe to legalize euthanasia, Belgium has become the state with the highest rate of deaths through assisted dying in the world [112], but also the indisputable leader of leniency regarding the acceptance requirements for intentional death, having turned into a counterexample for the countries that legalized or are about to legalize assisted dying practices. Several amendments to

the initial euthanasia law have transformed Belgium into the most open-minded country as far as euthanasia is concerned and also the most debated and controversial of all the states which recognize assisted dying. In this sense, the following aspects should be mentioned:

(1) The Belgian controlling system of euthanasia cases which functions *a posteriori* has not proved itself capable of protecting the patients against the procedures that infringe the law [110] (p. 28). The physicians [113] (p. 617–618) as well as the members of the CFCEE seem to be overwhelmed by the very high number of cases they have to assess [114]. This led to only a summary evaluation of the thousands of annual cases and to an underreporting of approximately 50% [115], a fact which confirmed many of the previous worries and warnings [116]. Moreover, this commission raised a series of suspicions as to the objectivity and independence of its members given that almost a half of the 16 commission members are affiliated to *right to die* associations [69];

(2) *The disregard of the requirement relative to a serious and incurable disorder* or the acceptance of euthanasia in the case of persons with "multiple disorders" [110, 117] – a commonly used expression which is however not found in the euthanasia law [109], nor in the parliamentary reports [110] (p. 30). The requests of those persons are approved with increasing frequency, although they cannot attest they have a severe incurable disease, and suffer from various age-related afflictions like, for example, polyarthritis, while having reduced mobility, weakened eyesight, or hearing disorders [110, 117];

(3) *The disregard of the requirement with respect to physical or mental suffering* or "the 'cure' of suicidal depression" [118] (p. 193). In this situation there are some problematic issues which tend to be ignored: (a) the usual confusion between mental suffering and mental illness; (b) the fact that there are no measurable parameters for objectivity in this regard [110] (p. 34); (c) depression and other similar forms of mental suffering consist of exactly the loss of any wish to live and of any life perspectives, which means that the feeling of having no perspectives and the wish for euthanasia do not indicate the prognosis of the mental suffering [119], and (d) the Belgian euthanasia law stipulated that psychiatric disorders, dementia and depression do not fall under the category of afflictions admitted for euthanasia [109]. However, the list of these excluded afflictions is constantly reconsidered and modified

along with the acceptance of an increasing number of euthanasia applicants with psychiatric disorders, dementia or depression [120];

(4) *Being tired of living* has become a relatively common condition for which physicians permit euthanasia [121];

(5) *Palliative care centres have become real euthanasia houses* as soon as euthanasia was officially accepted as an option within the palliative care program [122] despite the reactions of the World Health Organization [123] and the European Association for Palliative Care [124] which had opposed the introduction of euthanasia in palliative care. The Belgian model of combining euthanasia with the palliative care represents the promotion of a culture with "a high degree of tolerance and compromise" [125] (p. 524) and creates an unclear image, so that many people at the end of their days are afraid to resort to a palliative centre due to the possibility of euthanasia [126] (p. 105–106). At the same time, this integral model testifies to the negative impact that euthanasia has on the palliative care sector [127];

(6) *Permission for the transplant of viable organs from euthanized persons* [128] causes a new dilemma concerning the possible pressure exerted on a patient who could be euthanized only for the extraction of organs [129] (p. 488). Part of the debate are also the requests of some inmates in prison who, deprived of freedom, claimed to be suffering from psychological afflictions and, accordingly, asked for euthanasia and agreed to donate their organs [130]. In contrast, the most important international transplant organizations condemn the acquisition of organs from detainees in China, which is deemed as commercial exploitation, a violation of human rights, and an unacceptable practice [131];

(7) *The extension of the law to include minors* [110] (p. 41) without previous serious consultations with approval from paediatricians with experience in treating severely ill children [132], and neglecting that: (a) "emerging adulthood" – the coming of age takes places at the age from 18 to 25 years [133]; (b) a minor's capacity to fully understand the terms and medical details of the informed consent is insufficient [134], and (c) the external influences in making very difficult decisions can be sometimes exceedingly powerful, so that the freedom of decision-making is diminished [135];

(8) *The illegal practice of PAS* – although the Belgian legislator decided from the beginning that PAS has to be excluded from the application

of the euthanasia law [110] (p. 35–36), euthanasia and PAS are considered medical procedures [125], on which ground requests for PAS are regularly approved [136];

