



Arguments in Support and Against Euthanasia

Visnja Strinic^{1*}

¹Municipal Criminal Court, University of Split, Dracevac bb, 21000 Split, Croatia.

Author's contribution

Author VS designed the study, wrote the protocol, searched the literature and wrote the manuscript.
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ABSTRACT

The aim of this article is to present and confront the arguments in support of euthanasia and physician assisted suicide, and the arguments against. The arguments for and against euthanasia are listed and discussed to literature cited.

Euthanasia is an act of mercy, and, basically means to take a deliberate action with the express intention of ending a life to relieve intractable, persistent, unstoppable suffering.

The phenomenon about both the morality and legality of euthanasia and physician assisted death have been a significant debates of the last decades of the twentieth century and they will remain further a source of controversies.

This paper explores and analyze the arguments in support and against euthanasia and physician assisted suicide. For the purpose of this article has been viewed over the Internet and Google total of 247 journal articles, book chapters and websites, and, in writing of this article we used 74 references cited in the manuscript.

The 'end of life' issue in relation to euthanasia and physician assisted suicide is a most widely discussed phenomenon not only in academic and official literature, but also in daily life.

Euthanasia should be legally permissible if certain conditions are present: the patient is terminally ill, death is imminent, and, treatment was appropriate and well. If a patient autonomously chooses to end his life or have someone else assist him in doing so, then it is morally permissible. Patient must be fully informed of the diagnosis and prognosis of an incurable, fatal disease, and competent

*Corresponding author: Email: tstrinic@kbsplit.hr;

to make the decision.

This article is a contribution to the debate on the important topic of euthanasia.

We conclude that euthanasia should be used only in cases of last resort and not as an alternative to palliative care.

Keywords: Euthanasia; physician-assisted suicide; medical arguments; arguments support euthanasia; arguments against euthanasia.

1. INTRODUCTION

Advances in medical technology means that people are living longer. The population is aging, and modern medicine has extended people's life span with the result that it is more likely now than in the past that the people will die of chronic degenerative diseases. Euthanasia has been a subject of controversy for more than three thousand years [1].

Some people argue that there are many people suffering greatly who would benefit hugely if euthanasia were legalised. The response given by some is that the number of people who would feel threatened by a law allowing euthanasia is much greater—the elderly, people with disabilities, people who are unwell etc. Euthanasia and the physician assisted death involving many medical, ethical, legal, personal, sociocultural, anthropological, and religious issues. The anthropological issue is the core of both human rights and bioethics. The debate on legalizing euthanasia and physician assisted suicide has a broad range of participants including experts in health law, physicians, experts in ethics, politicians, and the general public [2].

Palliative care developed new ways of caring for terminally ill patients, emphasizing moral values and virtues such as compassion, quality of life, and hope.

Euthanasia is illegal in most countries worldwide, because, euthanasia and assisted suicide are against the law. The most important reasons for her illegal status are: euthanasia is murder, and, legalization of euthanasia leads to more and more killing and destroying a life. The goal of medicine is to heal and not harm, euthanasia is a direct violation of doctors' Hippocratic Oath, and destroys patient trust in the medical profession. Euthanasia is unnecessary because of hospices, modern drugs and other alternatives. People who request mercy killing don't actually want to die. Legalization of euthanasia sends a message that life is not worth living. Euthanasia or assisted suicide have been legalized in a small number of

countries and states worldwide, and, only in few European states. Currently, Switzerland, Belgium, Luxembourg, and the Netherlands are the only European nations whose laws allow euthanasia [3-6].

This paper explores and analyze the arguments in support and against euthanasia and physician assisted suicide. For the purpose of this paper has been viewed over the Internet and Google total of 247 journal articles, book chapters and websites. Keywords in the search were euthanasia, good death, physician assisted suicide, assisted death, euthanasia arguments pro and contra. In writing of the manuscript we used 74 references cited in the paper.

The aim of this article is to present and confront the arguments in support of euthanasia and physician assisted suicide, and the arguments against.

