

The Ethical Council's opinion on euthanasia

1



DET
ETISKE
RÅD

Contents



DET
ETISKE
RÅD

03 1. Preface

04 2. The Ethical Council's position

- 2.1 The work of the Ethics Council
- 2.2 The Ethics Council's recommendations
- 2.3 The Ethics Council's discussion

15 3. Euthanasia – what is it?

- 3.1 The Ethical Council's use of language
- 3.2 The international development
- 3.3 Procedure of the report

24 4. The Danish practice at the end of life

- 4.1 The Danish legal situation
- 4.2 The current practice for palliation at the end of life

29 5. Foreign experiences with euthanasia: two models

- 5.1. The Oregon model
- 5.2 The Dutch model

Contents



40

6. Basic ethical arguments

6.1 Basic ethical arguments for euthanasia

6.1.1 *Reduction of suffering as an argument for euthanasia*

6.1.2 *Self-determination as an argument for euthanasia*

6.2 Basic ethical arguments against euthanasia

6.2.1 *The right to life and the inviolability of life*

6.2.2 *Reduced autonomy and decision-making competence as well as environmental pressure*

6.2.3 *The difference between palliative measures and euthanasia*

57

7. Basic practical-political arguments

7.1 The difference between debating whether euthanasia is ethically acceptable and whether euthanasia should be legalized

7.2 Basic practical-political arguments for euthanasia

7.2.1 *What is required for euthanasia to be said to be justified in practice?*

7.3 Basic practical-political arguments against euthanasia

7.3.1 *There is too great a risk of error, misuse and slippage indications*

7.3.2 *There will be negative consequences for vulnerable groups*

7.3.3 *This will have negative consequences for the doctor-patient relationship the team*

7.3.4 *There will be negative consequences for the palliative care effort*

1. Preface

The Council of Ethics hereby publishes its opinion on euthanasia. On 26 May 2023, the citizens' proposal 'Legalisation of active euthanasia' achieved 50,000 supporters. In connection with this, the Council of Ethics received on 29 June 2023 an inquiry from the Danish Parliament's Health Committee, which called on the Council of Ethics to issue a statement on active euthanasia, which could be included as part of the basis for the Danish Parliament's discussions of and decision on the citizens' proposal.

The Ethics Council thanks you for the inquiry and presents its opinion with this statement views.

In connection with the work with euthanasia, the council has been helped by a number of people who have willingly made their knowledge and views available at council meetings or in other contexts. In the case of:

Kathrine Lilleør, parish priest

Mette Asbjørn Neergaard, clinical professor, senior physician, PhD.

Ditte Guldbrand Christensen, Not dead yet

Flemming Schollart, Right to die

Klaus Peder Klausen, chief physician, Medical Association

Thomas Søbirk Petersen, professor RUC

Ole Hartling, former chief physician

Marianne Dees, MD, ph.d.

Theo A. Boer, professor i Health Care Ethics

The statement has been created with secretarial assistance from project manager Frank Beck Lassen. The statement has been finalized at the Ethics Council's meeting on 21 September 2023.

Leif Vestergaard Pedersen
Chairman of the Ethics Council

Mia Troll Borup
Head of Secretariat

2. The Ethical

5

Council's position

2.1 The work of the Ethics Council

In the work of taking a position on the subject of euthanasia, the Ethics Council has emphasized two dimensions. Partly a review of the most significant ethical arguments for and against euthanasia. Partly, a presentation of the most significant features of two different models for euthanasia, as implemented in Oregon and the Netherlands respectively. While a number of ethical arguments will be well known to many, as they are often used in the general debate, and have also formed the basis for previous statements from the Ethics Council¹

then they are concrete conditions and experiences from other countries less well lit. With this opinion, the Ethics Council wishes to bring the ethical arguments in connection with concrete experiences in the form of statistical calculations and scientific studies, with the aim of providing an overall picture of euthanasia as an ethical issue, as it appears in the light of more practical experience. The hope is that the Ethics Council can in this way help to qualify the discussion about the advantages and disadvantages of a possible legalization of euthanasia.

The Ethical Council's recommendations must be seen in the light of one overriding insight: euthanasia is not a uniform phenomenon, but exists in different variants. Therefore, **it is crucial to be aware that if you legalize euthanasia, it is above all the model that determines the consequences.** The Ethical Council finds it remarkable that a large part of the Danish discussion on the possible legalization of euthanasia takes place without taking this fundamental fact into account.

The reason why the Council of Ethics considers it important to relate concretely to other countries' different models is because you cannot answer what the consequences of legalizing euthanasia will be without specifying which model you are talking about. In the **Netherlands**, which allows euthanasia and has no requirement for terminal illness, the number of people who die through assisted dying is **10 times greater than in Oregon**, which only allows assisted suicide and requires terminal illness. Differences also appear, for example, in the question of what motivates people to wish for euthanasia in different models. In **Oregon, the fear of losing quality of life and independence** at the end of life is the dominant motive. In the **Netherlands, suffering without hope of recovery** is the main motive.

The Ethical Council will therefore, in addition to making a more general recommendation about the legalization of euthanasia in Denmark, point to 5 very fundamental questions connected with the legalization of euthanasia. Regardless of whether you are of the conviction that it is not possible to draw up sound and fair legislation on euthanasia, or prefer legislation based on one of the mentioned models, you cannot avoid taking a position, to these five questions. They help determine the appearance of models, and thus their consequences. Council members would like to highlight these issues, but do not make any actual recommendations about them.

2.2 The Ethics Council's recommendations

The decision to request euthanasia is a serious one. So is the decision to offer euthanasia. If assisted suicide or euthanasia is carried out, it is an irreversible act. We are therefore justified in making high demands that no mistakes are made and that the wish is formulated and the decision made on an informed basis.

In the general debate, examples of patients who describe their lives as suffering and hopeless, and who appear clear and well-considered, are not infrequently discussed. However, reality also consists of a large number of borderline cases, where people's suffering and ability to make decisions are difficult to determine accurately and can also vary over time. If euthanasia is to be allowed, it requires a regulation which can not only deal with such clear and unambiguous cases, but also the many more borderline cases, and which manages to protect all citizens without exception. If one were to think that euthanasia will be the best for a selected group of people, then only the system which gives access to euthanasia for everyone in this group, and which rejected everyone outside this group, will be clear in the boundaries, fair in the grounds for access or sound in terms of control mechanisms.

Council members have considered the Oregon model and the Dutch model. The Oregon model is primarily characterized by only allowing assisted suicide and by limiting access to patients with a terminal illness. The Dutch model is primarily characterized by both allowing assisted suicide and euthanasia and by having more open access for patients who are in a state of unbearable suffering. This also includes minors, people with somatic and psychological disorders and people who have

issued advance directives. On the present basis, there are no members of the Ethics Council who find the Oregon model or the Dutch model sufficiently clear in their delineations, fair in their justifications for access, or sound in terms of control mechanisms.

Recommendation 1

The following members of the Ethics Council are of the conviction that it is in principle impossible to establish proper regulation of euthanasia, and therefore recommend that euthanasia not be legalized in Denmark (Berit Andersen, Svend Brinkmann, Grethe Christensen, Ida Donkin, Christian Gamborg, Anette Hygum, Henrik Nannestad Jørgensen, Knud Kristensen, Jacob Giehm Mikkelsen, Lise Müller, Christine Nellemann, Merete Nordentoft, Mie Oehlenschläger, Leif Vestergaard Pedersen, Rasmus Willig, Mikkel Wold)

As justification for this recommendation, the council members have emphasized one or more of the following considerations:

The members acknowledge that there are situations for an unknown number of people where the desire to hasten one's own death and the desire to help another person into death is understandable, but at the same time would like to point out that even people with a long-term death wish, experiencing moments of ambivalence. However, they do not believe that legislation can be developed which will be able to function properly. The only thing that will be able to protect the lives and respect of those who are most vulnerable in society will be an unexceptional ban.

The members point out that euthanasia risks causing unacceptable changes to basic norms for society, the health care system and human outlook. The very existence of an offer of euthanasia will decisively change our ideas about old age, the coming of death, quality of life and what it means to take others into account. If euthanasia becomes an option, there is too great a risk that it will become an expectation aimed at special groups in society. An institution

nationalization of euthanasia therefore risks threatening the principle that we have the same claim to respect and dignity regardless of how much we suffer and how high the quality of life is assessed to be. If we offer euthanasia, it says, directly or indirectly, that some lives are not worth living.

These council members' knowledge of the Oregon model and the Dutch model indicates that the two most important issues of consent and access cannot be regulated in a satisfactory manner. It will 1) be impossible to determine with sufficient certainty when a wish for euthanasia has the necessary depth and persistence. The members note, after consulting professional environments, that many terminal patients experience a change of opinion in connection with euthanasia when the right help in the form of palliative treatment is given. These change their view of what a dignified life is as they become sicker and thus change the yardstick by which they judge life. It will 2) be impossible to offer euthanasia to those members of patient groups who may wish to do so, without people in the same life situation being affected and burdened unreasonably. It will also be too difficult to determine when there are sufficiently good reasons for wanting euthanasia that health professionals should be faced with such decisions.

The members consider euthanasia to be in conflict with palliative care and are therefore against the legalization of euthanasia as long as we as a society have not exhausted the possibilities for relief.

If you in the healthcare system get better at not overtreating

dying patients and become better able to talk with patients about the necessary decisions to be made at the end of life, and if palliative care is fully developed and functioning satisfactorily, then

it is to a large extent possible to create a decent framework for a dignified death for seriously ill people simply by having sufficient focus on palliative care.

Recommendation 2

One member of the Ethics Council (Birgitte Arent Eiriksson) is of the belief that it may in principle be possible to establish proper regulation of euthanasia and therefore recommends that a thorough investigation be initiated with a view to investigating the need for euthanasia in Denmark, and whether a system can be established which can function properly taking into account both basic societal values etc. and the right to self-determination for people who, according to themselves, live a life of unbearable suffering and want a dignified end. Such an investigation should also focus on elucidating unintended consequences in relation to specific Danish value-related, health-related, legal, political and economic conditions.

As a justification for this recommendation, the member has emphasized, among other things, the following considerations:

The member finds that the issue of euthanasia constitutes a real dilemma in relation to a limited number of people who are forced to lead lives or end of life characterized by unbearable suffering, which can hardly be reached by palliative care. These people are difficult to describe as a group, but criteria will be clarified during the proposed investigation.

The member believes that the risks that are present when euthanasia is legalized should, in principle, be able to be identified and minimized to a certain extent, among other things through a carefully prepared screening process, where, based on both an objective and subjective assessment, it is ensured that this is a sane person with a firm and persistent desire to end his life due to a permanent unbearable suffering that cannot be remedied. **The member does not consider the two foreign models that the Ethics Council has applied to have achieved satisfactory regulation.**

In addition, the member finds that the current legal situation also entails concerns, e.g. when relatives feel obliged

to assist in ending a life and thus - depending on the circumstances - risk a shorter or longer prison sentence, and where at the same time doubts can be cast about the timeliness and firmness of the deceased's wishes. In addition, people who are capable of committing suicide themselves can worsen their situation in the event of unsuccessful attempts, just as the circumstances will often be highly stressful for both themselves, their relatives and other surroundings.

Other recommendation

Some members of the Ethics Council (Christian Gamborg, Knud Kristensen) believe that it should be investigated whether it will be possible to justifiably amend § 239 and § 240 of the Criminal Code so that murder on request (§ 239) and aiding and abetting suicide (§ 240), under certain specific conditions, can be done without penalty. Such a **change to the penal code's penalty reduction rules in relation to § 237 (murder) will entail a decriminalization, but not a legalization, of euthanasia in these special situations.**

In the wake of these two recommendations, a joint Ethics Council wishes to draw attention to three general issues:

- 1) Regardless of the position on euthanasia, the question is linked but with whether it is possible to **receive the right life support**. The council wishes to highlight that much more can still be done to ensure the right help for people with special needs in the form of mental illness, functional impairments, lonely lives and difficult living conditions in general.

- 2) Patients should not be kept alive at all costs by giving life support prolonged treatment in situations where the patient is **irreversibly dying**. Treatment options must not be used to keep patients alive beyond the limit of what is meaningful, which the current legislation does not allow for either. For some patients, such an extension of life will simply lead to an experience of increased suffering and extend the period during which euthanasia can be an alternative to life.
- 3) Two matters in particular regarding the existing possibilities to alleviate, plays into the debate on euthanasia: a **lack of access to adequate palliative care** and a **lack of knowledge about access** to such palliative care. If the debate about euthanasia is to be conducted on an informed basis, far more people should know about the possibility to refuse treatment and to receive palliative care and care, as well as pain treatment until death occurs.

2.3 The Ethics Council's discussion

It has been part of the discussion in the Ethics Council that legalization could be started according to known models, in this case the Oregon model or the Dutch model.

One could thus legalize euthanasia in Denmark with **Oregon** as a model, with a view to establishing restrictive standards for euthanasia, both in terms of consent and in terms of justification. A number of enclosures of a possible practice could thus be relevant, such as the fact that it will only be about assisted suicide, only for patients with a terminal disorder where the time of death can be predicted with considerable precision, only patients without psychiatric diagnoses.

The purpose of such regulation should be to open up a limited offer of euthanasia to those persons who are at the end of life and who are difficult to reach through palliative care, or who have wishes for the end of life that differ significantly from, what palliative medicine can offer.

No member of the Ethics Council has wanted to recommend such a solution.

One could also try to legalize euthanasia in Denmark with the Netherlands as a model in order to establish restrictive standards in terms of consent, but different open standards in terms of justification. The advantage of the Dutch model could be that a large number of significant forms of unbearable suffering can thus be captured, and not just those patients who may be terminal.

This emphasizes the right to self-determination to a large extent, and it becomes possible for people who may have the prospect of a long life in unbearable suffering and hopelessness to make use of this.

No member of the Ethics Council has wanted to recommend such a solution.

In addition to presenting its recommendations, the Ethics Council would like to highlight 5 important issues that have been particularly difficult to deal with. Seen in the light of the current citizens' proposal, the council would like to emphasize that these questions are some that no attempt at legalization can avoid dealing with.

1st question: Should it be assisted suicide and/or euthanasia?

If you want to legalize euthanasia, it will require a decision on what kind of euthanasia it should be. There are two ways in which this can take place. In assisted suicide, a doctor prescribes a lethal agent to a patient who then self-administers the agent. In euthanasia, it is another person, often a doctor, who uses the lethal agent and thus ends up giving the lethal dose.

Some may find assisted suicide less problematic than euthanasia because the patient is the cause of his own death. In principle, all citizens in Denmark have the option to take their own life if they no longer wish to live. In practice, however, very ill patients rarely have this option because they are confined to their beds.

A legalization of assisted suicide can therefore be said to give them the opportunities to take care of themselves that most other citizens have. For doctors in particular, one must assume that it will be less responsible to contribute to suicide than to practice euthanasia.

2nd question: Should it be offered to those who are dying or/and those who are not dying?

If you want to legalize euthanasia, it will require a decision on who should first and foremost have access to it. Internationally, there are two basic criteria to choose from. Either the access must be based on a known, terminal prognosis, so that one must have a manageable lifetime left, or the access must be based on a state of great or unbearable suffering. The challenge is that those who will be the most obvious candidates to receive euthanasia are people who, in their own assessment, have the **prospect of a terrible life**, and not those who, in their own assessment, have the prospect of a *terrible death*. If you rely on doctors with clinical experience, they agree - they say that there are very few patients who, with the right palliative care offer, have the prospect of a horrible death. It must be added, however, that this is not the same as the fact that all these patients also want to participate in a palliative process. This leaves – and much suggests that this is a question of basic values and outlook on life – a need for those who, in their own assessment, have the prospect of a terrible life. The challenge is that if people of this type, for example with severe physical disabilities, chronic pain conditions, existential challenges, debilitating mental illness, etc., are to have access to euthanasia, then the demarcation problems and the problems with unmanageable and unintended side effects for people are multiplied, who do not want euthanasia, but who are at risk of having their lives judged as terrible lives, based on a group affiliation. Or to put it another way: **the model for euthanasia, which may seem to some less unproblematic to introduce, is also the one that will satisfy the demand, broadly understood, the least.** The model for euthanasia which will satisfy the demand the most is also the type of euthanasia which there will probably be far more of, so problem

3rd question: Should it be offered to patients suffering from somatic illnesses and/or those suffering from mental illnesses?

If you want to legalize euthanasia, it will require a decision as to whether it is only on the basis of a somatic diagnosis that you can gain access to it, or whether people with a psychiatric diagnosis can also gain access. Physical pain can play a large role in the experience of suffering, but can often be controlled with drugs. In contrast to this, it must be assumed that the psychological and existential pain of some people's life situation can be experienced as just as life-destroying as physical pain can, and that they are inevitably subjective, since each patient must assess his own thresholds and understandings of unbearable suffering. A significant difference, however, is that physical pain is often detectable, and precisely as a result of this in many situations can be alleviated, while mental illness is generally poorly understood medically, and therefore offers far less certain prognoses, while at the same time the question of the benefit of further treatment is much more difficult to determine. Finally, the mental disorder itself can influence the decision-making competence, so that doubts can be raised about inform

4th question: Should euthanasia be carried out by doctors and health the creature's complicity?

If you want to legalize euthanasia, it will require a decision on whether it is doctors who must assist people with suicide or perform euthanasia. Doctors participate in a number of models, either by assisting patients in suicide or by performing euthanasia themselves. To the extent that a decision has to be made as to whether a given person meets set criteria to gain access to an offer of euthanasia, this will be an assessment. As conditions are now, an assessment is what a doctor is most often expected to do. In all the countries and states where euthanasia takes place in one form or another, it is a medical assessment that determines whether a person can be assisted in dying.

5th question: What consequences will the existence of euthanasia have for the assessment of quality of life?

Euthanasia is fundamentally about respecting the self-determination of suffering persons. In order to receive help in dying, a person must demonstrate to an assessing person that they have a sufficiently low quality of life to warrant euthanasia, i.e. there is a sufficiently great suffering that a hastening of death will alleviate. If the focus is solely on self-determination, there may be a risk that one will disregard the fact that people are also **vulnerable and impressionable**, and that **not everyone possesses the same independence and determination**. It is therefore an open question what the consequences of euthanasia can be for vulnerable groups and for the general assessment of their quality of life. On the other hand, such concerns can be difficult to fully justify. It can be difficult to make it likely that the choices you, as a suffering person, have to make about euthanasia, or the risks of stigmatization that you, as a member of groups where only some wish for euthanasia, may face, should be of a completely different nature. moral order than choices one might otherwise be forced to make due to **difficult life circumstances**.

3. Euthanasia – what is it?

All men must die. There is no one who can avoid it. It is pre-ordained that we will die. However, the way it takes place is not. Basically, one can observe that some people die alone, while others die together with others. One can also observe that some people die voluntarily and others involuntarily.

Involuntary death occurs in a number of ways. Obvious examples are fatal accidents or murder, but many who die a 'natural death' due to age or illness can also be said to die involuntarily, in the sense that there is no wish (fleeting, well thought out or formulated) to die reason for the occurrence of death.