(9) *Sedation as clandestine means of euthanasia* or "underground euthanasia" – one has ascertained an increase in the use of sedation as secret means for euthanasia [137] (p. 251) as well as for causing death without the consent or request of the patient/family in 27,9% of the cases reported by specialists in the medical field [138], a fact even recognized by the representatives of the Belgian Society for Intensive Care Medicine [139] (p. 174);

(10) *Going from an exception or ultimate solution to a legal right, normality, and particular dynamic* – in 2002, euthanasia was presented as an ethical violation, an exceptional act or an ultimate solution for extreme cases [140]. Then, it was claimed that "euthanasia is neither an exception nor an ethical transgression and its practice, properly regulated, is part of end of life care" [141] (p. 24). Today, one may find websites [142], official documents [143] and informative brochures [144] that confirm *man's right to euthanasia* [145] (p. 229), something that is being stabilized in Belgian society as a rather current practice [145] (p. 230), as a valid option at the end of life [146] (p. 1180). In addition, one can notice

> there is an indication that euthanasia, once the barrier of legalisation is passed, tends to develop a dynamic of its own and extend beyond the agreed restrictions, in spite of earlier explicit reassurances that this would not happen – in Belgium, such reassurances were given when the 2002 law was being debated [145] (p. 226).

C. Luxembourg

In 2009, the Grand Duchy of Luxembourg adopted a law regarding assisted dying, becoming the third European state to legalize it after the Netherlands and Belgium. This law stipulates that the physicians who perform euthanasia or PAS will not face legal sanctions or civil suits provided they consult with a colleague first, in order to attest that the patient suffers from a severe, incurable disease [147]. The prerequisites for a request to be accepted are: (1) the patient suffers from an incurable disease that causes him/her unbearable physical or mental suffering; (2) the patient is in serious medical condition as a result of an

accident or illness; (3) the patient is conscious and capable when submitting the request, and (4) the request must be written on a voluntary basis, repeatedly if necessary and should not be the result of external pressure [148]. The law was voted by the members of the small Luxembourgian Parliament with high support of its citizens, despite the firm opposition of the Roman-Catholic Church. The Church, by means of a powerful campaign against this law, succeeded to provoke one of the biggest debates in the history of the Grand Duchy. The euthanasia law even led to the need to change the Constitution following the refusal of the Grand Duke, Henri, to sign the Act, thus forcing the Parliament to add an amendment to the Constitution that reduces the monarch's power to a mostly ceremonial role [149].

D. Switzerland

In Switzerland, assisted suicide (AS) does not have a special legal status as is the case in the other states which recognize this practice. The assistance in suicide is based on Art. 115 of the Criminal Law that decriminalizes this practice as long as one does not act in one's own interest [150]. Different from other legislation, the preliminary condition of the existence of a terminal disease is not specified in Art. 115, nor are other conditions. Thus, the logic behind the decriminalization of AS resulted from the lack of incrimination. According to the principle *nulla poena sine lege*, a person must not be punished for something that is not prohibited by law. Since the parliamentarians did not have a medical perspective when they elaborated Art. 115 in 1918 [151], the Federal Supreme Court of Switzerland recognized an individual's right to request AS when this person (1) is aware of the procedure, (2) does not act under the influence of a third party or out of impulse, (3) the wish to die persists, and (4) he/she commits the act with his/her own hand [152]. In Switzerland, there is no obligation to report AS cases in a central register, and so the registration of the cases may be incomplete. However, the Federal Statistical Office makes considerable efforts to track the cases of AS in collaboration with the *right to die* organizations, the institutes of forensic medicine and physicians [153] (p. 1).

Contrary to the situation in the Netherlands, Belgium, and Luxembourg, the Swiss law does not authorize physicians to perform AS [154]. Switzerland is the only country in the world where the

alternative practice to PAS, AS, is performed. This process allows a non-resident patient to obtain a lethal substance (barbiturates) from the *right to die* organizations. Thus, suicide assistance can be given to a person who: (1) is aware of this procedure; (2) does not act by impulse or under the influence of another person; (3) has a persistent desire to die, and (4) commits the act himself/herself [152].