2. DEFINITION OF EUTHANASIA

The word euthanasia, originated in Greece means a good death. Traditionally, euthanasia has meant an easy, painless death. Frequently names are mercy killing and assisted suicide [1]. World Health Organization (WHO) in 2004 defined euthanasia and assisted suicide:

Assisted suicide – The act of intentionally killing oneself with the assistance of another who provides the knowledge, means or both.

Euthanasia—A deliberate act undertaken by one person with the intention of either painlessly putting to death or failing to prevent death from natural causes in cases of terminal illness or irreversible coma of another person. The term comes from the Greek expression for good death [7-9].

The words “euthanasia” and “assisted suicide” are often used interchangeably. However, they are different and, in the law, they are treated differently. Euthanasia is defined as intentionally, knowingly and directly acting to cause the death

of another person (e.g., giving a lethal injection). Assisted suicide is defined as intentionally, knowingly and directly providing the means of death to another person so that the person can use that means to commit suicide (e.g., providing a prescription for a lethal dose of drugs) [9].

3. PALLIATIVE CARE

The European Association for Palliative Care has voiced concerns that legalising euthanasia would be the start of a slippery slope resulting in harm to vulnerable patients such as elderly and disabled people and that it would impede the development of palliative care by appearing as an alternative [10]. Although palliative care and legalised euthanasia are both based on the medical and ethical values of patient autonomy and caregiver beneficence and nonmaleficence, they are often viewed as antagonistic causes [11].

Substantial attention in the palliative care was paid to spiritual care, to issues of meaning of life and quality of life, but the most was focused on the topic of euthanasia. The philosophy of palliative care expressed in euthanasia is that dying is a part of life and, therefore, can have meaning [12]. Hospice offers a vision of living and dying, with the view that the patient can choose death when the time comes. Hospice holds that life is a good. To eliminate pain and suffering are also good for the patient because they make life better. Vulnerability, interdependence, and the need for care are, for hospice are constitutive of being human [13]. On the arguments against euthanasia lies the conviction that adequate palliative care can prevent people from requesting euthanasia. One of the main goals of palliative care is the alleviation and the control of pain. Many workers in palliative care have the opinion that there is inadequate care when they have patients with unbearable pain. Furthermore, they have the feeling that palliative care has failed when a patient expresses the wish to end his life. The most of palliative care workers are convinced that palliative care relieves pain and other symptoms. But, others of them have the opinion that palliative care cannot always prevent the suffering of a patient, and it becomes unbearable. Furthermore, palliative care cannot guarantee every patient a peaceful and painless death. Because of this fallibility, some authors conclude that there can be a place for euthanasia in palliative care [12]. In cases where palliative care is effective it is a suitable

alternative to death. Palliative care and rehabilitation centers are better alternatives to help disabled or patients approaching death live a pain-free and better life. If palliative care is sufficient to relieve suffering, patients do not need to request help to die. Unfortunately, in many cases patient suffering cannot be alleviated with palliative care, and helping them to die would be justified. In recent years there has been a decriminalisation of euthanasia and physician assisted suicide in the Netherlands, Belgium and Netherlands. At the same time there has been a strong development of palliative care [14].

4. ARGUMENTS FOR AND AGAINST EUTHANASIA

In 2001, the Dutch Parliament decided that euthanasia should be legalized, and, the Euthanasia Act came into effect to regulate the ending of life by a physician at the request of a patient who was suffering unbearably without hope of relief. The patient's request is voluntary and well-considered. Terminally ill patient is informed about his situation and prospects, and, there are no reasonable alternatives. The termination of life should be performed with due medical care and attention. Another independent physician should be consulted [15-17].

Proponents argue that legalizing euthanasia/assisted suicide is a necessary "insurance policy" that will ensure that no one dies in painful agony or unremitting suffering. Legalized euthanasia would protect the vulnerable from wrongful death and enables peaceful death with dignity.

Furthermore, proponents of euthanasia and physician assisted suicide identify three main benefits to legalization: Realizing individual autonomy, reducing needless pain and suffering, and providing psychological reassurance to dying patients [18].