Voluntary death is, all else equal, more rare and at the same time more open to doubt about how voluntary a given wish or action really is. People may take on dangerous work or single actions where there is an increased risk of dying, but as an observer, doubt whether this is the result of an unrealistic assessment of the probability of dying. One can sacrifice oneself, for example in war, and thus die willingly, but also leave a doubt as to whether this is the same as dying voluntarily. One can also take one's own life through **suicide**, which to an immediate consideration may seem voluntary, but the question is whether the act or the desire behind it can be said to be **fleeting, well thought out** or rather an **expression of despair**.

Finally, there is a voluntary death, linked to illness and suffering, where one can assume that the desire to die is less fleeting, and that the act that causes death is done with a view to reducing suffering. *Such a **voluntary or self-chosen death is the subject** of this report.*

It can be difficult to separate voluntary and self-chosen death from what we call suicide. It is therefore an independent discussion whether there are significant ethical differences between 'suicide' and 'euthanasia'. Already in the meaning of the words, however, there is a possible difference. This relates to the second observation that can be made, namely that some people die alone, while some die with others.

A number of people die alone. It can be while you are sleeping, in your own home, or due to an accident, as mentioned before. It will often be associated with death occurring unexpectedly. If death is expected, usually due to illness, it is more rare to die alone. Dying with others can take place privately, in the company of family or friends, but it can also be in the company of health professionals, either at home or in health care institutions.

When we die together with others, it is often because they can help as part of what is called 'the end of life'. However, it is up to him to describe what it means to help others. Is it acting on behalf of the person who has lost the capacity to act? Is it to do what the sufferer wants? Is it to do what you as a helper consider good for the sufferer? Often the help, regardless of whether it is given by relatives or health professionals, will consist of alleviating the last time, but this also leads to difficult questions about whether the alleviation of suffering must mean that death is accelerated to varying degrees, right from death as predicted side effect of a palliative treatment, to death caused as a means of ending suffering. In addition, wishes for help in dying are not only formulated by people where death is imminent. Persons without current illness, but nevertheless in great suffering, can also formulate wishes to die with the help of others, where, by virtue of an assessment of one's own life as suffering, one does not wish to continue living it, but of for a number of reasons also not wanting to commit suicide.

Such assistance in dying, assisted or accomplished by another person, is the subject of this statement.

The report is limited in scope. The statement is about whether it is ethically justifiable to legalize voluntary euthanasia. This is about one delimitation of actions, within the spectrum of possible actions which accommodated by 'euthanasia'. The statement thus does not relate to involuntary euthanasia and related issues about demented persons, about minors or mature minors and on the use of advance directives to announce the decisions of previously competent persons.

3.1 The Ethical Council's use of language

The words that are used to denote a given phenomenon can be of great importance, as they guide the thinking in advance about what is remarkable and what is inconspicuous. If others begin to think about a subject in the words that you yourself want, it helps to increase the likelihood that they will think the same as you do.²

An example of how the normative assessments can change, depending on the choice of words, can be found in the formulations that were tested on a test audience prior to the adoption of the Death with Dignity Act, the legislation that in 1998 opened up assisted dying in the state of Oregon. It describes how support for the legislation fell

10% and 12%, respectively, when the process was described as 'suicide' or as 'euthanasia' rather than 'a dignified death'.³

In the attempt to characterize or define the phenomenon of euthanasia, a number of different terms have been used. In Danish legislation, euthanasia is called 'murder on request' and 'assisting someone to take their own life', respectively. Others distinguish between active and passive euthanasia, physician-assisted death or simply assisted death, 'self-chosen end of life' or 'mercy killing'.

An example of the linguistic difficulties is the phrase 'end of life', which is often used to define the period of life, or the persons relevant to the subject of euthanasia (in English 'end-of-life'). Such a phase of life is important to define, since many are advocates that patients who are at the end of life can receive euthanasia, but not others. One also talks about 'end-of-life decisions'. This often indicates that death must be irreversible as a consequence of the patient's condition and that it will occur within the foreseeable future. Patients of this type are often described as 'terminal' when talking about euthanasia, but this often means something other than the clinical use of this term, which often refers to a few days or weeks. When it comes to euthanasia, there is often an expectation of a longer period of time, without any agreement being established as to whether it is a matter of weeks, months or even years.

A basic example of the confusion is the term 'euthanasia'. Firstly, the word will not necessarily be perceived as neutral, all the while part of the disagreement - it consists in whether assisted suicide or euthanasia is an expression of help at all, and not of an overly sober or harsh view of humanity. On the other hand, some would think that the word nicely captures that someone is asking for help, and that the discussion about whether something is a help starts from the fact that the help is about helping someone in relation to their preferences or a query about help.

Euthanasia is often used as a term for all actions that are taken at the patient's initiative and that cause death to be hastened, regardless of whether this is due to the use of drugs from which the patient dies or if life-sustaining treatment is interrupted. In order to distinguish between such situations, withdrawal of treatment, relief of symptoms and palliative sedation have often been called 'passive' euthanasia.

The Ethics Council deliberately avoids using the terms 'active' and 'passive' euthanasia. Partly because it is very easy to suggest that even abstaining from life support

treatment, presented as 'passive euthanasia', constitutes euthanasia. Partly because the term 'active' implies that there is a 'passive' duplicate. The term 'passive euthanasia' is often used as a term for efforts in palliative medicine, which have in common that they can potentially hasten death. However, it can be perceived as misleading to call these efforts 'passive', as they involve conscious actions that actively try to help a dying patient.

There is therefore a clear purpose in dealing with the use of language: to establish clear divisions and distinctions, so that it becomes clear what new options there are discussed introduced. Therefore, the following words will be used throughout the report:

”

In this explanation, euthanasia is understood as: the effort that is made following the express wish of a person, where the intention is that the effort will cause his death.

In this explanation, euthanasia is understood as: the effort which is made following the express wish of a person, where the intention is that the effort will cause his death.

Euthanasia, which occurs when someone other than the person carries out the decisive action that leads to the person's death, is called *euthanasia in this report*.

Assisted suicide, where the person himself performs the decisive action that leads to the person's death, is called *assisted suicide*.

Throughout the statement, reference is made, depending on the context, to 'person' or 'patient' when talking about the persons who would possibly want – and in other countries obtain – euthanasia. Most often the word 'patient' is used. This is because most people for whom euthanasia may be a wish are patients with a diagnosis, either because they are in a current course of treatment or because they have a chronic condition or a functional impairment that has been diagnosed.

3.2 The international development

Euthanasia has undergone considerable development over the past 25 years. Before 1997, only Switzerland allowed it, while by the end of 2022 it will be legal in 10 countries and a number of US states. In list form, these are: Switzerland (since 1942, but in practice from the 1980s), the Netherlands (2002), Belgium (2002), Luxembourg (2009), Colombia (2014), Canada (2016), Austria (2021), New Zealand (2021), Spain (2021) and Australia (2022). In the United States, assisted suicide is legal in 11 states or districts: California, Colorado, District of Columbia, Hawaii, Montana, Maine, New Jersey, New Mexico, Oregon, Vermont, and Washington.

Some countries only allow euthanasia for patients diagnosed as 'terminal' or likely to die within 6 months (Australia, New Zealand and all 11 US states). In other countries, people who are not dying, but living with chronic, debilitating and incurable physical conditions that cause unbearable pain or make a dignified life impossible, can obtain euthanasia (Austria, Belgium, Canada, Colombia, Luxembourg, the Netherlands, Switzerland and Spain). In a few countries, this has been extended to also apply to people with chronic, long-term mental illness (Belgium, Canada, the Netherlands, Luxembourg, Spain and Switzerland).

Some countries have only introduced assisted suicide, which requires the lethal dose to be self-administered (Austria, Switzerland, the 11 US states). Others allow doctors, or in some cases nurses, to do it unless the person wants to self-administer (Australia, Belgium, Canada, Colombia, Luxembourg, the Netherlands, New Zealand and Spain).

3.3 Procedure of the report

One of the difficulties in the debate on euthanasia is that in Denmark it is currently illegal to perform euthanasia or to assist in the death of others. Therefore, there is no practice for euthanasia that can be evaluated. There are no health professionals to learn from, no relatives to ask about experiences or legislators to consult about their intentions.

”

Fact-based arguments are about alleged case conditions that are considered relevant for taking a position, for example, these could be claims about what the consequences of legalizing euthanasia might be.

This is where international experiences come into the picture, as 'empirical substitutes' for the missing domestic experience base. A number of countries have legalized euthanasia in recent years. This has meant that in many of them there are significant amounts of research and public statistics that shed light on euthanasia as a practice.

This also means that the opportunities to test the strength of a number of the arguments put forward for and against the legalization of euthanasia in Denmark have increased.

These increased possibilities can already be seen in a certain sense in the Danish debate. In step with an increased basis of experience, more and more international examples are included in the Danish debate. The question is, however, whether this option has so far contributed to improving the Danish debate. Rather than contributing to deepening and qualifying the debate, the presentation of fact-based claims has often resulted in proponents and opponents entrenching themselves in isolated factual claims, where each side presents its own 'facts' in the form of single stories, single statistics or references to supposed results, without specifying a source.

In this statement, the Council of Ethics has therefore made a decision – strongly inspired by a 'knowledge compilation' carried out by the Swedish National Council of Medical Ethics in 2017 – to divide the many arguments used for and against euthanasia into two categories: **value-based arguments** and **fact-based arguments**.⁴

Value-based arguments are about which values or principles you believe should guide a decision on euthanasia. An example of a value argument for euthanasia concerns the right to self-determination, which claims that the right to decide on one's own life also entails the right to decide how one wants to end it. An example of a value argument against euthanasia is the argument about the inviolability of life, which states that it will always be wrong to end a life.

Fact-based arguments are about alleged case conditions that are considered relevant for taking a position, for example, these could be claims about what the consequences of legalizing euthanasia might be. A frequently used fact-based argument for the legalization of euthanasia is that it will help to reduce suffering for people at the end of life. A frequently used argument against euthanasia is that it will lead to a slippery slope, where more and more patients will eventually have access to euthanasia.

Value-based arguments are often of such a nature that they can be difficult to confirm or disprove through observations. Fact-based arguments, on the other hand, are in principle possible to test through observations of reality. The question, however, is how far one can get by looking at the experiences of other countries and comparing them with typical arguments from the Danish debate, when the goal is to decide whether euthanasia should be legalized in Denmark. The experience gained from the preparation of this statement shows that one can probably approach an assessment of the durability of fact-based arguments, but that a decisive position on the possible legalization of euthanasia requires more than this.

The position on euthanasia as such requires that one also assesses *the relevance* of fact-based arguments. This implies an independent ethical assessment, which includes the value-based arguments put forward, in an overall weighing of the advantages and disadvantages of legalizing active euthanasia. One reason for this is that it is not just empirical questions and answers that can exhaust all the questions worth asking. Ethical questions require a balancing of opposing or perhaps decidedly incompatible values. However, in this balance, knowledge on the other hand also plays a role. It is necessary in order to decide to what extent values are promoted or threatened by different models for the legalization of euthanasia.

Finally, it should be noted that one can of course also exaggerate the difference between value-based and fact-based arguments. Also fact-based arguments are value-based (to be relevant it is assumed, for example, that reduction of suffering is valuable). Furthermore, not all factual arguments are fact-based, that is, they are not supported by facts. On the contrary, the debate on active euthanasia contains many claims about what would be the consequences of an introduction, which are made without reference to any factual basis. What separates factual arguments from value-based arguments is that they can be tested against observations of reality (is there suffering that cannot be alleviated with conventional pain relief?). It must also be emphasized that by far not all arguments can easily be placed in one or the other category. Many are a combination of value- and fact-based arguments, where one can say, for example, that given that a certain fact about euthanasia exists, then a certain value argument should be promoted.⁵

The Ethics Council has made a decision to present arguments for and against the legalization of euthanasia and to compare ideal-typical fact-based arguments from the Danish debate with knowledge from two ideal-typical models for euthanasia. The Ethical Council's statement is also supported here by the State Medical-Ethical Council's report from 2017. This applies to a certain extent to the design of the statement itself, where fact-based arguments are compared with empirical findings, but this especially applies to the discovery of the empirical material itself. Here, the Ethics Council makes use of the many insights established in SMER's report, but supplements these with an update when necessary. This particularly applies to the annual reports from Oregon and the Netherlands. During this presentation, conclusions from SMER's report will be highlighted under the heading 'This is what we want to k

There are basically two empirical sources of other countries' experiences with euthanasia. Authorities' official annual reports and independent scientific studies.

Annual reports. Legislation in both Oregon and the Netherlands requires that every case of euthanasia be reported. In Oregon, the physician who writes a prescription for euthanasia drugs must submit medical records to the authorities and additional documentation after the patient has died. This information forms the basis of annual reports which are published by the relevant authorities. In the Netherlands, each individual case of euthanasia must be reported to a special assessment committee, which investigates whether the law has been complied with and which publishes annual reports based on this. These reports contain a number of statistical information on the conditions surrounding euthanasia. This statement will

focus on three of these, namely the numerical extent of euthanasia, the distribution of cases of euthanasia by patient groups, and the reasons given for requesting euthanasia.

Scientific studies of the two models. In both Oregon and the Netherlands, empirical research has been carried out on a number of topics. These are, for example, studies of patients who have died through euthanasia; patients who have received permission for euthanasia; patients who have requested euthanasia; patients who have considered or expressed an interest in euthanasia; and practitioners of euthanasia. It can also be developmental studies that compare clinical practice over time or comparative studies that compare different countries, states or regions in order to discover patterns or deviations.

Each country's legislation, healthcare system, and traditions of clinical practice are different, so while the starting point is two different countries or states (Oregon and the Netherlands), it is for the purpose of describing two ideal-typical models, in order to clarify in which the most significant differences consist, and judge how the experiences with these can influence the discussion of euthanasia.

The Oregon model, introduced in Oregon in 1997, allows only assisted suicide, while euthanasia is illegal. The decisive criterion for access to euthanasia is that you are terminally ill, which means that you are judged to have no more than six months to live. It is not a criterion that you must experience unbearable suffering. Patients must be 18 years of age and competent to make decisions, which means that they must be able to both understand and make decisions about their condition.

The Dutch model, which is generally also adopted in Belgium and Luxemburg, allows both euthanasia and assisted suicide. The decisive criterion for access to euthanasia is that one is in a state of unbearable suffering and that there are no other ways to relieve the condition. The disorder can be physical or psychological. There is no requirement that persons must be terminal or otherwise at the end of life. In the Netherlands, children under the age of 18 are allowed to receive euthanasia, provided they are judged to be sufficiently mature to look after their own interests. In the Dutch model, you can express your wish for euthanasia through an advance directive, which means that people who have lost decision-making capacity can in certain cases receive euthanasia.

Why is it important to relate concretely to countries' different models? This is because different models have different consequences.⁶ This means that

”

Why is it important to relate concretely to countries' different models?

This is because different models have different consequences.

This means that you cannot

answer what the consequence of legalizing euthanasia will be without specifying which model you are talking about.

you cannot answer what the consequence of legalizing euthanasia will be without specifying which model you are talking about. In the Netherlands, which allows euthanasia and has no requirement for terminal illness, the number of people who die by euthanasia is 10 times greater than in Oregon, which only allows assisted suicide and requires terminal illness. Differences also appear, for example, in the question of what motivates people to wish for euthanasia in different models. In Oregon, the fear of losing quality of life and independence at the end of life is the dominant motive. In the Netherlands, suffering without hope of recovery is the main motive.

The great difference can also be expressed in this way: there is no requirement in Oregon that patients must be suffering unbearably or simply suffering. The legislation in Oregon thus turns the Dutch admission criteria on its head, which require a state of unbearable suffering, but do not contain any requirement that patients must be terminal. In this way, Oregon law allows both more (no claim of suffering) and less (a claim of being terminal).

The statement consists of a substantive consideration of two parts.

Chapters 4 and 5 present the current knowledge that the council has had the opportunity to establish. Chapter 4 is primarily a presentation of the most basic facts about the existing Danish legal situation and the current clinical practice when it comes to help in connection with the end of life.

Chapter 5 briefly presents the basic facts surrounding the legislation in Oregon and the Netherlands, as well as the most significant statistical facts that describe the extent and distribution of euthanasia and the most common reasons for requesting euthanasia.

Chapters 6 and 7 describe the most significant arguments for and against euthanasia. Along the way, significant fact-based arguments that SMER's statement provides knowledge about will be collected in separate text boxes with the heading 'This is what we want to know'. It should be noted that the Ethics Council has decided to separate the description of the most significant ethical arguments from the most significant practical-political arguments. The separation can be experienced as artificial. Basically, in both cases it is about ethical arguments and discussions. However, the legalization of euthanasia is not a necessary consequence of considering euthanasia to be ethically justifiable. It is possible to think that euthanasia can be defended in principle, but cannot be implemented in practice, without having to compromise with other principles that are also considered essential, or without having to accept unreasonable consequences.

4. The Danish practice 25 at the end of life

4.1 The Danish legal situation

Euthanasia, as defined in this opinion, is not legal in Denmark.

The 25th chapter of the Criminal Code on crimes against life and limb states in section 239 that "Whoever kills another at his specific request shall be punished with imprisonment for up to 3 years". § 240 says "Whoever contributes to someone taking their own life is punished with a fine or imprisonment for up to 3 years". If it is a so-called 'mercy killing', the sentence can possibly be reduced.

In recent years, several cases have been brought before the European Court of Human Rights, which have had to decide whether the right to die is protected by the European Convention on Human Rights. An example is Diane Pretty, who was extensively paralyzed and wanted her husband's assistance in committing suicide.

With this, he risked being punished for assisting suicide, and the question was thus whether it was a violation of Diane Pretty's human rights that she was thus prevented from taking her own life. In the *Pretty v. UK* case, the court found that there were violations of both Article 2 (right to life), Article 3 (right not to be subjected to torture and other inhuman or degrading treatment), Article 8 (right to privacy, including self-determination) and Article 14 (discrimination). It is particularly emphasized in relation to Article 8 that the legislation's ban on assisted suicide was an interference with her right to privacy and self-determination, but that the ban was based on the consideration of protecting weak citizens from being pressured to commit suicide .7

4.2 The current practice for palliation at the end of life

Today, the average lifespan has been significantly increased. The most significant causes of death are heart disease and cancer. Since we are today able to treat these diseases, the process before death has changed in character and has been significantly extended compared to before. Often, the health care system is able to keep people with the disorders in question alive long after the disease is discovered, and that

looks like the person will probably die from it. This is due to the development of the many forms of medical treatment which, among other things, make it possible to replace or supplement the body's natural functions and/or delay the development of the diseases. This includes, for example, ventilators, pacemakers, medical treatment of cancer, operations, etc.

An important issue is how the treatment measures that enable life extension affect the patient's quality of life. One can discuss whether in some cases it is better for the patient not to be treated and perhaps instead to live for a shorter time, possibly with increased presence or less discomfort.

Palliative medicine is in a sense a reaction to this development. Palliative medicine is built around this relationship, that suffering calls for an answer, for a reaction and, when it can be done, for relief.

The WHO emphasizes that palliative care must be seen as a very broad form of care. The aim of palliative care is to promote the quality of life of patients and families who are faced with the problems associated with life-threatening illness.