Non-governmental organizations play a central role in facilitating AS in Switzerland and in the US State of Oregon. In Switzerland, the so-called *right to die* organizations offer assistance to their members who want to commit suicide [155] (p. 810). The most influential are: Exit Deutsche Schweiz [156], Exit ADMD (Association pour le droit de mourir dans la dignité) [157], ExInternational [158], Dignitas [159], SPIRIT [160] (p. 612), and StHD + SterbeHilfe Deutschland [161] (p. 612). Four of these organizations provide suicide assistance to non-Swiss citizens, and this situation has led to the emergence of the term *death tourism*. The most well-known organization that offers this service is Dignitas, which is also the most controversial organization. The particularities of the organization have led to intense discussions on *suicide/death tourism*. Media investigations revealed that the suicides committed by some Dignitas members were carried out in cars, by using plastic bags or inhaling helium, all of which are anything but assistance with the aim of an *easy death* [161, 162]. Former volunteers of the organization argued that applicants did not even have enough time to reconsider their wish to hasten their deaths. In addition, there were cases in which patients received lethal drugs on the same day they arrived after only a short interview [163]. At the same time, the Dignitas organization is constantly accused of a lack of transparency in financial terms, and it is further suspected that many members leave them their inheritance, contrary to the Swiss law that compels the respect of altruistic behaviour [154] (p. 249). The online news outlet the *Mirror* has reported that

> Healthy people are travelling abroad for assisted suicide simply *weary of life*, research has revealed. […] Around 16 percent of the people who use *right-to-die* organizations such as Dignitas have no underlying health problems listed on their death certificates. And women, highly educated, divorced and rich people are more likely to die from assisted suicide [165].

According to the law, members must repeatedly request assistance to commit suicide because of unbearable suffering; then, the person is examined by a physician who decides whether the patient has the ability to decide for him/herself and if he/she can be prescribed with barbiturates. In case of approval, a volunteer within the organization purchases the barbiturates from a pharmacy and then deposits them at the clinic until they are used. On the day the suicide is scheduled, a volunteer will re-evaluate the member's ability to make decisions, and if it is determined that the patient reaffirms his/her wish to die, the volunteer will mix the substances in drinks or food and will then hand them over to the patient. If the patient is unable to swallow, a feeding tube will be inserted into his/her stomach through the abdominal wall or intravenously, so as for him/her to be able to administer the lethal substances by him/herself [166] (p. 295). In the presence of friends and family, the patient will self-administer the lethal substance and then he/she will say goodbye to his/her loved ones and fall into a deep sleep. Death occurs in a very short time as the result of cardiac arrest. After the patient is dead, the Swiss police is notified, which, together with a coroner and a district attorney, assess the legality of the file and of the procedure [155, 166, 167].

Because there is no central registration system, as mentioned above, the existing data about the frequency and amplitude of AS are limited. There are however several international studies that used the official data from the Institute of Forensic Medicine in Zürich, the organization responsible for the investigation of all the *extraordinary deaths* in this region where the centres of Exit and Dignitas are located [168]. In the interval January 1st, 2008 – December 31st, 2012, 950 cases were registered, of which 611 cases of *suicide tourism* were analysed – the cases of *suicide tourism* doubled from 2009 to 2012 [160] (p. 613–614). The most recent study regarding the rate of AS in Switzerland shows a tripling from 2003 to 2014 [153]. The increasing incidence of AS cases in Switzerland is based on a large acceptance by the Swiss population confirmed through referenda and social inquiries [169].

E. Germany

The German legal and political elites have a long history of ethical reflection on the topic of euthanasia. In order to avoid any approach that could lead to similarities to Nazi *euthanasia*, those who supported

the legalization of assisted dying wanted to clarify the non-involvement of the state in the decisions of the patients, with it being considered a decriminalization rather than a right. Prior to the current law, assisted dying existed in a *grey* legislative zone of the German legal system. Physicians were allowed to speed up death for terminally ill patients by providing high doses of painkillers or by withdrawing treatment following patient requests. This legislative vacuum also existed because of the historical connection of the practice of euthanasia with the Nazi regime. During the National Socialist government, *clandestine euthanasia* began as a eugenic measure in 1939, and approximately 275,000 people with physical or mental disabilities, children and adults were systematically killed [5] (p. 158). Hence, today's avoidance of the term *Euthanasie* ("euthanasia") and the use of the terms *Sterbehilfe* and *assistierter Suizid* ("euthanasia" and "assisted suicide").

The German Parliament adopted a bill on November 6th, 2015 which allows assisted dying provided it takes place *on an individual basis*, *for altruistic reasons* [170], while it prohibits this practice if it has a profit as its purpose [171]. The Parliament of Germany modified Art. 217 of the Criminal Law in order to decriminalize it, although only under certain circumstances. The law (1) prohibits and punishes any attempt to commercialize assisted dying services; (2) any kind of material benefits and *death tourism*, as in the Swiss case, shall be punished by imprisonment of up to three years, and (3) the patient's relatives and close friends as well as the physicians who act out of altruism in individual cases of assistance to the persons who wish to hasten their own death will not face prosecution [172]. Nevertheless, the law remains unclear and inaccurate because of the type or the specific mean of assisted dying is not mentioned [173] (p. 691).