The arguments in favor of legalizing physician assisted suicide are weighty, and compelling individual cases of suffering are distressing [19]. Among the most important reasons for euthanasia include medical arguments, such as great suffering and pain caused by incurable diseases in the terminal phase, persistent vegetative state, possibility of organ transplantation in special cases, and conditionally, equitable distribution of healthcare costs.

Among the most famous cases is Diane Pretty, the British woman with motor neurone disease, who lost a legal battle to allow her husband to help her commit suicide [20]. Belgian writer, poet and artist Hugo Claus has died aged 78, ending his life by euthanasia. He had been suffering from Alzheimer's disease [21].

Next famous case is Terri Schiavo from Florida, USA. She collapsed in her home in full cardiac arrest on February [25], 1990. She suffered massive brain damage due to lack of oxygen and, after two and a half months in a coma, her diagnosis was changed to persistent vegetative state. At the request of her husband, County judge ordered the removal of Terri Schiavo's feeding tube in February 1995, and she died one month later [22].

Interesting is the case of American Sidney Cohen, who was diagnosed with cancer and given three months to live. He asked for euthanasia to be administered. He was suffering agonizing pain and was bed-ridden, but was refused euthanasia because it was illegal. Eight months later, he was still living, and said: "I now know that death is inevitable and since coming under hospice home care I now enjoy a full life." His fears of an agonizing death had been allayed and he was now staunchly opposed to euthanasia [23].

In permissive countries the main determinants of physicians' willingness to perform euthanasia are not physician- but patient-related. The clinical condition of the patients and their wishes are foremost [4,24-26].

Euthanasia or physician-assisted death should only be a last resort when all medical treatments have failed. In support of euthanasia is rational to stop medical treatment when the patient is in a terminal condition. The most important arguments supporting euthanasia include ending suffering, freedom of choice to decide how and when one dies, and being able to die with dignity. A terminally ill patient can have a terrible pain. Such a patient also can have difficulty with sleeping. Medications used in the treatment of pain have the potential to alter consciousness, change the state of mind, and even cause death. It should be noted that without physician assistance, patients may commit suicide in a messy, horrifying, and traumatic way. When the patient is unable to speak, the decision regarding treatment becomes more complicated. The instruction to the physician must be as close as

possible to that which the patient, if able, would give. In such a case, the physician must find out any wishes the patient had expressed previously. If the patient is unable to communicate on their own, the physician is obligated to communicate with the family [27]. Then, the physician must try to obtain consent from a proxy. Almost always the patient has a close family tie with a spouse, a parent or a child. Pertinent information from relatives and close friends is extremely helpful at these times [28].

The Nursing Times in the United Kingdom reported the results of a poll of 2700 nurses that established that two out of three nurses think that euthanasia should be legalised [29]. In addition, 80% of the British public surveyed in a recent report support changes in existing laws that legalise the option of euthanasia for terminally ill patients [30]. However, a study from the United States of America, which surveyed 2333 oncology nurses, suggested that only 30% support assisted suicide and 23% approve of euthanasia [31]. A similar study in Japan showed that 25.7% resident doctors surveyed supported the concept of euthanasia whereas 48% of first-year medical students supported the idea [32].

Alexander Scott in 2013 found that in the Netherlands over 25 000 patients per year seek assurance from their doctors that they will assist them if suffering becomes unbearable. Each year there are about 9000 explicit requests for euthanasia or assisted suicide, of which less than one-third are agreed to. In most cases alternatives are found that make life bearable again, and in some instances the patient dies before any action has to be taken [33]. Attorney Rick Santorum, Republican Party politician and United States Senator representing Pennsylvania, said in 2012 that 10% of Netherlands deaths are from euthanasia [34].

Doctors' prognostic estimates are a central element of both patient and physician decision making at the end of life. The important preconditions for planning physician-assisted suicide are that diagnosis must be certain, disease hopeless and unbearable suffering must be present. Unbearable suffering, diagnosis, and prognosis must be confirmed by at least one independent doctor, patient or family must give consent, and procedure must be performed in accordance with the medical standard.