And this must be done by preventing and alleviating suffering through early diagnosis and immediate assessment and treatment of pain and other problems of a physical, psychological, psychosocial and spiritual nature. In other words, palliative care does not necessarily consist first and foremost of medical disease treatment, but must also include psychological and spiritual care for the patient, where conversation and presence are the mainstay of the contact. Suffering is thus also perceived as suffering in an existential or spiritual sense, and the purpose of palliative care is, among other things, to alleviate this form of suffering, which can take many forms depending on the patient's situation, outlook on life and future plans. For example, there may be fear of dying; anxiety about the death process itself; anger and powerlessness in relation to the basic condition that death represents in human life; concern in relation to whether the bereaved will be able to fend for themselves; grief at having to leave loved ones; sadness at not being able to complete one's life projects and much more.⁸

In connection with palliative care, there are a number of treatment decisions, all of which have the potential to shorten the life of the patient. These naturally attract enough attention in connection with a discussion about euthanasia. Do not actions taken in the health care system that can hasten death also constitute euthanasia? Whether these constitute 'euthanasia', or possibly not, is for many a significant part of the issue and will be discussed in more detail in section 6.2.3. In this section, which only presents the current conditions, the Ethics Council has chosen to distinguish between euthanasia and actions that can hasten death,

and which belongs to palliation, and which is therefore probably partly the end of life, but is not categorized as euthanasia. It must also be emphasized that this section only presents circumstances surrounding the palliative practice which are relevant for an assessment of the issue of euthanasia. Relief and help at the end of life takes place in many other ways than described here.

When it comes to potentially life-shortening actions, there are four basic actions:

1. Not initiating or continuing life-sustaining treatment at the patient's request

In some cases, starting or continuing treatment will be necessary to sustain life at all. In such cases, the refusal of treatment becomes life-threatening. Even when the effort is so high, the Health Act requires that competent and decision-making patients' free and informed refusal of treatment be respected.

Patients may therefore wish not to start or to stop life-prolonging treatment, which from a medical point of view makes sense. It is an act which follows the patient's wishes, and where it may consequently be the patient's own purpose that death should occur. From the health professional's perspective, the purpose of not initiating or continuing life-sustaining treatment is to respect the patient's self-determination, and death is in a certain sense a side effect. That patients have this option to opt out of treatment is due to the basic principle of self-determination in Section 15 of the Health Act, which states that no treatment may be initiated or continued without the patient's informed consent. The same paragraph also states that the patient can revoke a given consent at any time. 9

2. Not initiating or continuing life-sustaining treatment that does not benefit the patient

If a life-sustaining treatment is judged to be hopeless, i.e. do more harm than good, the treating physician may decide not to start or continue treatment. Such a decision is a medical decision, and is therefore based on

not at the patient's request. The intention here is not for the patient to die, but to avoid further harm or suffering. 10

3. Provide symptom relief, which may hasten death

The end of life may be associated with physical ailments such as pain, shortness of breath, nausea, dizziness or delirium. A number of drugs are used in palliative medicine to relieve suffering caused by pain and other physical symptoms. For example, many cancer patients in their final days will need painkillers delivered in an 'analgesic ladder', where the aim at each step is simply to give the smallest dose necessary to control the pain.

If a patient experiences pain, the attending physician may decide to prescribe pain-relieving drugs, even if this entails the risk of hastening the onset of death. The starting point for such treatment is not the patient's wish, but an assessment of a medical need, and a decision on pain relief can be made without the patient being competent to make a decision. The aim of the treatment is to relieve the patient's pain, not for the patient to die. Slowly increasing the dose of the medicine, until the patient is relieved, must ensure that the patient does not die from the medicine, but is relieved in the dying process, which is already underway due to the disease.

4. Give palliative sedation

Most types of pain that occur in connection with the end of life can be controlled through symptom relief. But not all.

A minority of patients experience pain or other physical, psychological and existential symptoms that cannot be alleviated. With palliative sedation, the level of consciousness is lowered with sedatives and anxiolytics so that the patient no longer experiences severe symptoms. If the patient is kept in this state until death occurs, it is called continuous palliative sedation. The decision to start sedation is aimed at symptom relief. As long as sedation is judged to be necessary, it is not considered euthanasia, even if the treatment were to hasten death. Only exactly enough medicine is given to keep the patient asleep and not suffering.

”

Current research finds it doubtful whether the use of symptom-relieving agents or palliative sedation actually hastens death. It is emphasized that when the palliative effort is delivered correctly, then it is the reduction in respiratory function that can accelerate death, a very rare side effect. The notion that symptom relief or palliative sedation generally hastens the patient's death is thus at odds with the field's experience.

That healthcare professionals have the right to relieve symptoms and sedate, as described, finds its basis in § 25, subsection 2 of the Health Act. 2, which states that an irretrievably dying patient can receive the painkillers, tranquilizers or similar agents that are necessary to relieve the patient's condition, even if this may lead to hastening the time of death.¹¹

It should be noted that the current research finds it doubtful whether the use of symptom-relieving agents or palliative sedation actually hastens death. It is emphasized that when palliative care is delivered correctly, the reduction of respiratory function, which can hasten death, is a very rare side effect. The notion that symptom relief or palliative sedation generally hastens the patient's death is thus contrary to the field's experience. On the contrary, proper use of pain relievers can prolong patients' lives as they are more rested and pain-free. The concern among professionals is rather the opposite, that due to persistent notions of symptom relief and sedation as potentially life-shortening, there is a greater risk of undertreatment and that patients live their last days with unnecessary pain.¹²

Most recently, the Danish Parliament has expanded the options for self-determination through a treatment will, which expands the options to refuse treatment and is binding on healthcare personnel. It should also be noted that the guidance for healthcare personnel on relief using pain-relieving medications was updated in 2018, precisely to make it easier for staff to make use of the options for relief after the end of treatment.

5. Foreign experiences with euthanasia: two models

5.1 The Oregon Model

In Oregon, assisted suicide, but not euthanasia, is allowed through the so-called Death with Dignity Act. The law was created as a result of a citizen proposal and came into force in 1998. Before the law was passed, it was first passed in a referendum in 1994, then blocked by a court and finally passed in a new referendum in 1997. In 1994, the law was passed with a narrow majority of 51% for and 49% against. In 1997, the law was passed again, this time with a larger majority of 60% for and 40% against.¹³

The law gives doctors the right to write a prescription for a drug in a lethal dose to patients who are 18 years of age, capable of making decisions and suffering from a terminal illness which, according to a 'reasonable medical judgement', is expected to lead to death within six months unless treatment is given to slow the progression of the disease. In the past, there was a requirement that one should be domiciled in Oregon, but this requirement no longer applies as of 13 July 2023.

The first step in the process is for a patient to express a wish to die. The patient's own doctor must then confirm that the patient meets the requirements to receive euthanasia and that the wish is voluntary. The doctor must also inform the patient of:

- 1) The medical diagnosis
- 2) The prognosis
- 3) The potential risks of taking the prescribed drugs
- 4) The expected result of taking the prescribed medicines
- 5) The alternatives available, including but not limited to palliative care, hospice care and pain relief.

The doctor must also inform patients of their right to withdraw their request at any time. The doctor must also recommend that the patient inform their next of kin of their decision and consider whether another person should be present when the medicines are taken. Both the medical requirements and the patient's capacity to make decisions and act voluntarily must be confirmed by another doctor. If one of the doctors believes that the patient may be suffering from a mental disorder that affects his judgement, a psychiatrist or psychologist must be consulted. No prescription for drugs for assisted suicide may be given until it is established that the patient's judgment is not impaired by 'psychological or psychiatric disorder or depression'.

”

Before the responsible doctor writes out the prescription, the patient must make a verbal request. This request can be made no earlier than 15 days after the first oral request. In connection with the discharge, the doctor must again ensure that the decision is informed, and give the patient the opportunity to withdraw his request

After it has been determined that the patient meets the requirements and after the patient has been informed, the patient can request assisted suicide in writing. The written request must be witnessed by two people who can confirm that the patient is capable of making decisions, acts voluntarily and is not subject to any coercion. At least one of the witnesses must be a person who is not a close relative, has no inheritance rights from the patient and has no connection to the institution where the patient lives or receives care. The doctor responsible for treatment may not be a witness. Prescription of medicines may not take place earlier than 48 hours after the written request has been submitted. Before the doctor in charge writes the prescription, the patient must make a verbal request. This request can be made no earlier than 15 days after the first oral request. In connection with the discharge, the doctor must again ensure that the decision is informed and give the patient the opportunity to withdraw his request.

The law states that no healthcare professional is obliged to assist in assisted suicide. Pharmacists have the right to refuse to dispense drugs for assisted suicide. Coercing or otherwise exerting undue pressure to get a patient to request euthanasia is considered a crime, as is forging or altering a written request for assisted suicide.

No wills, contracts, insurance policies or other legal requirements may depend on a person requesting or refraining from requesting euthanasia under the Death with Dignity Act. The patient's wishes, medical assessments and offers to withdraw the request must be documented in the patient's medical record. No later than seven days after the responsible doctor has prescribed drugs for assisted suicide, the information must be sent to the state's health authority. The person who supplies the medical supplies must also report to the authority. Regardless of the cause of death, the doctor must submit a form about the circumstances of the death, including the patient's reasons for requesting assisted suicide, no later than ten days after the patient's death. If the health authority finds that any part of the regulations has not been followed, this is reported to the state licensing authority, Oregon Medical

Board. The reported information is collected every year by the health authority in a report on the application of the law.

”

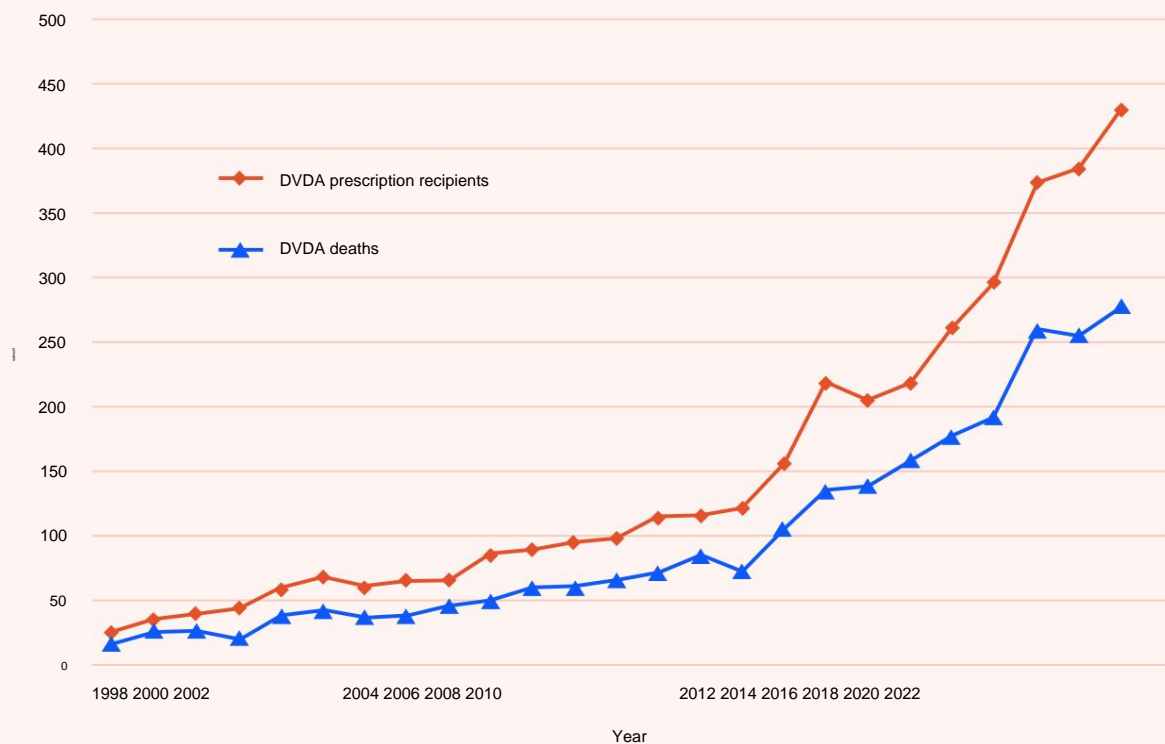
Public statistics from Oregon show that the proportion of patients using their prescriptions has been about two-thirds since the law took effect.

The rest of the patients die in other ways.

Since the law came into force in 1998, two changes have been made. From 2020, it became possible for doctors to disregard the 15-day waiting period if the patient's death is imminent, and as previously mentioned, from July 2023, the requirement that recipients of euthanasia must take up permanent residence in Oregon has been abandoned.

Scope

The annual reports from Oregon health officials show that in the first full year that assisted suicide was legal in Oregon, 24 prescriptions for assisted suicide were written and 16 cases of assisted suicide were completed that year. These 16 deaths accounted for 0.5 per thousand of all deaths in the state. In 2022, 431 prescriptions were issued and 278 patients died using assisted suicide. The official statistics from Oregon show that the proportion of patients using their prescriptions has been approximately two-thirds since the law took effect. The rest of the patients die in other ways. The reasons why more prescriptions for assisted suicide are written can be both that more people request it and that a larger proportion of those who request it are granted it.



Trends in number of prescriptions written (red line) and completed assisted suicides (blue line) in Oregon, 1998-2022/14

Distribution

According to the health authorities' annual reports, 64% of patients who die by assisted suicide in Oregon have a cancer diagnosis. This is followed by heart disease convictions with 12% and neurological diseases with 10%. Seen in relation to the number of affected patients, ALS patients are the patient group in which it is most common to choose to die by assisted suicide. The annual report in Oregon is more detailed than stated here, and distinguishes, for example, between benign or unclear tumors, respiratory diseases other than COPD, neurodegenerative diseases other than ALS, diseases of the muscles, skeleton and connective tissue, viral hepatitis, diabetes, stroke and cirrhosis. Illnesses, such as depression or dementia, have not been reported as a primary diagnosis in Oregon, which is related to the requirements of terminal illness and preserved decision-making capacity.

Diagnostic group	2022	1998-2020
Cancer	178 (64)	1.420 (73,9)
Neurological diseases (e.g. ALS)	27 (9,7)	207 (10,8)
Cardiovascular diseases	32 (11,5)	105 (5,5)
Respiratory diseases (e.g. COPD)	27 (9,7)	109 (5,7)
Endocrine/metabolic diseases (e.g. diabetes)	4 (1,4)	19 (1)
Gastrointestinal diseases (e.g. liver disease)	4 (1,4)	17 (0,9)
Infectious diseases (e.g. AIDS)	2 (0,7)	14 (0,7)
Other diseases	4 (1,4)	30 (1,6)

Distribution in absolute numbers and (%) between different diagnostic groups among the patients in Oregon who died by assisted suicide. 15

Reasons

After a patient who has been prescribed a prescription for assisted suicide has passed away, the responsible doctor must complete a questionnaire from the health authority, in which the patient's reasons for requesting assisted suicide must be stated (the possible reasons are predefined). These data are reported in the annual

statistical reports. As shown in the table below, most patients were reported to have more than one reason for their decision.

Reason for requesting about euthanasia	2022	1998-2020
Less able to participate in activities that provide quality of life	89	90
Loss of self-determination	87	90
Loss of dignity	62	74
Burden for relatives/carers people	47	47
Loss of control over bodily functions	45	44
Inadequate pain relief or concern about it	32	28
Financial consequences of continued treatment	6	5

*Patients' reasons for requesting euthanasia, according to their own doctor, given in %.
The respondents could state more than one reason. 16*

The picture that loss of independence, low quality of life, loss of dignity and the desire to control the circumstances surrounding death are more important reasons for choosing assisted suicide than experienced physical pain is confirmed in several studies from Oregon, where both patients, relatives and doctors as well as other healthcare professionals have been asked.¹⁷ Healthcare professionals in Oregon believe that the feeling of being done with life and that continuing to live is meaningless is a prominent reason for requesting euthanasia, but this view is not shared by patients and their relatives. However, it is confirmed in several studies that a relatively important reason for the patients is not to be a burden to their surroundings.¹⁸

Although symptom-based factors seem to be less important motives for those who die by assisted suicide, a study from 2000-2002 among relatives of 1,400 deceased people shows a clear correlation between the experience of pain and other symptoms in the last week of life and the likelihood of choosing assisted suicide. A possible explanation, which is put forward in a commentary to the study,

”

The picture that loss of independence, low quality of life, loss of dignity and the desire to control the circumstances surrounding death are more important reasons for choosing assisted suicide than perceived physical pain is confirmed in several studies from Oregon, where both patients, relatives and doctors, and other health personnel have been asked.

is that when the symptoms are so severe that they make the patient consider assisted suicide, the disease is so advanced that the patient does not manage to complete all the necessary steps for a request or does not meet the requirements for decision-making competence. A reflection made by the authors of one of the studies is that many patients who request assisted suicide seem to want to foresee a future situation that they fear would be unbearable (with greater emphasis on existential than purely physical suffering), in rather than reacting to an existing disorder. This may indicate that the desire for security is an important factor behind many patients' desire for euthanasia. Before legalization in Oregon, ALS patients were asked about their interest in assisted suicide. Four out of five of those who would consider requesting assisted suicide if it were legal said they would save the prescription for future use and not use it in the coming month, which the authors say may indicate that the safety factor is important.¹⁹

5.2. The Dutch model

The Netherlands was the first country in the world to allow assisted dying in the form of both assisted suicide and euthanasia. In 1973, the public debate about euthanasia gained momentum in the Netherlands when a female doctor was prosecuted for euthanizing her cancer-

After several similar trials, a practice gradually developed where prosecutors failed to prosecute doctors who gave euthanasia to their patients. This was subject to certain specific criteria being met, including repeated requests from the patient, assessment of the patient's decision-making capacity and a state of unbearable suffering that could not be alleviated by other means. Euthanasia was still illegal and there was no guarantee of immunity for the doctor. This led, among other things, to a lack of reliable statistics on the incidence of euthanasia, as doctors' concern for the legal consequences meant that far from all cases were recorded. In 1984, the Dutch Medical Association (KNMG) contributed to the preparation of a report which proposed five criteria that had to be met in order for doctors to avoid prosecution. The patient's request had to be (1) competent, voluntary, explicit and sustained, (2) based on full consent, (3) the patient had to be in a state of unbearable and hopeless suffering, (4) with no prospect of further treatment that could alleviate the suffering, and (5) the physician involved should consult at least one other physician whose assessment was to be considered independent. These guidelines developed into unofficial guidance for prosecutors when deciding whether cases of euthanasia should be prosecuted. While both euthanasia and assisted suicide remained de jure illegal in the Netherlands according to the criminal code, they were de facto permitted, so

as long as the KNMG guidelines were complied with. In 1990 it was formally declared that doctors who followed the established criteria would not be prosecuted, and in 2002 a law was finally passed to regulate assisted death and euthanasia. At the same time, it was written into the Criminal Code that euthanasia given in accordance with the rules does not constitute a crime. According to the law, only doctors can give euthanasia without penalty. In order for a doctor to have the right - but not the duty - to provide euthanasia, he must meet the so-called 'criteria for proper care'. These criteria mean that the doctor must:

- 1) Ensure that the patient makes a voluntary and considered request.
- 2) Ensure that the patient's suffering is unbearable and without possibility of improvement.
- 3) Have informed the patient about his or her situation and prognosis.
- 4) Together with the patient, reach the conclusion that there are no others reasonable alternatives in the patient's situation.
- 5) Have consulted at least one other independent doctor who must have met the patient and confirmed in writing that conditions 1-4 are met.
- 6) Having ended the patient's life or assisted in his or her suicide in a manner consistent with good medical practice.

