

Euthanasia: The Balance of Personal Autonomy Against Legal Safeguards in a Global Debate

AP Seminar

5/12/2024

1319 Words

As global life expectancy rises and populations age, more than 40 million individuals annually require palliative care, yet still too many suffer in vain with no hope of relief (WHO, 12). This trend has caused a global debate on euthanasia, creating disputed answers on ethics, human rights, and the proper role of the state in end-of-life decisions. Additionally, the issue of euthanasia sits at the forefront of personal rights, medical ethics, terminally ill patients, physicians, and governments as central stakeholders. A few nations, such as the Netherlands, Belgium, and Canada, have legalized euthanasia within rigorous parameters, affirming dignity and the right to die willfully, while other nations oppose it based on culture, religion, or ideology. As more countries grapple with end-of-life care issues, the matter of concern moves to how respect for individual autonomy can be balanced with the protection of vulnerable groups. Individual autonomy is at the heart of euthanasia debates, and what experience exists in countries where euthanasia has become legalized gives direction on the necessity for heightened protections to prevent abuse, ensure ethical medicine, and public confidence.

Comparing countries that legalized euthanasia provides valuable information regarding how policies can be written to protect vulnerable individuals and promote individual autonomy. In the Netherlands, euthanasia was legalized in 2002 after years of public debate (Weyers, 2001). Dutch law obliges individuals to suffer intolerably with no possible improvement, and that an autonomous physician confirms that the request is in strict medical and ethical requirements (Chambaere et al., 2015). Protection is the order of the system, including obligatory reporting and analysis of each case by a regional euthanasia review committee. This aims to ensure euthanasia is administered only after specific conditions are met, ensuring patient dignity and the integrity of medical practice.

Similarly, Belgium's euthanasia act of 2002 mandates that the patients have to be in a medically desperate condition marked by continuous and intolerable suffering. The act also requires doctor visits and, on some occasions, the potential of euthanasia request by children, which raises concerns about their ability to provide informed consent (Cohen-Almagor, 2016). The mention of children in specific situations brings up one of the most controversial aspects of euthanasia law: uncertainty in measuring competency and vulnerability to coercion. Both countries also emphasize procedural protections, i.e., mandatory reporting and comprehensive medical screening, to ensure that euthanasia is restricted to eligible patients and coercion is avoided. Such models are proven to uphold respect for vulnerable groups, the elderly and disabled, without sacrificing patient autonomy (Somerville, 2001). Canada's MAiD (Medical Assistance in Dying) since 2016 parallels similar concerns but is more deeply based on the promise that patients' suffering is irreparable and that no alternative exists (Downie, 2016). Individually and together, the examples each point to a requirement of connected dual obligation to individual rights and ethical oversight.

Globally, euthanasia law varies immensely, depending on culture, religion, and legal tradition. While some countries like the Netherlands, Belgium, and Canada legalize a form of euthanasia under highly controlled conditions, others prohibit it entirely or allow passive euthanasia. For example, France and the United Kingdom allow withholding of life-sustaining treatments but prohibit active euthanasia (Lewis, 2007). In this case, the focus is on not letting patients die unnecessarily, but short of actually helping people to die. Switzerland, where assisted suicide is legalized under specific conditions, is the only nation that offers an interesting model where non-medical individuals can actively be involved in the process, provided there is no self-interest (Hurst & Mauron, 2003).

In contrast, very Catholic countries such as Italy and Poland still maintain prohibitions on euthanasia, in line with a religious emphasis on the sanctity of life (Biggar, 2004). Such variations in culture and law serve to convey the deeply embedded values involved in the euthanasia controversy. The varying legal regimes create a conflicted global landscape, making it challenging for patients to attain end-of-life decisions and enabling ethically questionable phenomena like "suicide tourism." In the Netherlands, for example, residents of countries with more prohibitive laws increasingly seek travel abroad to undergo euthanasia, prompting worries regarding exploitation and inequity of access (Cattapan & Baylis, 2014). This mirrors the tension between respect for individual autonomy and the enforcement of social values, and the difficulty in providing equal access to euthanasia.

At the heart of the euthanasia debate is the conflict between the freedom of the individual and the obligation of the state to maintain life. Supporters of euthanasia argue that allowing terminally ill patients to choose death is a human right. While patient activists and some doctors see euthanasia as a widening of personal freedom and human dignity, particularly when additional life entails only endless suffering (Dworkin, 1993). This approach is seen in the state legislations of aforementioned countries like Belgium and the Netherlands, where patient autonomy is foremost, provided rigorous protocol is followed (Weyers, 2001). However, others argue that euthanasia legalisation is at risk of forcing vulnerable groups, whether they be elderly, disabled, or mentally ill individuals, to actively terminate their own lives, especially where palliative care centres are unavailable (Somerville, 2001).