However, there are many opponents of euthanasia and physician assisted suicide. The

important reason why some societies should never legalize euthanasia is that the doctor-patient relationship will be seriously weakened. When the physician becomes involved in euthanasia, relationship between patient and doctor is radically undermined. It is important that a dying patient may not be able to make a rational decision. Many people recover after being "written off" by doctors. A patient may have said they want euthanasia when they were nowhere near death; however, when faced with death they may change their mind but be incapable of telling anyone. Opponents of legalised euthanasia typically argue that pain and suffering at the end of life can be controlled in almost all cases to a level that is satisfactory to the patient, and, that the few patients whose pain cannot be adequately controlled do not justify the legalisation of euthanasia. They claim that complete sedation can be used to alleviate a patient's pain when it can no longer be controlled. Opponents generally argue that public funds should be spent on making sure that all patients who are dying have access to palliative care rather than on setting up the legislative and procedural framework necessary for the safe provision of euthanasia. Opponents of the autonomy argument argue that terminal patients cannot impose on a physician to take an immoral action, such as voluntary active euthanasia. They believe that actively ending a life is murder and therefore physicians cannot actively end patients' lives even if a patient has given consent [35,36].

5. DISCUSSION

Frileux and colleagues have important questions: Should a terminally ill patient be allowed to die? Should the medical profession have the option of helping such a patient to die? [37].

Anthropologists debated very long about euthanasia and assisted suicide, and they have known that the end of life and assisted suicide are perceived quite differently from culture to culture. They conclude that social and cultural expectations, and bioethical issues play a considerable role. Before the twentieth century there was the idea of the good death, but by the late twentieth century death not is understood as good, and it is always a failure. However, as anthropologists said people still want a good death as occurring at the moment before one loses his faculties. Because of this, physician assisted suicide becomes increasingly common way to die. Yolán Koster-Dreese, vice president of The Netherlands Council of the Disabled

argued: Biomedical ethicists are creating only the illusion of freedom of choice, when discussing the patients' right to discontinue treatment or choose active euthanasia [38].

Furthermore, according to Merry, the concept of sovereign bodies, moral individualism and freedom of choice within the human rights discourse has dominated in anthropological analysis of euthanasia and assisted death. This is the foundation for the legalization of euthanasia and physician assisted suicide [39].

Who the human being is? What is the meaning of human life? What determines the worth of a human being? This is so-called "anthropological question" which is fundamental to concepts like democracy, freedom, dignity, equality, that are the pillars of modern secular civil society and consequently of the health professions. This "anthropological question" impacts the practical choices physicians and health care workers make every day. Consequently, no person or hospital shall be coerced, held liable or discriminated against in any manner because of a refusal to perform or assist to euthanasia [2]. Anthropological and bioethical access to euthanasia is regarded as a fundamental moral right based upon the principle of autonomy and the duty to relieve suffering. It should be noted that anthropologists of medicine and bioethics are well aware of problems death and end of life [40].

Professor Thaddeus Pope, who is expert for Health Law and Clinical Bioethics, reported that perception of legal liability has a considerable impact on physicians' life support decisions. Pope said that sometimes physician's misperception of some legal constraints has led to the overtreatment of patients, causing unnecessary suffering. So that, with sufficient legal education physicians may better and adequately treat patients.

As Pope said, in cases where the patient is brain dead, courts may permit a confirmation of the diagnosis. The court or the judge can adjudicate that hospital to stop medical treatment, because a patient's brain is dead and further treatment is not required [41]. In 1999 American pathologist dr Jack Kevorkian served eight years in prison for conducting voluntary euthanasia on patient with amyotrophic lateral sclerosis in the final stage. It was claimed that he had exercised euthanasia for at least 130 other patients. After this euthanasia became a public issue in United States [42].

When a terminally ill patient can not communicate, a proxy may make decisions on behalf of the patient. In this circumstance, substituted judgment is used with the expectation that the proxy will communicate the same medical decision that the patient would have made if he were able to communicate [43,44]. Medical professionals supporting assisted dying suggest that even with the best palliative care, there will still be those terminally ill patients who make a rational request for euthanasia [45].