There is no requirement that a request be in writing. You can request euthanasia from the age of twelve, provided that you are considered sufficiently mature to look after your interests. Until the age of 16, parental consent is required. If you are 16 but under 18, the parents must participate in the decision-making process, but they cannot say no.

In 2005, medical and legal experts published the so-called 'Groningen protocol', which guides when and under what circumstances euthanasia can be given to children under 1 year of age. Criteria here include that there must be certainty of diagnosis and prognosis, a state of hopeless and unbearable suffering, consent from both parents and confirmation from an independent physician.

From 2024, it has been decided to extend the coverage area of the Groningen Protocol to also apply to minors aged 1-12.

According to the Groningen Protocol, it remains illegal in the Netherlands, even for doctors, to actively end the life of persons under the age of 12, unless compelling circumstances speak for it, and therefore allows the prosecution to refrain from

prosecute. Euthanasia for minors aged 0-12 is thus in a situation very similar to that in which voluntary euthanasia for adults was before the legislation in 2002.²⁰

Each case of euthanasia must be reported to the local coroner, who then reports to a regional review committee. If the coroner or the committee considers that the requirements of the law have not been met, the prosecution must be informed.

Violations of the rules can lead to up to twelve years in prison. The committees must also prepare a joint report to the Ministry of Health on the use of euthanasia every year. According to guidelines from the regional review committees, the question of what constitutes a reasonable alternative must be evaluated not only from the doctor's point of view, but also from the patient's perspective. It is permitted to give euthanasia (assisted suicide is not relevant in these cases) to demented and other patients who can no longer express their will if there is a written prior instruction and other rules are otherwise observed.

In addition to the law, there are a few important court cases that have had an impact on the interpretation of the criteria for proper care. In the so-called Chabot case from 1994, the Supreme Court ruled that mental disorders can be so severe that they meet the requirements of the law, but that doctors must be especially careful when dealing with patients whose disorder is primarily psychological. In particular, it must be ensured that the patient's judgment is not affected by the disease. According to the recommendations of the audit committees, two independent doctors should be consulted in these cases, including a psychiatrist. A key question is determining whether there is a lack of hope for improvement. If the patient receives reasonable treatment offers, the condition cannot be considered hopeless. In another case, the Brongersma case from 2002, the Supreme Court clarified that the suffering must have its origin in a medical condition - dealing with the fatigue of life or suffering of a more existential nature does not fall within the scope of access to assisted dying. There is currently no requirement that the condition be serious or life-threatening. According to the review committees, age-related multimorbidity can also cause unbearable suffering with no hope of improvement.

Scope

The annual reports from the Dutch health authorities show that more and more people in the Netherlands end their lives through euthanasia. In 2022, 8,720 cases of euthanasia were reported, which corresponds to 5.1 percent of all deaths.²¹ If the trend from the national death certificate surveys has held, the actual number may have been even higher. According to these studies, the reporting rate is approximately 80 percent, which means that one in five cases of euthanasia or assisted death are not reported. In the latest survey from 2015

”

Euthanasia accounts for the majority of euthanasia deaths in the Netherlands. According to the latest annual report from 2022, the proportion of people who die by euthanasia is 97.4%, while the number who die by assisted suicide is 2.1%.

it was estimated that 4.6 percent of all deaths met the requirements for euthanasia or assisted death, i.e. that they occurred as a result of an act carried out at the patient's request with a view to hastening death. However, the number of reported cases in the same year was only 3.8 percent of all deaths. In a previous euthanasia test study, it appeared that in all cases where they had not reported the death themselves, doctors did not classify the actions as euthanasia, but usually as palliative sedation. They also used different drugs than those used in 'ordinary' euthanasia. According to the researchers behind the death certificate investigation, this suggests that it is not about deliberate under-reporting, but about uncertainty about the effects of medicines and the purpose of various interventions.²² The increase in the number of euthanasia cases is due both to more people requesting euthanasia and to a greater proportion of the requests are granted.

Between 2010 and 2015, the proportion of requests for euthanasia rose from 6.7 to 8.4 percent of all deaths, while the proportion granted rose from 45 to 55 percent. Euthanasia accounts for the majority of euthanasia deaths in the Netherlands. According to the latest annual report from 2022, the proportion of people who die by euthanasia is 97.4%, while the number who die by assisted suicide is 2.1%. The remainder constitutes a combination.

Reported cases 2000-2022



Development in the number of cases of euthanasia in the Netherlands 2002-2022

Distribution

In the Netherlands, too, cancer, neurodegenerative diseases and cardiovascular diseases are among the most common diagnoses among patients who die using euthanasia. However, there is no requirement for a terminal illness to be considered for euthanasia, and it happens that euthanasia is given on the basis of, for example, multi-illness or mental illness. When it comes to mental illness, the regional review committees in the Netherlands have recently seen an increasing willingness among Dutch doctors to provide euthanasia in such cases. The frequency has increased from 0.4 to 1.0 percent of all cases between 2011 and 2016. The proportion of patients with multiple diseases has decreased between 2013 and 2016 from 5.7 to 4.0 percent. In a study specifically examining 66 cases of euthanasia among the mentally ill in the Netherlands, the most common diagnoses were depression (55 percent) and post-traumatic stress and other anxiety disorders (42 percent). 26 percent, including some of the depressed patients, had psychotic illness or psychotic symptoms. There were also cases of people with cognitive impairment (6 percent) and eating disorders (6 percent) receiving euthanasia.

The vast majority of patients had several different psychiatric illnesses at the same time, and half also had a personality disorder or problems related to personality. Half of the patients had a history of suicide attempts.

Diagnostic group	2022	2012
Cancer	5.046 (58)	3.251 (78)
Neurological diseases (e.g. ALS)	615 (7)	257 (6,1)
Cardiovascular diseases	359 (4,1)	156 (3,7)
Respiratory diseases (e.g. COPD)	277 (3,1)	152 (3,6)
Geriatric multimorbidity	379 (4,3)	-
Combination of diseases	1429 (16,3)	172 (4,1)
Mental illness	115 (1,3)	14 (0,3)
Dementia	288* (3,3)	42 (1)
Other diseases	212 (2,4)	144 (3,4)

Distribution in absolute numbers and (%) between different diagnosis groups among the patients in the Netherlands who died through euthanasia.²³

**Patients capable of making decisions: 282.
Patients not capable of making decisions: 6.*

Reasons

In the Dutch death certificate surveys, doctors are asked about the main reasons they had for giving euthanasia. In a 2015 study of this data, the most common responses were 'no prospect of improvement' (82 per cent), 'patient's wish' (80 per cent), 'severe symptoms other than pain' (60 per cent), 'loss of dignity' (59 per cent), 'expected suffering' (44 per cent) and 'pain' (40 per cent).

In a study asking relatives of patients in the Netherlands who had died by euthanasia or assisted dying about the patient's reasons for requesting euthanasia, the most common responses were unbearable suffering, loss of dignity, no prospect of improvement, meaningless suffering, dependence on others to cope with daily life, general fatigue and pain.

	Oregon	The Netherlands
Form of euthanasia	Assisted suicide	Assisted suicide and euthanasia
Is there a requirement for one medical diagnosis?	And	And
Is there an age requirement?	Yes, minimum 18 years	No, but special rules for ages 0-12 (Groningen-protokol-len) and special rules for ages 12-18 (mature minors)
Is there a requirement for a terminal forecast?	Yes, maximum remaining time of 6 months	No
Are there special requirements for the nature or extent of the suffering?	No	Yes, a claim for 'unbearable suffering'
Serious chronic conditions?	No	And
Serious chronic mental disorders?	No	And
Can advance directives be granted for physical ailments?	No	And
Can advance directives be issued for mental disorders?	No	And

Overview. The most important features of euthanasia in Oregon and the Netherlands.

6. Basic ethical arguments

41

6.1 Basic ethical arguments for euthanasia

6.1.1 Reduction of suffering as an argument for euthanasia

The main argument for euthanasia is simple: that for some life can be excruciatingly painful and that for them death can be a relief compared to such a life. This argument contains an appeal for mercy and for empathy for what it feels like to be in terrible circumstances and a desire to do what is possible to help them.

The argument about reducing suffering is a relatively simple and, for many, intuitive argument. Suffering is an evil in itself, and therefore something that should be prevented or alleviated whenever possible. As we have seen in section 4.2, palliative medicine is precisely the purpose of palliative medicine. Most forms of suffering at the end of life can be alleviated through good pain control. But, goes the argument for euthanasia, not all suffering is physical, and not all physical suffering can be fully alleviated.

It is in some of these latter cases that palliative sedation may come into play. Part of the rationale for the use of palliative sedation is its ability to relieve the patient of unnecessary suffering in the dying process. Such a justification should, the argument goes, have the same weight when it comes to the use of euthanasia.

For most of life, death, and especially premature death, is an accident that befalls us. We may fear our own death, we make great efforts to avoid it.

This applies personally, but also in society through rules, safety regulations, treatments and prevention. The argument for the reduction of suffering through euthanasia would argue that in rare cases it works differently.

The starting point for this is that being dead is not bad as such. Death is an evil worth avoiding because it robs us of the possibility of a future that we who most often would have benefited from. It's not because it's bad to be dead. That few have any insight into. But it is a condition which makes impossible the benefits which life would have contained if life had continued. So death should not be understood as an evil in itself, but only in terms of what it robs us of.

A consequence of this view is that it is not unrealistic to judge life as a calculation. The fewer goods that lie ahead of us in life, the less of an evil it will be to die - from the point of view of the dying person. Proponents of euthanasia point out that it is precisely such a 'calculation' that underlies the medical practice that allows patients to refuse life-sustaining treatment.

The argument for reducing suffering as a reason for euthanasia thus includes an assessment of the quality of life that we all continuously make. For most, this 'running account' will show that death right now and here will be a bad thing.

The accounting is in a sense simple, and depends on a comparison between two possible results. One where you die now and one where you live on. Life is often a mixture of good and bad experiences, but as long as the good outweighs the bad, then there is balance in existence, or 'life is worth living'.

The same applies to those who are considering euthanasia. The assessment of the hastening of death depends on the value of the life to be lived in the future.

How negative a hastened death will be for you depends on how much value could be achieved in the afterlife. And if the absence of death can be a good when it ensures the continuation of a good life, then death can also be a good if it saves you from having to continue a bad life, full of unbearable suffering.

Whether death is good or bad thus depends on your life circumstances.

Since we all have to die sooner or later, the practical question is not whether we have to die, but how. And having the ability to hasten death has it advantage that it is also an opportunity to take control of its circumstances (time, place, who is present), rather than leaving it to the course of the disease. 24

So, an argument for allowing someone to be assisted in dying is that life for someone can be a very large load. Here, physical pain can play a big role, and they often will could be controlled with drugs. Something else is the patients for whom the psychological and existential pain of their life situation is experienced as just as life-threatening as physical pain can be.

Pain is clearly a major issue for dying patients, and palliative medicine has a major focus on pain control. But alongside the fact that not all pain can be fully controlled, it is also crucial that not all suffering is caused by pain. According to a certain school of thought, pain is best understood as a clear and distinct feeling that we do not like. Pain causes suffering, but so do a number of other physical phenomena, such as nausea, itching, dizziness, shortness of breath, etc. None of these are exactly the same as pain, but all can constitute

part of the suffering. Furthermore, pain has an organic basis, while most forms of suffering are also psychological: anxiety, depression, despair, hopelessness, loneliness, humiliation, etc. Therefore, suffering is perhaps best understood broadly as an umbrella term for any experience or condition in life, which welcomes us strongly.

”

The assessment of the acceleration of death depends on the value of the life that is to be lived in the future.

How negative a hastened death will be for you depends on how much value would only be achieved in later life.

And if the absence of death can be a good thing when it ensures the

continuation of a good life, then death

can also be a good thing if it saves you

from having to

continue a bad life,

full of unbearable suffering

'We want to know': Can euthanasia be a last resort - either in the case of insufficient symptom control, or when life seems hopeless?

The literature reviewed by SMER does not provide an answer to the question of whether there are situations where even the best palliative care is not able, in most cases, to provide good symptom control.

Research and statistics from countries and states that have legalized euthanasia, however, suggest that the motivation for requesting euthanasia is often multifactorial, and that pain and other physical symptoms are often not the only or even the most important reason. Some studies even indicate that patients who die by euthanasia in Oregon have fewer disease-related symptoms than other patients who die of the same diseases. Overall, the reviewed literature suggests that severe pain symptoms are a less important reason for requesting euthanasia for a large proportion of patients.²⁵

One way to approach suffering is to perceive it as a subjectively experienced reaction to critical changes in life - for example in connection with illness.²⁶ Sources of suffering can be the physical symptoms, but for example the treatment of the illness, the isolation in relation to normal social life and the fear in relation to the development of the disease can also be sources of suffering. Physically caused pain is thus one among many possible sources of suffering, which for most people will be recognizable because one can imagine being in a painful state without experiencing physically caused pain. But the difference between suffering and pain is also seen in that the experience of severe physical pain in some people is not at the same time experienced as actual suffering, while the experience of less severe physical pain in others can give rise to suffering to a great extent. Suffering is therefore something that can essentially only be ascertained by asking the patient. There is therefore a subjectivity in the disorder, which can pose a challenge for the medical profession. Along with curing disease, alleviating suffering is a central goal of me

but at the same time the disorder is a phenomenon that cannot easily be made the subject of biomedical science. The disorder, unlike the physical symptoms, is not in itself accessible to a third-person perspective.

The fact that the suffering has this subjective character is, according to the point of view presented here, a reason why one should place great emphasis on self-determination when the question of the value of life becomes so difficult that people consider asking for help to die.

6.1.2 Self-determination as an argument for euthanasia

Granting that it may sometimes be preferable to die than to live, how is it to be determined when this is the case? How do you balance suffering against joy? The solution to this argument is relatively simple: the person who is in a state of suffering must decide the matter for himself. This is justified with a reference to the respect for autonomy, another word for self-determination.

The argument contains an appeal for respect. To respect others' self-determination is to be open to diversity and different life values, in an understanding that self-chosen habits, lifestyles and priorities can be just as meaningful to others as our own will be to ourselves, even if they may seem strange or even incomprehensible. People simply have different values and attach different importance to certain living conditions (eg independence). The idea is that for those people who want euthanasia, when given the opportunity, the choice becomes a confirmation of their values and priorities. If this opportunity is denied, it can be experienced as disrespect and provoke anger and despair.

This aligns with a common definition of autonomy, which precisely emphasizes the element of recognition: "To respect an autonomous actor is to recognize, with due appreciation, the person's abilities and perspectives, including his or her right to have certain views, to make certain choices and act in certain ways on the basis of personal values and beliefs".²⁷

One reason why rejected or accepted self-determination is experienced as disrespect or respect is that self-determination is about managing, controlling or unfolding one's life in accordance with one's own values and priorities. It is therefore important whether you make the decisive decisions in your own life. This is, for example, the idea behind informed consent in connection with treatments in the healthcare network and the right to refuse even life-sustaining treatment. The argument about self-determination in connection with euthanasia is that the same opportunity to decide for yourself should also be ensured when it comes to life and health in the final moments, where there is no life-sustaining treatment to refuse.

”

Proponents of assisted dying will often point to the current situation as one that offers a number of patients and persons an undignified death, precisely because they do not have the opportunity to decide on their own death, but are left to the development of an illness or a chronic condition lack of same. The first fear a horrible death. The others fear a terrible life.

The discussion about euthanasia is often conducted as a discussion about a dignified death. Proponents of euthanasia will often point to the current situation as one that offers a number of patients and persons an undignified death, precisely because they do not have the opportunity to decide on their own death, but are left to the development of an illness or a chronic condition lack of same. The first fear a horrible death. The others fear a terrible life.

According to advocates, self-determination is crucial for the discussion of euthanasia, because it is ourselves, and not others, who have to live with the consequences of a choice, or of the lack of opportunity to make a choice. Others may need to be cautious about drawing conclusions about what is best for people who want euthanasia. Because who is best informed about how life feels and about the factual aspects of the future such as treatments, prognoses, mobility, the nature of the disorders, etc.?

'We want to know': Can euthanasia give patients security, control and dignity at the end of life?

SMER's research shows that low quality of life, loss of dignity and independence, and loss of control over bodily functions are important motives for patients in Oregon to request active euthanasia.

SMER's research shows that low quality of life, loss of dignity and independence, and loss of control over bodily functions are important motives for patients in Oregon to request active euthanasia. What characterizes patients who request euthanasia, at least in Oregon where this has been studied, seems to be that these aspects are more important to them for a dignified death than to other patients. Research studies show that for many of the patients in Oregon who request euthanasia, it is not loss of control, or loss of dignity or pain that they experience in the current situation that motivates them. For many, it is instead more about the desire to anticipate future problems. This suggests that the safety aspect may be an important motivation for many of the individuals who request euthanasia in Oregon. It is also consistent with the fact that up to a third of patients do not use the medication, which may indicate that they are changing their attitude and no longer wish to hasten death. However, further research is needed to understand the reasons why such a large proportion of patients do not use the medicine.²⁸

SMER also points out²⁹ that in an interview study with 35 doctors in Oregon who had had patients who requested euthanasia, it appeared that the doctors perceived these patients as very independent individuals who throughout their lives had been used to control and independence. The doctors experienced that for many patients, self-determination was almost a philosophy of life. What worried patients most, and was the main reason for requesting euthanasia, was the prospect of losing control and becoming dependent on the health care system.

The idea of becoming a burden to their loved ones was also repulsive to many.³⁰ According to SMER, a general picture emerges that assistance with euthanasia, at least in Oregon, is in many cases a strategy for independent and independent patients to face future threats in connection with death, where addiction and loss of control are perceived as worse threats than physical symptoms. For the patients, it is about dying in the same way as they have lived, as 'master of their own house', in order to preserve their dignity that way.

Self-determination is sometimes described as a 'trump card', as a principle must be respected no matter what. The question is, however, about advocates for euthanasia itself considers self-determination to have the status of a trump card. Much suggests that it for a number of advocates more have the character of a starting point.

Because of course it is not certain that we ourselves know best. Common experience, but also scientific studies, show that this is not the case. Especially in highly consequential choices, we can benefit greatly from help in making a choice, for example when it comes to medical decisions. So, of course there are cases where you don't know your own best. If a younger person is in a grieving process with a desire not to live any longer, there are good reasons to believe that this is an expression of a momentary consideration of the situation and that he or she must be helped to see the possibilities that life offers can bring. But does it also apply to situations where people suffer terribly, have no prospect of recovery, are competent to make decisions and have made an informed choice? Here, advocates for euthanasia point out that others should be careful in judging what others can judge for themselves. We often know a lot about what it's like to be ourselves, and much less about what it's like to be others. Even if we ourselves imagine that we would enjoy a life under certain conditions, it is not certain that this applies to others.

The essential self-determination argument for euthanasia is then that euthanasia can be in the patients' own interest, as it will prevent further senseless suffering. By requesting euthanasia, end-of-life patients can try to control the timing and manner of death. They can choose to die earlier, rather than waiting for the disease to dictate the time and place of death. In this way, a request for euthanasia is a way of exercising self-determination.

Self-determination is of great importance for the possibility of doing what one considers to be in one's own interest, or in general just to do good.