Critics of euthanasia argue that euthanasia would become too much of a convenience for society, placing vulnerable individuals under systemic pressure to choose death rather than receiving needed care. The medical professionals are faced with a moral dilemma themselves, as the Hippocratic Oath obligates physicians to "do no harm," which places euthanasia in direct contradiction of their moral obligation. Furthermore, legalizing euthanasia would increase social inequalities if access to end-of-life services is not equitably distributed. Legal systems are therefore obliged to adopt balanced regimes permitting individual choice and incorporating multiple layers of oversight. Belgium's requirement of psychiatric consultations in non-terminal cases presents one example of a model of strict precaution (Lewis, 2007). Such policies seek to avoid coercion and guarantee ethical requirements while allowing for decent end-of-life options.

Furthermore, advances in life-sustaining interventions have contributed to ethical debate regarding euthanasia. Advances in ventilation, tube feeding, and resuscitation make the patient a candidate for being sustained for decades with compromised consciousness or quality of life. This has evoked public and medical worries about "overmedicalization" at the time of dying. Critics argue that keeping patients alive through artificial means with no real hope for recovery can unreasonably prolong suffering and rob people of their dignity. Arguing in support of euthanasia, others argue that it gives a humane option over the overuse of life-sustaining interventions, which in effect prolongs suffering and de-dignifies patients.

Euthanasia, when applied within regulated parameters, can be a dignified and humane alternative to the misuse of life-sustaining technology. It provides a wider vision of healthcare that is not merely survival but also suffering, dignity, and autonomy in a patient's terminal days. Furthermore, the growing recognition of a patient's right to exercise autonomous decisions regarding their state of health equally substantiates the case for euthanasia as a viable option in situations where death is certain and suffering unbearable.

The euthanasia debate remains under the influence of legal, ethical, and cultural factors, with governments, clinicians, and patients each having important parts to play. While some nations embrace the right to die on carefully controlled terms, others hold back. Still, the experience of those countries that have legalized euthanasia demonstrates that it is possible to create systems that balance individual freedom with safeguards. Stringent safeguards, such as multi-physician approvals, open reporting mechanisms, and eligibility criteria, work to minimize the risks of coercion or abuse while still respecting patient autonomy.

Future policymakers must learn from such precedent to enact laws governing euthanasia that are dignifying without sacrificing ethical honesty. With the world's healthcare systems evolving and aging populations, nations must emphasize making wise decisions so they remain compassionate while remaining cautious. Not only is the challenge that of respecting individual freedom of choice, but ensuring that vulnerable groups are protected from unnecessary stress or exploitation, and creating a legal and ethical framework to balance the hard and typically inimical values of these considerations.

Sources Cited:

Biggar, N. (2004). *Aiming to kill: The ethics of suicide and euthanasia*. Darton, Longman and Todd. <https://archive.org/details/aimingtokillethi0000bigg>

Cattapan, A., & Baylis, F. (2014). Assisted reproduction: Canada and the hybrid embryo debate. *Bioethics*, 28(6), 301–308. <https://pubmed.ncbi.nlm.nih.gov/23608245/>

Chambaere, K., Vander Stichele, R., Mortier, F., Cohen, J., & Deliens, L. (2015). Recent trends in euthanasia and other end-of-life practices in Belgium. *The New England Journal of Medicine*, 372(12), 1179–1181. <https://www.nejm.org/doi/full/10.1056/NEJMc1414527>

Cohen-Almagor, R. (2016). *The right to die with dignity: An argument in ethics, medicine, and law*. Cambridge University Press.

https://www.researchgate.net/publication/233785269_The_Right_to_Die_with_Dignity

Downie, J. (2016). Medical assistance in dying: Lessons for Australia from Canada. *Journal of Law and Medicine*, 24(2), 322–327.

https://digitalcommons.schulichlaw.dal.ca/cgi/viewcontent.cgi?article=1679&context=scholarly_works

Dworkin, R. (1993). *Life's dominion: An argument about abortion, euthanasia, and individual freedom*. Alfred A. Knopf. <https://archive.org/details/lifesdominionarg00dwor>

Hurst, S. A., & Mauron, A. (2003). Assisted suicide and euthanasia in Switzerland: Allowing a role for non-physicians. *BMJ*, 326(7383), 271–273.
<https://pmc.ncbi.nlm.nih.gov/articles/PMC1125125/>

Lewis, P. (2007). *Assisted dying and legal change*. Oxford University Press.
<https://archive.org/details/assisteddyingleg0000lewi>

Somerville, M. A. (2001). *Death talk: The case against euthanasia and physician-assisted suicide*. McGill-Queen's University Press. <https://www.jstor.org/stable/j.ctt7zq0n>

Weyers, H. (2001). Euthanasia: The process of legal change in the Netherlands. *Health Law Journal*, 9, 119–139.
<https://research.rug.nl/en/publications/euthanasia-the-process-of-legal-change-in-the-netherlands>