In the patients who are conscious and are in the final stages of the illness, euthanasia may take place if:

The request has been made on a voluntary, thoughtful and repeated basis and does not arise from being pressured into it; the request has to be made in writing. The medical situation does not allow for a positive outlook and causes constant and unbearable physical or psychological suffering which cannot be alleviated and is caused by a life threatening and incurable accidental or pathological illness. The physician must discuss the possible options available to the patient regarding both therapeutic treatment of the illness and the palliative care available and the consequences thereof, and must consult another independent and competent medical practitioner. Furthermore, the physician has discussed his patient's request with the medical team treating the patient and with the patient's close family, if the patient so requests.

In the same terminally ill patients who are unconscious, euthanasia can take place if:

The person is not conscious and the situation is irreversible according to current medical knowledge. The patient is suffering from a life threatening and incurable accidental or pathological illness. The person has drawn up and signed a declaration in advance requesting euthanasia, and may appoint one or several reliable individuals who have been entrusted with voicing the patient's wishes. The physician has consulted another independent doctor, and has discussed the declaration, which was drawn up and signed by the patient in advance, with the patient's medical team and any close family members [46].

In an article that has gained some notoriety the American anthropologist Glascock investigated the treatment of older people in forty one nonindustrialised societies. According to Glascock, in half of these societies death hastening behaviour occurred: the death of the elderly was systematically hastened by withholding care, refusing them food, leaving them behind to die, or by actively killing them [47].

Discussion on end of life should be paramount when a patient is informed that he has a terminal illness. The illness must be incurable and death is inevitable.

Len Doyal, professor of medical ethics and member of the British Medical Association's ethics committee, has called for all forms of euthanasia to be legalised. He said that decisions to withdraw life-sustaining treatment from severely incompetent patients who have irreversible terminal illness with a short life expectancy must be justifiable in their best interests. He called upon to professionally and legally justify withdrawing life-sustaining treatment from such incompetent patients. He believes that euthanasia should be legalized and rigorously and appropriately regulated. He has maintained that attempts to change the British law should not be restricted to euthanasia [48].

In their paper Randall and Downie argues that the most common argument for assisted suicide or voluntary euthanasia is that patients have a right to control when and how they die. Many patients with incurable illness experience intolerable suffering, and just, the next main argument used in favour of assisted suicide or voluntary euthanasia is intolerable suffering. Typical example are severe patients with advanced cancer and severe psychophysical state. The authors argue that the only effective way to end suffering is to cause death. Their attitude is that if assisted suicide and/or voluntary euthanasia be legalised, then doctors would take responsibility for making the decision that these interventions were indicated [49]. On the other hand, British General Medical Council notes explicitly that death is a serious adverse outcome of treatment [50]. But, Saunders believe that doctors should not be the key agents of assisted suicide and that, if legalised, assisted suicide should instead be delivered by non-doctors [51].

As de Haan reported two ethical principles are the basis for the physician assisted suicide: the

recognition of the autonomy of the patient that decides to die and the physician's solidarity in the quest for his patient's well-being. They are a patients who know that nothing can be done to cure disease or relieve suffering. They know that every day of life means more pain, anguish and indignity while awaiting a death known to be inevitable but that is taking too long. One of the main arguments is loss of all psychophysical function [52]. The distinction between active and passive euthanasia is thought to be crucial for medical ethics. The idea is that it is permissible, at least in some cases, to withhold treatment and allow a patient to die, but it is never permissible to take any direct action designed to kill the patient. In the subsequent ethics literature on euthanasia, there has been a widely accepted euthanasia taxonomy comprising two key distinctions. Firstly, there is Rachels' distinction between euthanasia performed by killing the patient (active euthanasia) and euthanasia performed by omitting to prolong the patient's life (passive euthanasia) [53]. And second, cutting across this active-passive distinction, is a distinction between voluntary, non-voluntary, and involuntary euthanasia, depending on whether patients autonomously request their death, are unable competently to give consent, or are competent but have their views on the matter disregarded (or overruled). According to the rules of ethic, euthanasia is always morally wrong. But the behaviour which is described in the standard taxonomy as "passive euthanasia" is not morally wrong, because it cannot really be a form of euthanasia [54].