Self-determination can of course be valuable in its own right (as a way to shape one's own life as one wishes), but can also be the right means to pursue what is in our own best interest. A decision-making competent and well-informed person, so goes the argument in connection with a life of great suffering, will often be better able to act and make decisions that are in their own best interest than any third party. Especially if one's own best interest is understood as something very personal, so that it is the person's own goals, values and preferences that are at the center.

6.2 Basic ethical arguments against euthanasia

6.2.1 The right to life and the inviolability of life

Euthanasia is murder. It may sound like a colorful choice of words, but that is also, technically, what takes place when it comes to euthanasia. The question is, is killing always, in every circumstance, wrong?

In 2003, the Council of Ethics pointed out that on an intuitive level it was a respectable objection, all the while that the intuitive aversion to and the discomfort at the thought of taking the life of a human being should guide the assessment of euthanasia and thus justifying that legalization of this should not take place. 31

The right to life, as a conceptualization of this intuitive reluctance, constitutes one of the most principled objections to euthanasia, where euthanasia conflicts with one person's right to live and the other person's duty not to kill. The argument is principled, because it cancels any further practical-political debate about what a wise implementation could look like, or whether the risks of implementing legislation are so great that it should exclude or limit the possibility of euthanasia.

But what is the right to life? It may be difficult to say, but at a minimum it must involve the right not to be killed by another. To the extent that euthanasia consists precisely of a doctor or other person killing a patient, it can be said to be a crime against the right to life. Will that also entail a rejection that there should even exist ethically relevant differences between killing and euthanasia? If a person is killed, it happens against their will, but if euthanasia is performed on the person, it happens with the person's will. If the argument about the right to life rejects any ethically relevant difference between killing and euthanasia, then it is due to a premise that the right to life is in some sense inalienable or inviolable.

The question is whether one can meaningfully waive the right to life - and thus the duties owed to others not to kill? It perhaps makes less sense to discuss whether one should or can do it completely and utterly, as much as it is about whether there are specific situations of an exceptional nature.

For example, isn't a consent to the end of life-sustaining treatment an example of how, on the basis of informed consent, you can give up such a right, at this time, for this purpose, in this situation?

The principled objection to ever killing another human being is sometimes formulated as a principle of the inviolability of life. The argument goes that the principle of the inviolability of human life constitutes a fundamental ethical norm, and that legalizing euthanasia would go against this norm and contribute to undermining respect for life. The term 'inviolability' represents an assertion that something priceless is lost every time a person dies, also regardless of how this person himself, or others, values the concrete life situation.

The argument here is that euthanasia would be a violation of a respect we owe everyone, including ourselves. The argument goes that a decision about one's own death is, in a certain sense, of a completely different order than other decisions in life, and a person's own death cannot therefore meaningfully be said to be the subject of a free and automatic choice. Making a choice to die is described as a denial of one of the basic conditions of being human and thus of a significant part of the individual's general identity as a human being. A choice that would improve life by abolishing it entirely is irrational according to this view, because the choice can appear absurd when held up against this basic human condition. An agreement between two people that one takes the life of the other would, in this view, be a denial that life is also its own purpose and cannot be definitively judged to be worth less than dying. In this sense, the value of life is not up for negotiation, or evaluation.

6.2.2 Reduced autonomy and decision-making competence as well as pressure from the environment

A major argument in favor of euthanasia is that it will increase people's ability to decide for themselves about this specific part of their life: how it ends. However, an often raised internal objection to the self-determination argument is that its focus on autonomy risks disregarding human vulnerability in an abstract understanding of the equal decision-making competence of all people. People are (in an echo of the justification for respecting the autonomy of persons) different, and in a crisis situation, self-determination for exposed and vulnerable persons can also be equal to being alone in one's decision, being abandoned by others and left to do one's own calculation of the value of life - and such a situation is completely and utterly different than it can be for those persons for whom there can be a final 'triumph' or a final unfolding of life, in the control of one's own death. 32

Furthermore, it is emphasized that the desire for control over one's own death is essentially formulated by healthy, well-functioning people who are unable to imagine how they would be able to accept deterioration of their basic level of functioning.

”

The thinking can be summed up in this way: the autonomy of people who want euthanasia is undermined by the very situation in which self-determination is thought to unfold.

The main objection is therefore that it is an insurmountable problem for a number of people who can be considered candidates for euthanasia that they are challenged on the quality of the autonomy they are supposed to possess. Unbearable suffering is something that, in and of itself, helps to undermine the ability to make rational decisions.

A number of people should therefore be considered 'practically unfree'. Unfree, not because formally speaking they must be considered not to be competent to make decisions, but because those who suffer unbearably, and therefore want to end their lives, are so marked by illness - but are under such great psychological pressure that it can be difficult to talk about different options for action being sorted out, that one's own situation is reviewed and understood, and that the choice one then makes can be said to be informed.³³

The thinking can be summarized in this way: the autonomy of people who want euthanasia is eroded by the very situation in which self-determination is thought to unfold.

The Ethics Council has also previously put forward this argument: that the possibility itself changes the electoral situation considerably. The previous council emphasized that consent regarding any treatment is based on information about treatment options. The idea is that the information should open up choice situations for patients. Therefore, euthanasia will be pushed for everyone for whom the opportunity could be

relevant, and the suffering or dying patient will therefore not be able to refrain from deciding on euthanasia if it is made legal. The entire group of patients who are thought to be included in an offer of euthanasia are burdened with being able to choose between life and death, even if such a choice might otherwise never have occurred to them, or even if they did not want to have such a choice .34

If euthanasia is legalized, the possibility itself will be present in everyone's consciousness: patients, doctors, relatives, care providers. And how self-determining can vulnerable people basically act if the outside world assesses their sick, dependent and suffering lives as candidates for euthanasia? Opponents of euthanasia emphasize here that the decision to want one's own death is not made in everyday contexts and is not made in situations where the person is in a state of self-control. The choice of one's own death is thus significantly different from most other choices that are usually associated with self-determination.

'We want to know that': are there people who justify a wish for euthanasia by being a burden to the environment?

Opponents of euthanasia sometimes highlight, in connection with the question of voluntariness, the possibility that the decision to request euthanasia stems from the desire not to be a burden to the environment. SMER points out that there is much evidence that this is a motivation for many patients, both in Oregon and in the Netherlands. A key question in this context is of course to what extent such motivation makes the decision less voluntary.

It is worth highlighting the picture of the patients that emerges in the research from Oregon. For many of them, independence, autonomy and control seem to be a deeply rooted part of their identity and sense of dignity. It seems likely that the reluctance to be a burden to the environment is in many cases a matter of a will to protect this self-image rather than being an expression of influence from relatives, who often seem to experience the patient's care as less burdensome than the patient even imagines.³⁵

In this connection, the doctor Ole Hartling has argued that the two basic values that advocates of euthanasia appeal to – self-determination and preventing unbearable suffering – are more intertwined than many people realise. They are presented as arguments that support each other, but perhaps they are also in an insoluble tension, which helps to give rise to a number of the practical-political problems of deciding who should have access to euthanasia, and the extent to which persons in great suffering are competent to make decisions about their situation.

”

If euthanasia is legalised, the possibility itself will be present in everyone's consciousness: patients, doctors, relatives, carers.

And how self-determining can vulnerable people basically act if the outside world assesses their sick, dependent and suffering lives as candidates for euthanasia?

The challenge is that the right to decide for oneself and the purpose of euthanasia to do what is good for the patient can also be experienced as being at odds with each other. This is because the assessment of what will be good for/is in the patient's interest will be an expression of paternalism, if that assessment is not made by the person himself. To the extent that an assessment has to be made of whether a given person meets set criteria to gain access to an offer of euthanasia, it will be an assessment, and as the conditions are now, it is an assessment that most often a doctor is expected to make. In all the countries and states where euthanasia takes place in one form or another, it is a medical assessment that determines whether a person can be assisted in dying.

This has a consequence that a number of opponents highlight as unacceptable. In order to receive help in dying, a person must demonstrate to an assessing person that they have a sufficiently low quality of life to warrant euthanasia.

Said in another way. When another person's professional assessment plays such a large role for access to euthanasia, then perhaps it is the same with self-determination, which also constitutes an argument. After all, the reasoning goes, it is the assessment of quality of life that gives access, and not the right to decide for oneself. It is more to be understood as a 'control phenomenon' that must ensure the voluntariness of aid. Some formulate the objection even more clearly, and point out that the justification for euthanasia is based on the fact that "certain lives are not worth preserving", when "the value of the patient's life must be so low that euthanasia will be more merciful".³⁶

Respect for self-determination is thus fenced off, if you will, by what you think should be counted as 'doing good'. This entanglement between autonomy and paternalism is also highlighted as a major reason why slippages in connection with the regulation of access to euthanasia are both realistic and inevitable.

For more on the glide path argument, see section 7.3.1.

However, advocates of euthanasia have pointed out that they consider these objections to be generalising.

When it comes to the criticism of self-determination for being an abstract and excessively individualistic understanding of people's vulnerability, it is pointed out that no one, not even advocates of euthanasia, argues for such a concept of autonomy. Instead, a moderate concept of self-determination is emphasized.³⁷ As the philosopher James Childress has pointed out, autonomy does not imply that an individual's life plan is his or her own creation and that this should exclude an interest in others.

Autonomy simply means "that a person chooses and acts freely and rationally based on his own life plan, no matter how poorly formulated it may be [...] Personal autonomy therefore does not imply an asocial or ahistorical approach to life plans. It just means that no matter what the life plans look like, and no matter what the source of it may be, an individual assumes that it is his own".³⁸

'We want to know': is there no demand for assisted dying among sick people?

According to one argument, the legalization of euthanasia is primarily driven by healthy individuals, while there is virtually no demand among the seriously ill patients actually affected. SMER highlights that among ALS and cancer patients in Oregon, only a few percent choose to end their lives through euthanasia. This may suggest that most patients suffering from serious illness value the time they have left in life and have no desire to hasten death.

If you compare the small number of patients who actually choose euthanasia with the support for the Death with Dignity Act among the people of Oregon (according to one survey, this support is up to 80 percent), you can sort of argue that it is primarily among the healthy people that there is an interest in euthanasia. At the same time, in both Oregon and the Netherlands, there is a growing number of people who have been diagnosed with a terminal illness and are requesting euthanasia.

In the Netherlands, where the number of patients who die by euthanasia is significantly higher than in Oregon, 64% of them suffer from cancer (2022-speak up). Therefore, the claim that there is no demand for euthanasia among the seriously ill is a claim that these facts bear out

against.³⁹

Such an understanding of self-determination is more realistic because many wishes to die may be an expression of a misjudgment. A number of people who want to die should not want to, but have ended up in a situation where they place too much emphasis on hopelessness and desperation, and do not see that there can be ways out of the suffering. However, this does not change the fact that even if some death wishes are an expression of a misjudgment, it does not follow that all wishes are an expression of this. For some people, the argument goes, it is their own correct assessment of their lives that there is no realistic hope for better days in the future.⁴⁰

Advocates therefore doubt that the choices you, as a suffering person, have to make about euthanasia should be of a completely different moral order than choices you may otherwise be forced to make in crisis situations. When it comes to the erosion of the capacity for self-determination due to great suffering and life crisis, it is emphasized that suffering in patients is not necessarily constantly present, and that today we know of a number of situations in the healthcare system, where people in complex and painful situations -ner, must decide on treatment options - and that they are entrusted with that competence. In cases where there is doubt about decision-making competence, one could imagine that there was an opportunity to advise, test and then, on an informed basis, refuse access to euthanasia.

6.2.3 The difference between palliative measures and euthanasia

In connection with arguments for euthanasia, comparisons have already been made several times with the palliative measures described in section 4.2. The purpose of this is to show that it is fundamentally incoherent to insist on the ethically justifiable nature of these actions associated with palliation and at the same time to claim that the actions associated with euthanasia are of a different ethical nature.

Opponents of euthanasia point out that euthanasia differs from all other treatment options at the end of life in two different ways: euthanasia contains an intention to cause the patient's death, and euthanasia also causes the patient's death. Euthanasia, it is said, is therefore unique in terms of intention and causality, and both dimensions help to draw a decisive ethical boundary between palliative medicine and euthanasia.

The discussion about whether there are ethically relevant differences between palliative interventions that risk hastening death and euthanasia is also conducted in a more popular form, as a discussion about whether there is a difference between helping the patient to die and helping the patient to die. The question is whether this linguistic difference also captures an ethical difference? These two distinctions are further described by some

know as the verbalization of the much more widespread, unarticulated feeling that with euthanasia 'the limit has been reached'. We cross an important line when doctors are allowed to kill patients or are allowed to help patients kill themselves.

It must be said right away that this problem only applies to patients who are at the end of life, where you can compare cessation of treatment and palliative measures, which risk hastening death, with euthanasia.

Causality. When it comes to euthanasia, it is the delivery of the lethal drug that is the direct cause of death. The opposite of this is the patient's wish to stop life-prolonging treatment, where the patient dies of the underlying disease. The reason is thus not the cessation of treatment, but the underlying disease. In the case of euthanasia, something is 'done', the patient is killed. In the second case, 'something is allowed to happen', the patient is left to die. This distinction between 'doing' and 'letting happen' is often what causes some to distinguish linguistically between active and passive euthanasia.

It should perhaps be noted that this distinction between doing and letting happen is considered by some to be less applicable when it comes to drawing a line between euthanasia and symptom relief or palliative sedation, in cases where the latter also hastens death. The argument draws on the broader principle that it is not permissible to *inflict* damage on others, while it would be permissible to let the same damage befall a person. In both cases, it can be argued that the actions associated with symptom relief and palliative sedation, in cases where they hasten death, 'help it happen'. They are not part of the cause of the patient *dying soon*, but they are *part* of the cause of death, or part of the cause of the patient dying *at a particular time*, even if the underlying disease is the primary cause.

Intention. With euthanasia, the intention is for the patient to die. Patients, such is the basic thought of both advocates and opponents, request euthanasia to avoid further suffering at the end of life. As such, the patient's death is merely a means to an end. In comparison, other interventions at the end of life, such as symptom relief and palliative sedation, are aimed at alleviating suffering, even if in the eyes of some they should hold the potential to shorten life. If the patient's death is thereby hastened, then this is an unintended, but possibly predictable, side effect of the treatment. The argument here uses the 'doctrine of the double effect', which is about the fact that it is not permissible to harm another person as an intended effect, while it would be permissible to inflict the same harm if it were an unintended and for-

unspeakable side effect.⁴¹ It is this distinction between death as an intended effect and death as an unintended but predictable effect that, according to some critics of euthanasia, distinguishes palliation from euthanasia.

The argument that there are significant ethical differences between the actions that take place in palliative medicine and euthanasia, and that euthanasia can therefore be incompatible with both palliative medicine and the practice of medicine as such, has found many formulations. An impressive formulation is given by the Norwegian doctor and ethicist Morten Magelssen:

"Not all consequences of our actions, not even those that we know with complete certainty will occur, are necessarily part of our purpose, our plan or our motivation. When I cycle, I do not intend to cause wear and tear on the bicycle tyres, even though that is a guaranteed and foreseen consequence of the cycle trip. Even if we know that limiting treatment in a given situation will contribute to the patient's death coming earlier than it would otherwise have done, hastening death does not have to be part of our purpose and our motivation. On the other hand, we can be motivated by not wanting to endure a painful death process. This is not the same as intending the patient's death, which will always be a central and unmistakable part of the intention in euthanasia. We can also bring out the difference by a 'counterfactual test question': If the patient had not died, and death had not been hastened, would the action and the agent's plan have failed? In the case of euthanasia, the answer is 'yes'. But in the case of treatment restriction, the answer is 'no', because the purpose was not to hasten the patient's death, but to refrain from treatment that was no longer in the patient's interest. Intention is also not the same as wish: We can wish that the patient will be 'let go', that death will come quickly, without that being the purpose of the treatment restriction. No action follows from a desire, until an intention is needed."⁴²

A number of advocates for euthanasia emphasize, however, that palliative efforts and euthanasia should be considered as parts of a spectrum of ways in which patients and persons can be helped with their dying process. Proponents argue that euthanasia for terminal patients should not necessarily be seen as a particularly drastic measure compared to the mentioned palliative offers. They thus emphasize the continuity between palliative care and euthanasia, and that euthanasia should be seen as a 'further step' in the continuation of palliative care.

It is also emphasized that in debilitated and life-threatening patients, "the thread of life is so thin that it easily breaks".⁴³ The image must suggest that the distinctions concerning intention and causality both revolve around a zone of impairment and imminent

death, and that the patients' condition also helps to obscure the causality that is at work when people in a palliative process finally die.

In this zone the passive and the active are entangled. A body that is close to death also risks that all measures or cessation will have an effect that can be directly measured against the onset of death. On the one hand, all actions can seem like a push in a certain direction. On the other hand, actions are consequential precisely because the body is in an inexorable process, and one only shortens or lengthens a little, compared to what is destined to happen by virtue of the death process.

Proponents argue that the causal links between death and relief are so close that the intention 'to die to relieve' and the intention 'to relieve at the risk of dying' are more difficult to distinguish from each other than a range of everyday intentions will often be. You could perhaps say that these are complex intentions, and that the closer you get to the onset of death, the more this 'gray' logic comes into play.

This leads proponents to doubt that the differences in intention and causality should constitute such clear ethical differences that euthanasia should be based on actions of a different moral character when dealing with terminal patients. There are of course clear clinical differences, and they are nicely expressed with the concepts of causality and intention, but they do not constitute a decisive ethical difference. The reason for this is that the two main arguments for the existing measures at the end of life – what is in the patients' interests and their own wishes – are also what is claimed for euthanasia.

In addition, advocates of euthanasia will claim that there are no ethically relevant differences between palliative medicine and euthanasia, which are not based on a prior position on euthanasia, and to advocate significant ethical differences between the three palliative efforts and euthanasia, overlooks this. The doctrine of double effects is thus about the fact that it is not permissible to harm another person as an intended effect, while it would be permissible to inflict the same harm if it were an unintended and foreseeable side effect. But the arguments about euthanasia are not based on doing harm. They base themselves on doing good. And the people who request euthanasia hardly see the matter in such a way that it would be wrong to intentionally inflict a good on a person, while it would be permissible if it happened unintentionally and as a side effect.

The issue, it is emphasized by advocates of euthanasia, seems to revolve around the fundamental question of whether one considers euthanasia to be a good or an evil at all. Given that euthanasia is an evil, there will be talk of

”

The problem, it is emphasized by advocates of euthanasia, seems to revolve around the fundamental question of whether one considers euthanasia to be a good or an evil at all. Given that euthanasia is an evil, it will be a matter of intentionally causing harm.

Given that it is a good, it will be a question of intentionally causing relief.

intentionally causing harm. Given that it is a good, it will be a question of intentionally causing relief. The question of whether a clear ethical boundary can be drawn between palliation and euthanasia will thus, according to advocates, require a position to be taken on the very question that the distinctions should help to answer.

7. Basic practical-political arguments

58

”

a number of additional considerations come into play when the reasonable or unreasonable actions of individuals must be regulated by common rules. Because then we are not just discussing the consequences of an individual action, but the consequences for society as such. What will it cost to enforce it? And will there be negative consequences for third parties that have not been visible so far?