In the process of deciding on the law with regard to assisted dying, a moderate bill was accepted by the German Parliament that aims to indicate a middle way between complete incrimination and a total liberalization of such practices [174, 175]. Thus, the German law appears as different from other similar laws in the sense that, on the one hand, it protects assisted dying from being performed for financial reasons, and, on the other hand, it allows assisted dying not as a right of the citizen, but rather as a practice that does not contravene the law. In other words, the emphasis is not placed on the person and his/her

rights, but rather on whether this undertaking is or is not against the law [176] (p. 23).

V. Australia

On March 25th, 1996, the Northern Territory of Australia became the first jurisdiction in the world to legally allow euthanasia and PAS by adopting the *Terminal Act III 1996* [177] (p. 540). This law permitted adult persons suffering from a disease in terminal stage to request the assistance of a physician in hastening death. In 1997, the Australian Government abrogated the euthanasia law by limiting the legislating role of the regions of Northern Territory, Australian Capital Territory, and Norfolk Island [178]. Consequently, after 9 months and 4 suicide cases, the law was abrogated [137] (p. 239).

In June 2016, the Standing Committee on Legal and Social Issues of the Parliament of Victoria recommended the legalization of PAS in the Australian state of Victoria [179]. The final report of the Committee made several recommendations relating to the improvement in providing end-of-life care based on the laws in force in the state of Victoria as well as the legislation of the states where this practice had been legalized. In order to be eligible for PAS, the patients (1) have to be residents of the state of Victoria, (2) with a severe and incurable disease (3) that causes an unbearable and long-term suffering, and (4) have to be at the end of life, i.e. the last weeks or months of life [179] (p. 238). Following this legislative proposal, the Government had 6 months to respond to this project [180]. In December 2016, the Government announced that it accepted this bill [181]. The vote was given in November 2017 and in the middle of 2019 Victoria will become the only Australian state which legally recognizes PAS [182]. In this sense, Premier Daniel Andrews declared himself "proud today that we have put compassion right at the centre of our parliamentary and our political process" and he considered the day of the vote "a day of reform, a day of compassion, a day of giving control to those who are terminally ill" [182]. Victorian Health Minister Jill Hennessy said that the long debate gave the Parliament the chance to properly analyse what a *good death* means and added that "We've had some frustrating moments, but ultimately we have landed in a place where Victorians who are confronted with terminal illnesses, that are enduring

unbearable pains, will have a safe and compassionate option around assisted dying" [182].

VI. Conclusions

The meaning of the term *euthanasia* has undergone two major changes since its usage in Antiquity. The first change consisted in the contemporary re-appropriation of the ancient concept of a *good death* within the framework of the debates about the legalization of assisted dying in some countries. The second shift has taken place in the most recent years and represents the contrast between the initial definitions given by the first laws on euthanasia, assisted suicide, or physician-assisted suicide that were passed in several states of the world, and the actual effects of these laws on a practical level. With reference to the latter transformation, the discussion above has shown that euthanasia creates a dynamic and a direction of its own which can be measured not only by the worrying increase in the number of the euthanized persons, but also by the constantly expanding spectrum of afflictions approved for euthanasia or by the reduction of its restrictions. The momentum of euthanasia proves that it cannot be fully controlled by the law and that the slippery slopes associated with euthanasia transform it into a slippery slope itself.

It is obvious that euthanasia and its surrogates have gained ground in a pattern of society characterized by a high degree of secularization. Within this type of dominant culture *homo hedonicus* affirms his wish (that has reached an almost sacrosanct status) for pure autonomy and boundless sovereignty over his own life and death. Moreover, one rewrites traditional morality by replacing it with the self as the centre of moral authority. On the contrary, studies have pointed out that religion and spirituality reduce the risk of suicide, that religious values, and the frequency of Church attendance form a vision that constantly undermines support for euthanasia or creates the feeling of non-acceptance of euthanasia. The main increase in openness to euthanasia is manifested in those with minimal religious dependence. A pious believer is less permissive in his/her morality than non-religious people who are less devoted to a particular moral system. The Christian Church, its doctrine and faith, can truly and comprehensively contribute to understanding the meaning and purpose of human life. The Church can maintain a scientific and clinical direction in

accordance with the adjacent rules, guaranteeing the relevance of the basic principles of Christian anthropology.

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