Patient is suffering to such a degree that dying is better than continuing to live.

Legalizing euthanasia and assisted suicide is a necessary as insurance that will ensure that no one dies in painful agony or unremitting suffering. The law should be changed to let anyone with some severe medical condition which is causing unbearable symptoms to have an assisted suicide. The achievement of this goal requires radical cultural change, the legal and social acceptance of assisted suicide. The right to physician-assisted suicide should be recognized by the law as a fundamental right. The pragmatic message is that the proponents of legal euthanasia might do well to promote palliative care then the advocates of palliative care may have no valid case to oppose the legalisation of euthanasia [55].

Pain and anguish of the patient's family and friends can be lessened. Many patients in a persistent vegetative state or else in chronic illness, do not want to be a burden on their family members. Euthanasia can be considered as a way to uphold the 'Right to life' by honouring 'Right to die' with dignity. Likewise, right to refuse medical treatment is well recognised in law, including medical treatment that sustains or prolongs life [56].

Famous theoretical physicist Stephen Hawking, immobile, heavy patient who suffers from Amyotrophic lateral sclerosis, in a September 17, 2013 interview with the BBC stated: I think those who have a terminal illness and are in great pain should have the right to choose to end their lives and those that help them should be free from prosecution. We don't let animals suffer, so why humans? [57].

The very strong medical argument must be that, when the diagnosis of terminal illness is clear, active euthanasia is permissible. Competent adults have the legal right to refuse unwanted medical treatment. In a society in which the sick, dying, disabled and elderly are undervalued, the right to die will all too quickly become a duty to die. In support of euthanasia is rational to stop medical treatment when the patient is in a terminal condition.

Furthermore, euthanasia in terminally ill patients provides an opportunity to advocate for organ donation. Vital organs can be saved, allowing doctors to save the lives of others. This in turn will help many patients with organ failure waiting for transplantation. Not only euthanasia gives 'Right to die' for the terminally ill, but also 'Right to life' for the organ needy patients. The possibility of organ transplants recently appeared a new dimension of euthanasia and physician assisted suicide. As Wilkinson and Savulescu reported, many patients die in intensive care following withdrawal of life-sustaining treatment whose organs could be used to save the lives of others. Changes to organ donation practice could dramatically increase the numbers of organs available, though they would conflict with currently accepted norms governing transplantation. The authors argue that one alternative, Project Organ Donation Euthanasia, would be a rational improvement over current practice regarding withdrawal of life support. It would give individuals the greatest chance of being able to help others with their organs after death. The authors argue that patients should be

given the choice of whether and how they would like to donate their organs in the event of withdrawal of life support in intensive care [58]. Likewise, Ysebaert and colleagues described Belgian example were four patients between 2005 and 2007 expressed their will for organ donation after their request for euthanasia was granted. Patients were aged 43 to 50 years and had a debilitating neurological disease, either after severe cerebrovascular accident or primary progressive multiple sclerosis [59].

The legalization of voluntary active euthanasia will lead to acceptance of non-voluntary active euthanasia. Furthermore, the argument that legalization of assisted suicide will lead to acceptance of euthanasia [60]. Attitude of euthanasia opponents is that the profession prohibits physicians actively ending their patient's life. In accordance with the Hippocratic Oath, physicians cannot kill or hasten a patient's death [61]. Accepting euthanasia accepts that some lives are worth less than others, and, euthanasia weakens respect for the sanctity of life. Physician assisted suicide or euthanasia might not be in a person's best interests, and, affects other people's rights, not just those of the patient. Voluntary euthanasia is the start of a slippery slope that leads to involuntary euthanasia and the killing of people who are thought undesirable. Good palliative care makes euthanasia and physician assisted suicide unnecessary, but, allowing euthanasia will discourage the search for new cures, and will lead to less good care for the terminally ill patients. Legalized euthanasia, to medical ethics, would violate one of the most important medical argument that physician has always the obligation of preserving human life. Likewise, euthanasia gives too much power to doctors, may become a cost-effective way to treat the terminally ill patients, and will lead to moral pressure to free up medical resources. Active euthanasia opponents have argued that patients would not want to end their lives if adequate pain control medications were available to everyone and if adequate palliative care facilities were available to everyone in need of such facilities. Opponents of active euthanasia argue that due to the medical advances in pain management by hospices and other end-of-life treatment facilities it is possible for physicians to treat all kind of pains and it is possible to relieve most of the suffering endured by terminally ill patients. Empirical data has shown that uncontrolled pain and a lack of access to palliative care facilities is not the most common or only reason for requests for active euthanasia.