7.1 The difference between discussing whether euthanasia is ethically acceptable and whether euthanasia should be legalized

At a very basic level, it is possible to take three positions in relation to any legislation on euthanasia. Either *none* of those who want euthanasia should have it. Or *everyone* who wants euthanasia must have it. Or *some* of those who want euthanasia must have it. In the first two cases, the patient's illness, prognosis or suffering are not relevant for an assessment of the wish, but in the third case, for example, the patient's prospects for recovery and level of suffering will play a role in who should have access to euthanasia. This position, the 'somebody' position, is by far the most widely held view, and all countries that allow euthanasia have legislation that reflects a range of choices made about who the 'someone' should be.

So far, the explanation has dealt with what basic values are at play in discussions about euthanasia, and what actions could possibly be justified. In this part, the report changes focus and deals with ethical questions on a different level. Now it is not only a matter of what is ethically justifiable, but also of what can be justified at all and, if this is the case, which different ways of regulating a practice can be considered ethically justifiable. An important reason for distinguishing, as is done in this account, is that it can be tempting to think that the answer to the practical-political questions must depend on the answer to the previously defined ethical question. But the ethical status of euthanasia is neither necessary nor sufficient to determine what legal status euthanasia should have.⁴⁴

An important reason is that a number of additional considerations come into play when the reasonable or unreasonable actions of individuals must be regulated by common rules. Because then we don't just discuss the consequences of a single action, but conse-

the consequences for society as such. A number of questions arise: is legislation enforceable? What will it cost to enforce it? And will there be negative consequences for third parties that have not been visible so far?

It is therefore not inconsistent to think that a type of action is morally wrong, but should not be made illegal for that reason. In the same way, it is conversely possible to hold that a type of action may be morally right, but should not therefore be legalized for reasons which are not 'ethical' in a narrow use of the word, but will be so in a 'extended' understanding, which not only connects ethics with the individual, but with society. Perhaps it is not at all possible to formulate legislation that will only allow the very cases that are considered morally justifiable?

For example, a number of former members of the Council of Ethics have held this position. It has been admitted that there are cases where euthanasia would be the right thing to do, but it is not trusted that any legislation will be able to distinguish these cases where euthanasia is the right thing to do from those where it is not.

In the Ethical Council's statement from 2012, some council members stated that it will always be the overall assessment of a number of very specific circumstances linked to the individual situation that will be decisive for whether or not it can come into question to allow euthanasia.

One will, for example, be forced to make a decision as to whether the patient seems competent and fully informed about his request for euthanasia, how long the patient is expected to live without euthanasia, what the nature of the patient's suffering is, whether they are impossible to alleviate within a period and whether they are completely unbearable. Just to mention some parameters.

It will therefore be necessary to deal with the specific situation in order to find out whether active euthanasia is an acceptable option or not. It may prove difficult to establish clear guidelines for in which cases active euthanasia must be permitted. Legislation, by its very nature, must cover a wide spectrum of situations, and can therefore hardly specify the specific circumstances that will be decisive for the assessment of the individual situation.⁴⁵

In this context, it should be mentioned that one option is to not establish a positive right to euthanasia at all, but simply ensure a negative right to, for example, assisted suicide. While a positive right to euthanasia will mean that you have the right to have euthanasia carried out if you otherwise meet relevant criteria, a negative right simply means that it is not criminal, for example, to assist others in the execution of a suicide .

With such 'decriminalization', no one will *be obliged* to comply with a request for euthanasia, but it will be legal to carry it out, possibly on the basis that certain criteria are met.

A significant feature of the ethical challenges of a more 'practical-political' nature, which must now be presented, is that they involve risk considerations to a much greater extent. The introduction of new technology or new treatments, one would typically think, requires attention to the risks of harmful effects or other unfortunate consequences. It is in the nature of the new that it can be difficult to foresee such risks. However, a number of new measures may call for very special vigilance, and thus stricter requirements for the risk assessment. The question is, does euthanasia constitute such a 'high-risk business' and perhaps even a special case in terms of regulation, where regulation should not be undertaken at all?

An example of the disagreements about whether euthanasia constitutes a regulatory special case are two different court decisions in Canada.

In several cases where courts have dealt with legislation that prohibited euthanasia and have refused to repeal such legislation, it has, among other things, been referring to the fact that a general ban without exceptions (a so-called 'blanket ban') is necessary to protect vulnerable parts of the population. In a decision from the Supreme Court of Canada in 1993, it was stated that: "In order to effectively protect life and those who are vulnerable in society, a prohibition without exception on the giving of assistance to commit suicide is the best approach".⁴⁶

Samme højesteret konkluderede i Carter vs. Canada-sagen i 2015 dog, at en forudgående dom fra 2012 lod sig opretholde, og at et generelt forbud mod assisteret selvmord var forfatningsstridigt. I 2012 lød det, at: "The risks inherent in in permitting physician-assisted death can be identified and very substantially minimized through a carefully designed system imposing stringent limits that are scrupulously monitored and enforced.". Det blev i 2015 bekræftet, at: "An absolute prohibition on physician-assisted dying is rationally connected to the goal of protecting the vulnerable from taking their life in times of weakness, because prohibiting an activity that poses certain risks is a rational method of curtailing the risks. However, as the trial judge found, the evidence does not support the contention that a blanket prohibition is necessary [...], that a permissive regime with properly designed and administered safeguards was capable of protecting vulnerable people from abuse and error." ⁴⁷

Or put another way, the question of legalization is one that is about a recognized need, faced with the risks that can be listed by fulfilling such a need

need. Some objections are about the claim that any policy or regulation will be violated, either as a mistake (ie, without intent) or as an abuse (ie, with intent). Consequently, any regulation will also produce cases of euthanasia that are not permitted under any given regulation. Another objection contains a claim that the conditions for access to euthanasia risk being extended over time, so that people who currently cannot get access to euthanasia will eventually be able to get it. This is often called the glide path argument. Finally, there is a set of consequential considerations which, in a slightly more unclear way, are about which societal values are dominant, and whether, with the introduction of euthanasia, there is a risk that these values will change in ways that we will all find unacceptable.

An example of such 'risk language' could be the question of whether legalizing euthanasia would also be able to guarantee a controllable development, so that access to euthanasia does not expand over time. Such a question is deeply complicated to assess, not least because it invites consideration of the nature of all legislation. What legislation has ever been able to guarantee that it could not be changed, either because it was later found to be unable to meet its purpose, because the purpose changed along the way, or because judicial decisions found parts of the legislation problematic? The work alone of clarifying the differences between risks for intended expansions and risks for unintended expansions can seem insurmountable.

An example of the difficulty of political control is the situation in Germany. Here, the parliament passed in 2015 that assisted suicide was illegal, but in 2019 this legislation was rejected by the Constitutional Court as being unconstitutional. The situation is different with the legislation in Oregon, where access to euthanasia is the result of a referendum and subsequent legislation, which has not changed significantly over the years. On the other hand, there can hardly be any doubt that the Netherlands has established a practice of euthanasia to a large extent due to court decisions which may have contributed to expansions, which can then be judged as being 1) contrary to an original political intention, 2) contrary to a current political intention, 3) in agreement with an original political intention, 4) in agreement with a current political intention, 5) in conflict or agreement with varying political groupings, originally or currently (for, *if* intention is what must count as decisive?).

7.2 Basic practical-political arguments for euthanasia

7.2.1 What is required for euthanasia to be justified in practice?

There are certainly unjustifiable ways of introducing euthanasia. The interesting thing, however, should be whether there are sound ways to do it. As part of an argument that the legalization of euthanasia can be controlled, a number of criteria are often highlighted that must be 'observed' in order for a practice of euthanasia to be considered justifiable. A number of these criteria are well-known and uncontroversial, and are therefore often put forward as an argument that euthanasia can be regulated in a controlled way, since these principles already enjoy great support widely in society, and have shown sustainability in relation to ensure that the right people have access to a service.

The thinking is that the two ethical values described in sections 6.1.1 and 6.1.2, self-determination and reduction of suffering, cannot in themselves show us that euthanasia as a practice will be ethically justifiable. So how do you ensure that euthanasia actually ends up doing good and will take place on a voluntary basis? Here, advocates for euthanasia highlight five conditions which can help ensure that the arguments about self-determination and what may be in the patient's own interest are also realized in practice.

Wish. To the extent that voluntary euthanasia is concerned, there must be a request from the patient himself. The decision maker must agree with the measure, and there should be a specific consent for this processing, at this time, given by this person.

Decision-making competence. The person must be competent to make decisions at the time a decision is made about an action. This refers to the ability to make a rational decision to say yes or no to a specific initiative. At a minimum, it requires an understanding of the content and consequences of requesting an action that is designed to, and will also cause, death. Decision-making competence can be said to

”

To the extent that voluntary euthanasia is concerned, there must be a request from the patient himself. The decision-maker must agree with the measure and there should be a specific consent to this

processing, at this time, given by this person.

be the 'default setting' for adults unless a psychiatric disorder or cognitive impairment can be demonstrated which impairs the ability to make a rational and balanced decision.

Voluntary. The wish must be made without unreasonable pressure and coercion, regardless of whether it comes from health professionals, family or friends. It goes without saying that our decisions are just as often a product of what other people think and think, or of our own ideas about what people expect of us. It would be unrealistic to expect that decisions were free of this kind of influence, and pressure and influence are thus about whether there is undue influence, not about influence as such.

Information. The person must have access to the necessary information about the measure and their own situation. Such information will usually be the patient's diagnosis or condition, prognosis in the absence of treatment, what may exist of available treatments or interventions, what the likely outcome of these may be and what risks are associated with them.

Diagnosis. The patient must have a medical diagnosis in the form of an illness or functional impairment that is sufficiently serious to justify the wish for euthanasia. Here, a fundamental question is whether the condition should be terminal, or whether it is more important to focus on whether the patient is in a state of suffering which the person judges to be unbearable and which cannot be alleviated by any other treatment.

Of these five conditions, which are often emphasized by advocates of euthanasia in one form or another, the first four are familiar in health care and medical ethics, as together they constitute the well-known principle of informed consent. The fifth criterion, on the other hand, is specific to actions that will hasten death. The reason for emphasizing that all other treatment options should be exhausted is straightforward: causing death is an irreversible and irreversible act. The action cannot be reconsidered or reversed. There is therefore a certain paternalism at work in the fifth condition, which emphasizes the value of whatever may be in patient-

your own interest over self-determination, in an attempt to avoid hasty or unnecessary requests for euthanasia.

'We want to know': can it be established with certainty that a request for euthanasia is ongoing and voluntary?

SMER's studies show that research conducted in Oregon and elsewhere suggests that interest in hastening death can vary over the course of a terminal illness. In a study in Oregon, it was found that interest increased in line with factors such as increased depression, increased hopelessness, decreased functional ability, decreased quality of life, increased dissatisfaction with the quality of care, increased suffering and an increased feeling of being a burden for the family. However, only a few of the patients who show an interest in hastening death go so far as to request euthanasia. A study in Oregon found that only one in nine patients who had ever considered euthanasia actually made a formal request. This indicates that for most patients it is a relatively large step from considering euthanasia to actually requesting it, and that going so far as to make a request is usually based on a well-considered and sustained desire. The requirement that the request must be repeated after at least 15 days (unless it is a particularly advanced illness) should also contribute to less well-thought-out requests not being granted. However, no studies have been found that have directly examined the stability of wishes of patients who have been granted euthanasia in Oregon. How many of the requests filed in Oregon are voluntary is more difficult to determine, primarily because it is not entirely clear what is required for a decision to be considered completely voluntary.

According to the Oregon model, two doctors must always confirm that the patient's request is voluntary, but there do not appear to be any guidelines as to when a request is considered voluntary or how this should be determined. There are recommendations that in case of doubt about diagnosis, prognosis and voluntariness, one should refrain from prescribing medicines, as well as a wording that the doctor who, according to the rules, must confirm prognosis, decision-making competence and voluntariness, if he or she is careful, must ensure that the patient undergoes a psychiatric or psycho-logical assessment to establish that the person is competent to make decisions.⁴⁸

Advocates will also highlight some of the procedural requirements that may be essential to ensure that it is an informed consent.

These read, among other things:

- That requests must be in writing and witnessed
- That requests must be repeated at least once over a period of time (some suggest days, others weeks)
- That a request can be withdrawn at any time
- That a request must be made without unreasonable pressure from family and surroundings
- That the person must be provided with the necessary information about diagnosis, prognosis, treatment options, the likely outcome and possible risks of treatments
- That the person must be provided with the necessary information about the palliative options
- That if the doctor is in doubt about the patient's decision-making capacity, this must be sent for an assessment by an independent psychiatrist
- That the attending physician must consult another, independent physician in order to confirm that the above points has taken place

'We want to know': can it be determined whether patients are competent to make decisions?

SMER points out that depression does not in itself exclude individuals from receiving euthanasia, either under the Oregon model or the

Dutch model. However, a patient who is granted euthanasia in Oregon must be competent to make decisions. As depression can affect decision-making capacity and how the patient perceives his situation and prospects for improvement (although this is not always the case), it is therefore important to identify patients with depression among those requesting euthanasia. Based on the limited information available from Oregon, it cannot be determined whether depressed patients are denied euthanasia to a greater extent than other patients due to impaired decision-making competence. There are several studies from the Netherlands that show that patients with depression are granted euthanasia to a lesser extent than other patients. However, all studies, both in Oregon and in the Netherlands, show that there are cases where patients who have had depression at some point in the process actually receive euthanasia. However, it is not always clear to what extent the depression continued when euthanasia was given, or to what extent it affected the patient's decision-making ability. In Oregon, a physician who suspects that a patient requesting euthanasia suffers from a mental disorder that affects judgment must refer the patient to a psychiatrist or psychologist for further evaluation. In the guidelines, it is emphasized that it is difficult for many doctors to diagnose mental illness or depression, and that a cautious doctor makes sure to refer the patient to a psychiatric assessment. However, only 4-5 percent of all patients who die by euthanasia receive such an assessment by a psychiatrist or psychologist. It's also worth noting that before the law was enacted, many Oregon psychiatrists doubted their ability to determine a mentally ill patient's decision-making capacity. A patient's decision-making capacity may also be impaired for reasons other than depression or other mental illness, such as cognitive impairment, which often affects patients in great distress. In these cases too, it is unclear to what extent such patients are caught in Oregon.⁴⁹

7.3 Basic practical-political arguments against euthanasia

7.3.1 There is too great a risk of error, misuse and slippage in indications

One possible type of error concerns mistakes made by doctors in connection with either diagnosis or prognosis. Especially in cases where there is a requirement for a terminal illness, the certainty with which prognoses can be provided becomes important for the question of how likely it is that it is the patients you want who will have access to euthanasia, and not a number of patients where the prognosis becomes too difficult to ma

'We want to know': Are the medical judgments uncertain?

Almost every year, Oregon health officials report patients dying by euthanasia more than six months after making their initial request (one patient lived nearly three years). There is information from Oregon that between 3 and 10 percent of patients live more than six months after receiving their prescription. In 2022, 16 patients survived longer than six months, which corresponds to 6% of all deaths by assisted suicide. The fact that some euthanized patients live longer than six months has been attributed to the difficulties associated with determining with certainty how much time a terminally ill patient has left. Although the assessments of the remaining lifespan seem to be correct in most cases, there is evidence that there is some uncertainty in the assessments, and that in individual cases they may deviate significantly from the actual outcome. In the Netherlands, nothing is recorded about prognostic precision, as there is no requirement that death be irreversible.⁵⁰

A frequently put forward argument against the legalization of euthanasia is that it opens up a slippery slope. The argument goes that if you open up euthanasia to a certain group of people, there will very likely be pressure to expand the definition of who should make up this group.

It is often argued that it is thus the first step and the first attempted regulation of euthanasia that constitutes the most important step, because after this it will be very difficult to imagine that you can return to a starting point where there is no was there any access to euthanasia. It is thus a decision with large and years-long perspectives. The question is thus whether rules, guidelines, safety measures, psychiatric evaluations, professional standards and similar risk-mitigating measures will be able to create the necessary security to ensure that there are no unwanted extensions of any legislation or in clinical practice.

Two types of glide paths are usually described. One which could be described as 'quantitative' and which concerns only the numerical scope of a model, and another which could be described as 'qualitative' and which concerns the types or groups of people who have access to euthanasia.

The first difficulty is 'objective', and consists in the difficulty of preventing a quantitative expansion. If a given suffering condition gives access to persons in a group, then surely it should give access to everyone in the group as long as they want it? The difficulty with this version of a slide is that there is nothing to suggest that an increase that occurs will also be incorrect. Only if the starting point is that no one should receive euthanasia, can it be said unequivocally that an increase is wrong. If one is open to the fact that a percentage greater than 0 may be desirable, it becomes difficult to say what the ideal percentage should be. It is also possible that an increase in the number is a development for the better. One can imagine a comparison with palliative treatment. It is, in a way, terrible that so many people are in such a painful situation that palliative treatment is necessary.

In one sense it is therefore unfortunate if the number of patients receiving this treatment increases. But, on the other hand, it is not certain that it is a development for the worse. Because it is possible that previously there were too few who received the right treatment. So, as long as one is open to the fact that the number of recipients of euthanasia can be higher than 0, one must also be open to the fact that an increased number of recipients is not automatically a development for the worse, but can also be a development for the better, because it is an expression of a gradual covering of the actually existing need. 51

The situation is different with the second variant of the slippery slope argument. Here a 'subjective' difficulty is presented in the sense that if members of a group with such-and-such features can gain access, surely members of a group who want access and who share features with nearby groups should also gain access?

Such an appeal, which one could imagine made by various groups who might wish to have access to euthanasia because their condition of suffering is so close to current indications for access to euthanasia, is not an appeal for equality before the law, such as a quantitative expansion had to rely on but an argument about justice. In stylized form, one could imagine such a 'justice discourse' looking like this:

- Why only euthanasia for the irretrievably dying, and not also for the chronically ill?
- Why only euthanasia for the physically ill, and not also for psychiatric patients?
- Why only euthanasia for persons capable of making decisions, and not also for patients who issue an advance directive?
- Why only euthanasia for patients, and not also for people who suffer unbearably?
- Why only euthanasia for people who are suffering, and not also for all people who might request it?
- Why only euthanasia for people who can request it, and not also for those who are unable to?

The Ethics Council dealt particularly thoroughly with the question of qualitative extensions in 2003. Here it was pointed out that the main argument for euthanasia was not about respect for the patient's self-determination, but rather the consideration of benefiting the patient who, according to a medical discretion is in a state of suffering, and that euthanasia would therefore "be seen as a good for everyone in whom it was judged that there was a need for it, and not just for those who are able to request it" .52 Especially if the indication had to consist of the wording 'unbearable suffering', people were critical of the possibility of a slippage.

'We want to know': are there signs of a slippery slope?