Furthermore, allowing euthanasia undermines the commitment of physicians and nurses. If physician assisted suicide and/or voluntary active euthanasia were legalised, this would disproportionately affect people in vulnerable groups, such as the elderly, the uninsured, the poor, racial or ethnic minorities, people with disabilities, people with sometimes stigmatised illnesses like AIDS, and others. These patients would be pressured, manipulated, or forced to request or accept physician assisted dying by overburdened family members, callous physicians, or institutions or insurers concerned about their own profits. The patients who are abandoned by their families may feel euthanasia as the only solution [62-66].

The opinions about physician assisted suicide and euthanasia of members of the medical professions have been extensively examined. A survey in 1996 of physicians throughout the United States found that, if it were legal, 36% of respondents would be willing to hasten a patient's death by prescribing medication and 24% would provide a lethal injection [67]. Surveys of public opinion have shown that, according to Blendon and colleagues, in 1991 in the United States, 63% of people support painless euthanasia of incurably ill patients [68]. Public opinion surveys in other countries have documented the same trend in the Netherlands [69], Canada [70,71], and Australia [72].

The philosopher John Hardwig thinks that terminally ill patient may has a duty to die when the burden of caring seriously compromises the lives of those who love him. They may be physically and emotionally exhausted by caring for the patient, and financially destroyed by the cost of his healthcare. Furthermore, their home may become a place of grief and sickness, and, other family members may be neglected as all attention is focussed on the dying patient. He wrote that an individual is not the only person who will be affected by decisions over whether they live or die. So, when deciding whether to live or die, a person should not consider only themselves, they should also consider their family and the people who love them [73].

Chapple et al. [74] were interviewed terminally ill people in their homes during 2003 and 2004 in United Kingdom. That UK law should be changed to allow assisted suicide or voluntary euthanasia was felt strongly by most people. Some people had multiple reasons, including the right to choose when to end their own life, pain and

anticipated pain, fear of indignity, loss of control, cognitive impairment, and concern that they may be a physical or financial burden on others. Some regretted that they may have to die alone if suicide became their only legal option. Others who opposed a change in UK law, or who felt ambivalent, focused on involuntary euthanasia, cited religious reasons or worried that new legislation might be open to abuse [74].

6. CONCLUSION

In conclusion, no law or ethical standard requires that ineffective or gravely burdensome measures be used to keep a dying person alive. Euthanasia can be considered as a way to uphold the 'Right to life' by honouring 'Right to die' with dignity. The law should provide a legal right for certain persons, specifically physicians, to be able perform assisted suicide for incurable patients when they want it.

Terminally ill patient can refuse to continue useless treatment, and, this is kind of passive euthanasia. We can conclude that such passive euthanasia exist in most states. Our proposals are: To legalize passive euthanasia and assisted suicide, approve them exclusively for terminally ill patients which does not help any kind of therapy, only doctors must participate in the conduct of euthanasia and assisted suicide, and, euthanasia should be used only in cases of last resort and not as an alternative to palliative care. I would especially like to point out that euthanasia must be a component of palliative care and a joint team must make decisions. This paper contributes to the debate on the legalization of euthanasia and assisted suicide.

Future studies should explore and thoroughly analyze arguments pro and contra and on this basis, to contribute to the debate on legalization euthanasia and physician assisted suicide.

COMPETING INTERESTS

Author has declared that no competing interests exist.

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