SMER points out that the criteria for receiving euthanasia in Oregon have not changed since the Death with Dignity Act went into effect in 1998. However, there have been two changes since SMER conducted its investigations. From 2020, it became possible for doctors to waive the 15-day waiting period if the patient's death is imminent, and from July 2023, the requirement that recipients of assisted dying be resident in Oregon has been abandoned. SMER highlights that there is no credible information that the application of the criteria should have changed from health authorities in Oregon, where all cases must be reported. The development in Oregon thus does not significantly support the assumption that a qualitative slide, in the sense that the rules are gradually extended to include more and more patients, is inevitable if euthanasia is allowed in one form or another.⁵³ All US states, which later legalized assisted dying, has chosen to apply the same criteria as in Oregon. Looking at the Netherlands, it is notable that the number of people receiving euthanasia has increased significantly. In the same way, the groups of patients who receive euthanasia have individually grown in size over time. The question is, however, whether this expansion can rightly be called a slippery slope. The reason for this is that none of the affected groups calculated in 2022 were also registered in the first annual report from 2002. Thus, the two most notable categories (challenging the issue of decision-making competence) are dementia and mental illness already represented in 2002, albeit to a small extent. In addition, the Dutch basic criterion of hopeless and unbearable suffering, as a condition for receiving euthanasia, is so broad and leaves so much definitional leeway that discussions about possible slippages quickly develop into a discussion about the intention of the legislation, something which is difficult to verify and to a greater extent is entangled with value-based arguments.

”

The motivation for putting forward the slippery slope argument is basically based on the idea that it must be the individual who makes the decision. Concerns about slippery slopes are thus about concerns about self-determination

With unbearable suffering as a criterion for admission, it was considered too difficult to set clear and durable boundaries, "because it is not possible to define objectively what constitutes unbearable suffering. As a consequence, there will be wide opportunities for euthanasia to be accepted for ever new types of patients". It was thus found that the complexity of disorders, e.g. the extent and assessment of existential disorders, would make a shift in the indications likely.

It was also found that the risk of a slippery slope was real, because the assessment of the degree of unbearableness of the suffering had to take place in a confidential relationship between doctor and patient, which could not be subjected to sufficient control mechanisms, as the assessment of suffering in relation to the value of life "is of such a subjective and complicated nature that it should not be institutionalized and form the background for such a serious and definitive decision as euthanasia".⁵⁴

A number of proponents point out that such a slippery slope makes use of the slippery slope argument as a fallacy, where one speculatively refrains from giving reasons why there is a causal connection between the various steps. This implies, for example, that while at the beginning of such a chain of inference one has considered the value of autonomy to be complex, one must end up regarding it as pure rhetoric, while it is only the paternalistic indication that constitutes the real justification for access to euthanasia. However, this is very rarely, if ever, the way in which the relationship between autonomy and the reduction of suffering is presented, cf. sections 6.2.2 and 7.2.

The motivation for putting forward the slippery slope argument is basically based on the idea that it must be the individual who makes the decision. Concerns about slippery slopes are thus about concerns about self-determination. In a similar way, advocates will emphasize that relevant criticisms of the risk of unreasonable pressure, which will cause one to make 'wishes' out of step with one's own values, or act out of step with one's own wishes, precisely say something about the value of self-determination.

7.3.2 There will be negative consequences for vulnerable groups

Euthanasia is often presented by advocates as an *option*. However, there is also widespread agreement that it must not, for all intents and purposes, become an *expectation* directed at particular groups in society. The attention to this slippage – possibilities that become expectations – is due to the fact that euthanasia, as an extension of people's opportunities to shape the conditions for their own death, can have more consequences than people in a hopeless situation being given more options to choose between .

One reason for this may be that most people derive their sense of value

not only from themselves and their own self-esteem, but from how they are judged in the eyes of others.

An institutionalization of euthanasia risks threatening the principle that we have the same claim to respect and dignity, regardless of how much we suffer and how high the quality of life is assessed to be. If we offer euthanasia, it says directly or indirectly that some lives are not worth living.

Critics therefore ask whether, by offering euthanasia, we risk adding further to the burden for vulnerable groups who, for various reasons, lead a life of great suffering? The danger, the thinking goes, is that people who, in the absence of an offer of euthanasia, would not have seen life as unbearable, now do so, because offering euthanasia can easily be heard as a 'societal statement' that it would be pray-re if you died. In short, it is argued that the existence of euthanasia as an option risks pushing the outcome space for the question: 'when is death preferable?'

”

Critics therefore ask whether, by offering euthanasia, we risk adding further to the burden of vulnerable groups who, for various reasons, lead a life of great suffering? The danger, the thinking goes, is that people who, in the absence of an offer of euthanasia, would not have seen life as unbearable, now do so, because offering euthanasia can easily be heard as a societal statement that it would be better if you died

'We want to know': are vulnerable groups over-represented when it comes to receiving euthanasia?

SMER assesses that information from annual reports from the health authorities and from research studies speaks against socially vulnerable groups being overrepresented among the patients who die using assisted dying in Oregon. Compared to patients who die of the same underlying diseases, patients who choose assisted dying in Oregon are more likely to be white, better educated, and younger. The same pattern with regard to demography and socioeconomics can be observed in the Netherlands. As for the question of whether patients choose assisted dying for economic reasons, this is a secondary motive according to the annual reports. According to these, virtually all patients in Oregon have health insurance when they die, and concern about the financial consequences of continued treatment is a rare reason for requesting euthanasia. The picture in the annual reports, based on what doctors report, is supported by surveys from Oregon of patients and relatives, who rank financial concerns as an unimportant reason. This may of course be due to the fact that

many of the patients belong to a socio-economically advantaged group, something that a strong predominance of the well-educated suggests, but this suggests that economic concerns are a less central factor in the choice to request euthanasia. With regard to the disabled and chronically ill, it must be mentioned that all terminally ill suffer from a chronic illness in one sense or another, and that most also have reduced functional ability. No cases have been reported where assisted dying has been granted to disabled or chronically ill people who were not assessed as terminally ill. Whether patients in Oregon who have been prescribed euthanasia had any disability or chronic illness before they became terminally ill is not known. Therefore, it is not possible to say whether these groups are over- or under-represented among patients who die by assisted suicide.

Recent studies concerning the Netherlands point to particular difficulties in applying the criteria for euthanasia to patients with intellectual disabilities and/or autism spectrum disorders. After reviewing a number of case reports, it is concluded that the safeguards in the form of the 'reasonable care criteria' are difficult to apply to people with intellectual disabilities or autism spectrum disorders, and that the usual standards may actually have the unintended effect of putting vulnerable patients at risk, as they must also ensure that inequality is not established in access to euthanasia. The Dutch legislation requires that euthanasia be allowed only in cases where the disorder has a medical basis and therefore raises difficult questions about how justifications such as "difficulty in dealing with changed circumstances", which are often linked to a lifelong disability rather than an acquired medical condition, is included in the assessment of requests. The researchers consider that the implicit message conveyed to patients by accepting requests on the basis of intellectual disabilities or disorders related to autism spectrum disorders is that such conditions are indeed hopeless and further question the use of a medical framework for the assessment of people with complex social and psychological needs, especially when assessed on the basis of a broad concept of suffering, is too simple and risky.⁵⁶

It is argued that there will be a significant risk that, after the introduction of euthanasia, it will be different to be a person suffering unbearably and/or dying. The surrounding society has decided by law that to be a suffering person also means to be a person who can request euthanasia and a person for whom it must seem understandable to prefer death. An 'understanding' that can be difficult to meet.

People in great suffering are forced in this way to make a decision about their life situation. However, it can be objected that such a position is not solely dependent on whether euthanasia is an option, and thus created by society. The patients' immediate situation, whether due to illness or functional impairment, can also call for reflection and force the question: is death preferable?

This may also have something to do with the fact that the option to choose euthanasia means that living on becomes a choice for which one can be held responsible, rather than being a pure and simple result of circumstances. This opens up a question which is perhaps a little speculative, namely whether euthanasia risks becoming a self-fulfilling prophecy, understood in the sense that it may become necessary to request euthanasia because the presence of this option puts the person in a more difficult situation than the person concerned would have been in if euthanasia was not an option.⁵⁷

Proponents of euthanasia also point out, however, that it can be very difficult to trace this kind of influence on societal values. What constitutes the causality in the individual arguments can be difficult to determine when it comes to whether something forces people to make a decision about their own quality of life. Is it patients' suffering that forces society to take a position on euthanasia, or is it society's position on euthanasia that will force patients to take a position on their situation? It is also argued that emphasizing people's quality of life in the assessment of whether they should have access to euthanasia does not mean that low quality of life is thereby allowed to play a specific role. Taking people's quality of life into account can also mean, for example, that resources are distributed so that those with the worst quality of life get the most.

Overall, the question is, what does the risk of stigmatization of particular life states or particular phases of life consist of? It is partly a question of *who* can be described as vulnerable, and partly a question of how *realistic* such a risk of stigmatization is.

”

It can be difficult to make sure that psychiatric patients have no realistic prospects for recovery and whether the patient has made a competent, consistent and independent choice to die.

The prognosis is not as clear as it can be for somatic illnesses, as it can be difficult to predict how mental illnesses will develop

Age and financial circumstances

Concerns have been raised about whether the elderly risk being over-represented as recipients of euthanasia. Concerns have also been raised about whether people with few financial resources or low social status risk being over-represented as recipients of euthanasia. The concerns include on whether the elderly and the socially disadvantaged are more susceptible to pressure from relatives or caregivers, so that the voluntariness behind a request for euthanasia can be doubted.

Mental disorders

Concerns have been raised about whether people with a psychiatric diagnosis are at risk of being over-represented as recipients of euthanasia.

One reason is that it can be difficult to make sure that psychiatric patients have no realistic prospects of recovery and whether the patient has made a competent, consistent and independent choice to die. The prognosis is not as clear as it can be for somatic illnesses, as it can be difficult to predict how mental illnesses will develop. The criticism also extends to those who suffer from a physical illness, but who also have a psychiatric diagnosis or are otherwise affected by conditions that can influence decision-making competence.

'We want to know': do patients choose euthanasia because of depression?

SMER emphasizes that it can be difficult to draw a line between what constitutes a natural depression in the face of the inevitability of death and what constitutes a depressive illness that can be treated in severely suffering patients. However, studies that have attempted to identify patients suffering from clinical depression have concluded that depression is common among patients at the end of life. Studies have also shown that there is a link between depression and the desire to hasten death in patients at the end of life. Results such as these support the argument that depression is often behind the desire for euthanasia. In a case-control study, where the researchers clinically assessed the patients for depression, a statistically significant correlation was found between depression and the wish for euthanasia. In comparison, studies from the Netherlands have

showed no significant differences in the incidence of depression in patients who want active euthanasia compared to other patients with the same underlying disease. This contrasts with a third study, considered the best-conducted, which found that depression was three times more common among patients who wanted active euthanasia. It can also be emphasized that several studies in Oregon show that the connection between the desire for euthanasia and a feeling of hopelessness is stronger than the connection with depression. Overall, there is evidence that at least some of the patients seeking euthanasia in Oregon actually suffer from depression. There is also evidence that patients, both in Oregon and in the Netherlands, suffer from depression more often than other patients, although the connection is less clear. The claim thus seems to be true to a lesser extent, with the caveat that many people who request are not depressed. Several studies show a stronger association between requests for euthanasia and a feeling of hopelessness, regardless of whether one is depressed or not. At the same time, consistent studies both from Oregon and the Netherlands show that a large proportion of the patients who want euthanasia do not suffer from depression. Available information therefore argues against the desire for euthanasia generally being an expression of depression.⁵⁸

Persons with functional impairments

In the Netherlands, functional impairments are included as a possible component in the medical justification for euthanasia. This has led critics to point to a danger of stigmatization and that people with a disability may have euthanasia presented as an option, given that one can lead challenging lives.

Stigmatization is both about the risk of inflicting problems or self-perceptions on individuals that they do not initially have, but which are only known as stereotypes. The danger, the criticism goes, is that the evaluation of quality of life, which must necessarily serve as a basis for access to euthanasia, will also act as an evaluation of the lives lived, which do not harbor any desire for euthanasia, but which nevertheless less is forced to see his life through the newly established glasses of euthanasia.

On the other hand, a concern can also be expressed that the possibility of assisted dying risks overshadowing the challenges that people with functional impairments actually have, and which can be a reason for a low quality of life, because certain expectations are set for and ideas about , who is and what it means to be resourceful.

There is a risk of inflicting or depriving people with functional impairments of vulnerability based on a preliminary consideration of who they are or which group they belong to. Vulnerability can come and go, life crises can come and go, and the level of help available helps determine what personal resources one has in such situations.

Essential to this criticism is that it is not the availability of euthanasia as such that can be experienced as stigmatizing, but precisely the certain assumptions about connections between functional impairments and quality of life, e.g. that it is easy for the outside world to understand that people with extensive physical disabilities do not manage to move so well and that it is therefore understandable why one might want to die. The stigma here consists in experiencing one's own bodily reality described as a legitimate reason for wishing one's own death.

7.3.3 It will have negative consequences for the doctor-patient relationship

An important principle for the medical profession's ethical self-understanding is the statement 'primum non nocere' (first, or foremost, no harm). It lies, so to speak, in the doctor's work to promote healing and therefore not to take life, even if in a few cases it can be assessed as useful.

It is claimed that the practice of medicine rests on a special life-sustaining moral foundation, or that there exists a special ethos for the practice of medicine and the healthcare system (embodied in the cry 'is there a doctor on board?'). In continuation of this, it is argued that it is conceivable that health professionals are subject to a higher ethical standard, their special competences taken into account.⁵⁹

The challenge is that even if one believes that killing or suicide is not wrong in principle, it is still possible to believe that it is if it is doctors who carry out such an act. The Danish Medical Association points out that euthanasia is fundamentally at odds with the role of the doctor and the healthcare system, which is to benefit the patient through prevention, treatment and care.⁶⁰

Thus, one should not be mistaken about how controversial an act of euthanasia can be seen with medical eyes, if you combine a basic principle of doing no harm with a healthcare life-saving ethos. An example of how, in the eyes of some, the doctor's role can help determine a certain perspective is already given in the discussion of causality and intention in section 6.2.3. The reason why the question of the special liability, by having an intention to kill the patient, is emphasized so often among doctors, could precisely consist in, or at least be reinforced by, a special duty or life-saving ethos.⁶¹

”

It is claimed that the practice of medicine rests on a special life-sustaining moral foundation or that there exists a special ethos for the practice of medicine and the healthcare system (embodied in the cry 'is there a doctor on board?').

It may therefore seem obvious that the practice of euthanasia is incompatible with working as a doctor. But maybe it's not quite that simple to decide? For what is the purpose of the practice of medicine and of the healthcare system as the practical framework of this practice? One purpose can be said to be to prevent and postpone death. Based on such an understanding, an offer of euthanasia does not seem likely. However, it can be argued that this is far too general a goal, and that the work of doctors in the healthcare system is about the treatment of disease. The aim of the health care system is, in this perspective, to avoid, remove or reduce pain and malfunctions.

The two purposes mentioned will often overlap, but are not quite the same. One is about preventing and curing illness (and thus also pain and suffering), the other about preventing and postponing death. And the two purposes can come into conflict with each other, especially when postponing death no longer helps to relieve pain or suffering.

One can think of cases where the relief of pain or the cessation of suffering requires giving up the other purpose, namely preventing or postponing death.

It can be argued that precisely doing good and respecting patients' self-determination is to a large extent part of a medical obligation, so that they are obliged not to let patients suffer if they have the means to avoid this.

There may be purposes which are sensitive to the fact that the medical practice exists in and is legitimized by a larger context, which also includes working for increased welfare or self-determination. Some would argue that euthanasia should reasonably be considered part of such a context.

In continuation of the question of the doctor's duties, it has been argued that regardless of whether it is justifiable or not for doctors to perform euthanasia, it will have negative consequences for patients' trust in the doctor and for his wholehearted interest in what is in the patient's best interest. Citizens should be able to rest assured that doctors treat them professionally and that they can say what is wrong or what is on their mind, without fear of it being used against them. Trust must be considered particularly important because the doctor will often have an authority in relation to the patient. The authority consists in the doctor having a special insight into the patient's general state of health and thus

can occupy a privileged position as an adviser on matters of vital importance to the patient's life. If it comes to be in the consciousness of patients and doctors that euthanasia is an option, it will also risk becoming a consideration in the course of treatment and thus make the doctor's role ambiguous for the patient.

A further difficulty is whether there are enough doctors who will be willing to perform euthanasia. It has been argued that, in addition to being a serious challenge to the ethics of the profession, it will also involve great spiritual and psychological costs for doctors. The psychological burden of having this right/option/duty may well prove to be a high price to pay for doctors, especially if it leads to a distance or insensitivity when it comes to harming a patient.⁶²

'We want to know': does euthanasia pose a burden to health professionals?

SMER emphasizes that there is relatively little information on how doctors and other health personnel are affected by being involved in the process of euthanasia. However, the available studies from Oregon and the Netherlands support the assumption that for many doctors, giving euthanasia or assisted dying entails a significant emotional burden and a great sense of responsibility. However, it seems that only a small proportion of them regret or are not willing to repeat the action. After legalization in Oregon, there have been reports that doctors who supported the law experienced concerns about being stigmatized because colleagues or patients could distance themselves from them if they participated in assisted dying.

However, no information is available on whether these concerns have been confirmed. Data show that it is very common for nurses and social workers in palliative care in Oregon to have conversations with patients about assisted dying. A third of those who have had such conversations found it unpleasant. Nevertheless, the nurses and social workers believed quite consistently that one should not abandon a patient who wants access to euthanasia, regardless of one's personal attitude to the issue. A majority of Oregon physicians supported the Death with Dignity Act when it was introduced. However, fewer were willi

in assisted suicide. The doctors who have participated report ambivalent feelings: the emotional burden is great, but they generally do not regret their participation.⁶³

Finally, it is also worth asking whether it even needs to be doctors who perform euthanasia? Few imagine that doctors should play no role at all. This is connected with the demarcation problem.

All models of euthanasia include conditions that the person requesting euthanasia must meet. The assessment of whether one does so is difficult to imagine being carried out by people without a medical background, as the assessment will often require expert knowledge of diagnostics and prognostics.

On the other hand, deciding on a request for euthanasia involves many issues which can be said to go beyond medical expertise. Some people find life unbearable and commit suicide. This can be due to depression, failure, or that life is experienced as empty and meaningless, while others commit suicide due to physical illness and great suffering. But, one might ask, how large a part of this great spectrum of disorders to which human life can belong should it be a medical matter to assess?

It is therefore hardly the case that with an offer of euthanasia, there can be talk of the patient's right, and thus the doctor's duty. More likely, it will continue to be illegal to take the life of others at their request, unless a complex of conditions are met (eg a number of the highlighted conditions in section 7.2 on practical-political arguments for euthanasia). Such a law would ensure freedom from guilt and would also be able to exempt doctors from a duty and make it up to the individual to decide whether to follow the person's request. However, this has the consequence that in each case the doctor would have to consider what the right thing to do in this situation would be, and whether the person met a possibly extensive complex of conditions.

In this connection, it is worth highlighting that in Switzerland, which allows assisted suicide, there is no requirement that the assistance must come from a doctor. In 1942, assisted suicide was made illegal, but with a significant loophole. According to Section 115 of the Penal Code, it is not permitted to assist someone else's suicide if you yourself have any gain from it. In jurisprudence, it has ended up meaning that everyone, and not just

doctors, can assist in the execution. Organizationally, this means that a number of private organizations offer euthanasia based on a court decision from 1999, which, among other things, requires that you see the patient yourself and make sure that he is competent to make decisions. Guidelines for implementation have been drawn up, i.a. by the Swiss Medical Association and by the National Council for Biomedical Ethics.⁶⁴

7.3.4 This will have negative consequences for palliative care

As we saw in section 4.2, Danish legislation is not designed for life support no matter what. Patients should not be kept alive at all costs by providing life-prolonging treatment when patients are irreversibly dying. It is part of an ethically defensible treatment of the dying. This relationship can be said to be a starting point for the distancing from euthanasia, which considers it to stand in opposition to palliative care, and which is skeptical of the legalization of euthanasia, as long as we as a society have not exhausted the possibilities to relieve.

The argument that euthanasia can have negative consequences for palliative care has several dimensions. It thus contains arguments about overtreatment, about the quality and creativity of the palliative services, and about the willingness to use sufficient resources in this field. The argument is often formulated on the basis of hypothetical conditions that are believed to influence requests for euthanasia, and which one believes should be addressed before resorting to euthanasia as a solution.

'We would like to know': is it the case that just access to palliation is sufficient, so there is no need for euthanasia?

SMER's research highlights that in the years following legalization in Oregon, there is information that up to half of patients who requested euthanasia and then received significant health care interventions, such as palliative care, changed their attitudes and no longer wanted euthanasia. In a study among cancer patients carried out from 1998 to 2001, a statistically significant correlation was found between the perception of low quality of care and interest in euthanasia. This information suggests that access to high-quality palliative care can reduce the demand for euthanasia. Both

however, these studies are relatively old, and since they were conducted, the proportion of Oregon patients accessing end-of-life palliative care has increased. Despite this, the proportion of patients choosing euthanasia is increasing. This may indicate that it is not just the lack of access to palliative care that prompts patients to request euthanasia, at least in Oregon, where access to palliative care is good. One explanation for the increase in demand for euthanasia, even though more patients are being offered palliative care, could be that the care offered is, in some cases, unable to provide adequate symptom control (perhaps combined with increased expectations of care regarding to manage physical and other symptoms). Therefore, there is not a good basis for assessing whether the desire for euthanasia in Oregon, which is due to unsatisfactory symptom control, could be expected to be less with access to better palliative care, as opposed to better access to palliative care, which has not reduced the demand. However, lack of symptom control is only one of the less important reasons for requesting euthanasia. The research into the motives of patients who choose euthanasia shows that for many of them the experience of a dignified death is linked to control over death and preserved independence. This is a need that cannot necessarily be met by palliative care. On the contrary, it seems that some patients choose euthanasia precisely to avoid increased dependence on care.⁶⁵

The starting point for the first hypothetical 'if' is that patients must not be kept alive at all costs by giving life-prolonging treatment in situations where patients are irreversibly dying. To the extent that advanced treatment options are used to keep patients alive far beyond the limit of reasonableness, such an extension of life will simply lead to an experience of meaninglessness and intensify a period when euthanasia can be an alternative to life. The argument goes that if the healthcare system becomes better at not overtreating dying patients and becomes better able to talk with patients about the necessary decisions to be made at the end of life, and if palliative care is fully developed and functions satisfactorily, then it will be much more possible to create a decent framework for a dignified death for seriously ill people simply by having sufficient focus on palliative care. Only then will one be able to make a realistic assessment of whether one exists at all

real need for euthanasia among the seriously ill. The thinking goes that it should not be because of a lack of effort in the palliative field that euthanasia can appear to be an attractive option for some patients.

”

Is palliative care sufficiently developed and expanded in Denmark?

The argument expresses a form of causality or at least a form of mechanism between medical norms, scope and quality of palliative care and wishes for euthanasia: to the extent that palliative care is insufficient, euthanasia will appear more attractive and vice versa; to the extent that euthanasia is established, the palliative effort will be weakened.

This naturally leads to the question: is palliative care sufficiently developed and expanded in Denmark?

In 2020, the State Auditors submitted a report to the Danish Parliament. Here they found that it was unsatisfactory that the regions had not ensured that patients with life-threatening diseases had access to specialized palliation when necessary. It was also found unsatisfactory that the regions had not sufficiently ensured a systematic and effective identification of the individual patient's need for specialized palliation.⁶⁶

Prior to this criticism, the National Board of Health pointed out in its recommendations for palliative care in Denmark (2017) that there was still much to be done. It was described how the field was still in its infancy and that more knowledge, routine, experience and better facilities were needed. In particular, it was emphasized that the dying have very different, often long and unpredictable processes, and the relevant staff were not always sufficiently trained. The majority of all palliative care is provided by health professionals at a basic level, and they do not have palliative care as their main area.⁶⁷

'We want to know': will palliative care deteriorate if euthanasia is allowed?

SMER estimates that the proportion of patients who have access to palliative care when they are nearing death in Oregon is increasing in the same way as in US states where euthanasia is not practiced. In Belgium and Luxembourg, the law on the right to palliative care for the dying was adopted

parallel to the legalization of euthanasia, and both countries have expanded palliative care after legalization. In the Netherlands, too, there has been a significant expansion of palliative care measured in terms of structural resources since legalization. Information from both Oregon and the Netherlands therefore does not readily support the assumption that the development of palliative care would slow down if euthanasia were legalized. In addition, the proportion of patients accessing palliative care near death in Oregon is increasing, both among all patients and among those who die by assisted dying. Access to palliative care is at the same level as in the rest of the United States. In other countries that allow euthanasia, palliative care has also continued to develop after legalization.⁶⁸

In the EAPC Atlas of Palliative Care in Europe from 2019, which provides statistics and compares the conditions between the countries in a series, Denmark is in 21st place when it comes to the specialized palliative care. That's enough for a mid-section position. Interestingly, Luxembourg and Belgium, which both allow euthanasia, are in 3rd and 5th place. The Netherlands, on the other hand, is in 24th place, not far below Denmark.⁶⁹

Some advocates of euthanasia have viewed with some skepticism the notion that palliative medicine should be in principle opposed to euthanasia. Indeed, some agree that only a minority of terminally ill patients are likely to wish to be euthanized if they have access to the full range of palliative options. On the other hand, there is a minority, the criticism goes, for whom the prospect of palliative treatment does not seem attractive or is even incompatible with their wishes for the end of life. Critics also point out that patients with chronically painful conditions will not see themselves helped by sufficiently increased palliative care.

Another point that advocates emphasize is that the likelihood of negative consequences for palliative care establishes a kind of argumentative fallacy mill: if there is a sufficiently good palliation, then there will be no need for euthanasia. If the palliative offer is poor, then euthanasia will be unjustified, as patients risk being pressured into choosing euthanasia due to a lack of palliative treatment.⁷⁰

Instead, it is argued that just as it can be emphasized that we do not know about the real need for euthanasia until we have a fully developed palliative medicine available to everyone, it can be emphasized that we do not know where well, conventional palliative efforts satisfy the dying before we have made euthanasia available to them.⁷¹

The question is also whether the relationship between palliation and euthanasia is an either/or, or a both/and? If only it were so, critics point out that the relationship between palliation and euthanasia had the reciprocal nature that one could make the other redundant. For some critics, this appears to be a somewhat convenient way of reasoning, because should one even accept that one must choose between offering good and adequate palliation or offering euthanasia?

1. The Council of Ethics has previously issued statements on euthanasia in 1996, 2003 and 2012. All statements can be found on the Council of Ethics' website.
The Ethical Council's opinion on possible legalization of active euthanasia (nationalcenterforetik.dk) b520785_indh.pdf (nationalcenterforetik.dk)
...The Council of Ethics... (nationalcenterforetik.dk)
2. Magelssen, M. (2020). "Language and reality in the euthanasia debate" in Horn, M., Kleiven DJH & Magelssen, M. (Ed.): Euthanasia in the Nordic region? Ethics, clinic and politics. Cappelen Damm Academic (2020), p. 36.
3. Campbell, Courtney S. og Cox, Jessica C.: "Hospice and Physician-Assisted Death: Collaboration, Compliance, and Complicity". Hastings Center Report 40, no. 5 (2010): 26-35.
4. Euthanasia. A knowledge compilation. The Norwegian Medical and Ethics Council (2017), p. 16. Hereinafter referred to as 'SMER'. The distinction between value-based arguments and fact-based arguments is also based on SMER's work.
5. DIRECTION, 2017, p. 150.
6. DIRECTION, 2017, p. 15.
7. Hartlev, Mette, Jakobsen, Peter & Cathaoir, Katharina Ó: Health and law. Health law perspectives on healthcare, healthcare professionals and patient rights. Jøf Forlag, pp. 254-56.
8. Recommendations for palliative care. The National Board of Health (2017). _ (sst.dk)
9. Hartlev, Mette, Jakobsen, Peter & Cathaoir, Katharina Ó: Health and law. Health law perspectives on health care, health professionals and patient rights. Djøf Forlag (2022), p. 203.
10. Guidance on opting out and interrupting life-prolonging treatment, the Swedish Patient Administration security (2019). Guidance on opting out and interrupting life-prolonging treatment (retsinformation.dk)
11. Hartlev, Mette, Jakobsen, Peter & Cathaoir, Katharina Ó: Health and law. Health law perspectives on healthcare, healthcare professionals and patient rights. Djøf Forlag (2022), p. 253.
12. Connor SR, Pyenson B, Fitch K, Spence C, Iwasaki K. Comparing hospice and nonhospice patient survival among patients who die within a three-year window. J Pain Symptom Manage. 2007 Mar;33(3):238-46.
Gelfman LP, Barrón Y, Moore S, Murtaugh CM, Lala A, Aldridge MD, Goldstein NE. Predictors of Hospice Enrollment for Patients With Advanced Heart Failure and Effects on Health Care Use. JACC Heart Failure. 2018 Sep;6(9):780-789.
Temel JS, Greer JA, Muzikansky A, Gallagher ER, Admane S, Jackson VA, Dahlin CM, Blinder-man CD, Jacobsen J, Pirl WF. Early palliative care for patients with metastatic non-small-cell lung cancer. N Engl J Med. 2010;363(8):733-42.
Maltoni, M., Scarpi, E., Rosati, M., Derni, S., Fabbri, L., Martini, F., Amadori, D., & Nanni, O. (2012). Palliative sedation in end-of-life care and survival: a systematic review. Journal of clinical oncology : official journal of the American Society of Clinical Oncology, 30(12), 1378-1383.
13. The health authorities of Oregon have collected all available material (legislation, annual reports and other publications on a unified Death With Dignity website): [Oregon Health Authority: Oregon's Death with Dignity Act : Death with Dignity Act : State of Oregon](#)
14. [DWDA 2022 Data Summary Report \(oregon.gov\), s. 5.](#)
15. [DWDA 2022 Data Summary Report \(oregon.gov\)](#)
16. [DWDA 2022 Data Summary Report \(oregon.gov\)](#)
17. Ganzini L, Goy ER och Dobscha SK. (2009). Oregonians' reasons for requesting physician aid in dying. Arch Intern Med, 169:489-492.

18. DIRECTION, 2017, p. 108.
19. DIRECTION; 2017, p. 109.
20. Buijsen, Martin & Verhagen, Eduard: "Should the Dutch Law on Euthanasia Be Expanded to Include Children?" in Cambridge Quarterly of Healthcare Ethics 32: 1 (2023).
21. All annual reports from the Dutch regional euthanasia review committees are collected available here: Home | Regional Euthanasia Review Committees (euthanasiecommissie.nl)
22. Onwuteaka-Philipsen BD m.fl. (2012). Trends in end-of-life practices before and after the enactment of the euthanasia law in the Netherlands from 1990 to 2010: a repeated cross-sectional survey. *Lancet*, 380:908-915.
23. [RTE_JV2022_ENGELS.pdf](#)
24. Sumner, L.W.: Physician-Assisted Death. Oxford University Press (2017), s. 38.
25. DIRECTION, 2017, p. 166-67.
26. Cassel, Eric: The Nature of Suffering. Oxford University Press.
27. Beauchamp, T.L. & Childress, J.F.: Principles of Biomedical Ethics. 8th Edition, Oxford University Press (2013).
28. Ganzini L, Goy ER och Dobscha SK. (2009). Oregonians' reasons for requesting physician aid in dying. *Arch Intern Med*, 169:489-492.
 Ganzini L, Goy ER och Dobscha SK. (2008b). Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross sectional survey. *BMJ*, 337:a1682.
 Ganzini L m.fl. (2000). Physicians' experiences with the Oregon death with dignity act. *N Engl J Med*, 342:557-563.
 Ganzini L m.fl. (2002). Experiences of Oregon nurses and social workers with hospice patients who requested assistance with suicide. *N Engl J Med*, 347:582-588.
 Georges JJ m.fl. (2007). Relatives' perspective on the terminally ill patients who died after euthanasia or physician-assisted suicide: a retrospective cross-sectional interview study in the Netherlands. *Death Stud*, 31:1-15.
29. DIRECTION, p. 114.
30. Ganzini L m.fl. (2003b). Oregon physicians' perceptions of patients who request assisted suicide and their families. *J Palliat Med*, 6:381-390.
31. Euthanasia - legalization of killing on request? The Council of Ethics (2003), p. 36.
[b520785_indh.pdf \(nationalcenterforetik.dk\)](#)
32. Hartling, Ole: Active euthanasia. Can we do more than we can handle? Gyldendal (2105), p. 56.
33. Moen, Ole Martin & Sterri Aksel Braanen: Active euthanasia. Cappelen Damm Academic (2019), s. 79.
34. Euthanasia - legalization of killing on request? The Ethics Council (2003), p. 21.
[b520785_indh.pdf \(nationalcenterforetik.dk\)](#)
35. DIRECTION, 2017, p. 177.
36. Hartling, Ole: Active euthanasia. Can we do more than we can handle? Gyldendal (2105), p. 56.
37. Dige, Morten: "Assisted death and the distorted concept of autonomy" in Library for doctors, 6 March 2023. Assisted death and the distorted concept of autonomy | Ugeskriftet.dk. In the same issue of Library for doctors, former chief physician Ole Hartling responds to the article: Hartling, Ole: "Euthanasia - an area with good intentions and euphemisms" in Library for doctors, 3 March 2023. Euthanasia - an area with good intentions and euphemisms | Ugeskriftet.dk
38. Childress, James : "Autonomy" i Veatch, Robert M. (red.): Cross-cultural perspectives in medical ethics. Jones and Bartlett Publishers, Inc. (2000).

39. DIRECTION, 2017, p. 170.
40. Moen, Ole Martin & Sterri Aksel Braanen: Active euthanasia. Cappelen Damm Academic (2019), s. 17.
41. Birkler, Jacob: Death in a professional perspective. Nyt Nordisk Forlag Arnold Busck (2015), p. 92.
42. Magelssen, M. (2020). "Language and reality in the euthanasia debate" in Horn, M., Kleiven DJH & Magelssen, M. (Ed.): Euthanasia in the Nordic region? Ethics, clinic and politics. Cappelen Damm Academic (2020), p. 46.
43. Hartling, Ole: Active euthanasia. Can we do more than we can handle? Gyldendal (2105), p. 31.
44. Horn, Morten: "Is it possible to create a clear, fair and justifiable euthanasia law?" in Horn, M., Kleiven DJH & Magelssen, M. (Eds.): Euthanasia in the Nordics? Ethics, clinic and politics. Cappelen Damm Academic (2020), pp. 291-309.
45. The Ethical Council's opinion on the possible legalization of active euthanasia. The Council of Ethics (2012), p. 20. [The Council of Ethics' opinion on the possible legalization of active euthanasia \(nationalcenterforetik.dk\)](https://www.nationalcenterforetik.dk)
-
46. Sumner, 134.
47. [Carter v. Canada \(Attorney General\) - SCC Cases \(lexum.com\)](https://www.lexum.com)
48. DIRECTION, 2017, p. 176.
49. DIRECTION, 2017, p. 174-76.
50. DIRECTION, 2017, p. 173.
51. Moen, Ole Martin & Sterri Aksel Braanen: Active euthanasia. Cappelen Damm Academic (2019), s. 102.
52. Euthanasia - legalization of killing on request? The Ethics Council (2003), p. 26. [b520785_indh.pdf \(nationalcenterforetik.dk\)](https://www.nationalcenterforetik.dk)
53. DIRECTION, 2017, p. 178.
54. Euthanasia - legalization of killing on request? The Ethics Council (2003), p. 27. [b520785_indh.pdf \(nationalcenterforetik.dk\)](https://www.nationalcenterforetik.dk)
55. DIRECTION, 2017, p. 180-81.
56. Tuffrey-Wijne et.al.: "Euthanasia and assisted suicide for people with an intellectual disability and/or autism spectrum disorder: an examination of nine relevant euthanasia cases in the Netherlands (2012–2016)". BMC Medical Ethics (2018) 19:17.
Tuffrey-Wijne et.al.: "Euthanasia and physician-assisted suicide in people with intellectual disabilities and/or autism spectrum disorder: investigation of 39 Dutch case reports (2012-2021)" in BJPsych (2023) 9(3).
57. Moen, Ole Martin & Sterri Aksel Braanen: Active euthanasia. Cappelen Damm Academic (2019), s. 91-92.
58. Ganzini L, Goy ER och Dobscha SK. (2008a). Why Oregon patients request assisted death: family members' views. J Gen Intern Med, 23:154-157.
Ganzini L, Goy ER och Dobscha SK. (2008b). Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross sectional survey. BMJ, 337:a1682.
Tolle SW m.fl. (2004). Characteristics and proportion of dying Oregonians who personally consider physician-assisted suicide. J Clin Ethics, 15:111-118.
Levene I och Parker M. (2011). Prevalence of depression in granted and refused requests for euthanasia and assisted suicide: a systematic review. J Med Ethics, 37:205-211.
van der Lee ML m.fl. (2005). Euthanasia and depression: a prospective cohort study among terminally ill cancer patients. J Clin Oncol, 23:6607-6612.

59. DiNucci, Ezio: Ethics4Medics. Munksgaard (2023), p. 105.
60. The Swedish Medical Association's position on active euthanasia (laeger.dk)
61. Hartling, Ole: Active euthanasia. Can we do more than we can handle? Gyldendal (2105), p. 56.
62. Kass, Leon: "Neither for Love nor Money: Why Doctors Must Not Kill" i Public Interest 94 (1989), s. 25-46.
63. DIRECTION, 2017, p. 182.
64. Mauron, A.: "Acting on a wish to die at the end of life: The Swiss situation" i C. Rehmann-Sutter, H. Gudat & K. Ohnsorge (Red.), The patient's wish to die. Research, ethics, and palliative care (2015), Oxford University Press s. 97-106.
65. DIRECTION, 2017, p. 169-70.
66. Report on access to specialized palliation. Folketinget, National Audit Office (2020). Report on access to specialized palliation (rigsrevisionen.dk)
67. Recommendations for palliative care. The National Board of Health (2017). _ (sst.dk)
68. DIRECTION, 2017, p. 171
69. EAPC Atlas of Palliative Care (2019). A PALLIATIVE Atlas Europa19 Proto Apr1_Miriam definitivo 17.indd (hospiz.at)
70. Moen, Ole Martin & Sterri Aksel Braanen: Active euthanasia. Cappelen Damm Academic (2019).
71. Sumner, L.W.: Physician-Assisted Death. Oxford University Press (2017), s. 150.



**NATIONALT
CENTER FOR ETIK**

Ørestad Boulevard 5

2300 Copenhagen S

dketik@dketik.dk

nationaltcenterforetik.dk



**DET
ETISKE
RÅD**