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Recent global perspectives and implications of medical-assisted death and euthanasia

Abstract

Medical-assisted death and Euthanasia MAD-E is a medical practice in some parts of the world that has become, more than ever, the center of a vast debate both within the medical scientific community and in the community at large due to various factors. MAD-E involves complex medical, ethical, legal, and societal considerations and public health implications. This paper will present some general aspects of MAD-E, its definitions, legal status, clinical applications, and domains, and discuss certain important elements of the debate, highlighting the most recent perspectives, considerations, and implications associated with the practice of MAD-E.

Keywords: medical assisted death, euthanasia, end-of-life care, patient-centred care

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Khayreddine Bouabida,[1,2,3] Breitner Chaves,[1,4] Enoch Anane,[3] Navaal Jagram[3]

[1]Public Health School of the University of Montreal, Canada
[2]Research Center of the Hospital Center of the University of Montreal, Canada
[3]St. George's University School of Medicine, Great River, United States
[4]Department of Public Health Research, Vitality Health Network, Canada

Correspondence: Khayreddine Bouabida PhD, Public Health School of the University of Montreal, Montreal, QC H3N 1X9, Canada, Tel +3473300857, Email Khayreddine.bouabida@umontreal.ca

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Introduction

The historical journey of Medical-Assisted Death and Euthanasia (MAD-E) is as complex as it is controversial, stretching back to ancient times yet continually evolving in the modern era. The concept of euthanasia, derived from the Greek words 'eu' (good) and 'thanatos' (death), implying a 'good death', has been debated since the days of ancient Greek and Roman philosophers. Notably, figures like Socrates and Plato offered differing views on the ethics of ending life to relieve suffering.[1–3] Over the last three decades, the practice of MAD-E, has been a part of a large thematic discussion regarding hastening the patient's death to put an end to their suffering when no cure can be found, such as in patients in terminal disease stages.[3–5] There is often a misunderstanding between the terms MAD-E and "Death with Dignity," with many using them interchangeably, though they represent distinct concepts.[1–3] MAD-E involves a healthcare provider's direct role in ending a patient's life. This can be through euthanasia, where the provider administers a lethal substance, or assisted death, where the provider supplies but does not administer the lethal means.[1–7] The intent here is an active intervention to end life due to unbearable suffering, typically in terminal illnesses.[1–7] On the other hand, "Death with Dignity" refers to allowing the natural process of dying without aggressive medical interventions. It involves decisions like withdrawing life-sustaining treatments, emphasizing the patient's comfort and respect for their natural end-of-life process. The key difference lies in the intent and the role of medical intervention: MAD-E actively hastens death, while Death with Dignity allows death to occur naturally, respecting the patient's wishes for a dignified end.[1–7] Understanding these distinctions is crucial for ethical discussions in healthcare, as they involve different approaches to autonomy, the sanctity of life, and the moral responsibilities of healthcare providers.

The definitions of medically assisted death or euthanasia change by country and context. Various terminologies are used to refer to and define the induction of the assisted dying process, including euthanasia, Physician-Assisted Suicide, medically assisted suicide, physician-assisted dying, voluntary assisted dying, and medical aid in dying.[1–8] Even though the ultimate goal of this practice is the same, the meaning and use of its terms are not globally in harmony or universally agreed upon, which might be confusing and add more complexity to the controversy and paradoxes already associated with them. For instance, in Europe, physician-assisted death is the term commonly used. Currently, in the United States and Canada, Medical Aid in Dying, along with the term death with dignity, are both frequently used in scientific literature and legislation.[1–11] Medical Assisted Death is a subject shrouded in ethical, medical, and legal complexities and remains one of the most polarizing topics in contemporary health care. This practice involves a patient voluntarily ending their life with the assistance of a healthcare provider, typically in the context of terminal illness or unbearable suffering [5-6, 8-19]. Across the globe, its legality and moral standing vary, reflecting deep cultural, religious, and philosophical divides [1-5, 8-10, 10-14]. This article aims to discuss and dissect the multifaceted perspectives surrounding Medical-assisted death and Euthanasia MAD-E, examining its ethical underpinnings, clinical application, protocols, domains, and various implications and challenges associated with Medical-assisted death and Euthanasia MAD-E. In the next sections of this paper, we seek to explore and illuminate the intricate global perspectives and considerations that shape this profound aspect of human and medical experience while maintaining a compassionate, constructive, and reflective lens and especially remaining neutral and nonjudgmental of this medical practice.

The moral debate and legislation

Globally, status and attitudes MAD-E are as diverse as they are passionate. The specific clinical applications and conditions for legal MAD-E can vary by country and region.[1–5,19–26] As of the last update of December 2023, countries, and regions with legal MAD-E status include the Netherlands, Belgium, Luxembourg, Canada, Colombia, and the United States.[1–7,19–26] In the United States, however, the legality of MAD-E varies by state. Some states allow it under certain circumstances, while others prohibit it. Switzerland has an unusual position on assisted suicide. Switzerland does not have a nationwide law legalizing euthanasia. However, assisted suicide is not illegal under certain circumstances, and assisted suicide has been

anchored in the penal code in Switzerland since 1942, making it legally condoned and can be performed.[7,20–24] In contrast, many other nations, often influenced by religious or traditional values, staunchly oppose it, viewing it as morally and ethically indefensible.[1–3,7,20–24] The countries which have legalized the practice of MAD-E under rigorous conditions acknowledged and considered the autonomy and dignity of patients suffering from incurable, terminal illnesses. This divergence underscores a broader cultural and legal schism, reflecting differing societal values and healthcare approaches and philosophies.[7,20–23] Over time, the debate around MAD-E has evolved, propelled by evolving societal values, advances in palliative care, and developments in the legal scene.[5–7] Narratives concerning MAD-E shifted from primarily ethical and religious discussions to more comprehensive, nuanced medical and socio-economical debates encompassing patient rights, patient engagement, and the principle of patient-centred care and quality of life and health care responsibilities.[8–19] But also, the financial question and the fair and equitable allocation of financial resources concerning the economic burden that care can generate during continued treatment of patients suffering from incurable terminal illnesses for no meaningful results but, in some cases, more physical and psychological damage and suffering to patients.[1–4,8–12] Notably, in areas where MAD-E is authorized, strict legal frameworks govern its application, ensuring careful legal and medical considerations and respect for the significance of the decision. Interestingly, today, we are witnessing a debate and rise of calls toward consideration of MAD-E.[1–4,20–25]

Certain countries such as the UK and Ireland, which traditionally have been religiously and socially conservative, predominantly Catholic countries, but have adopted social modernization over the last four decades, as have done some European Mediterranean countries such as Spain, France, Portugal, Malta, Italy, Greece, etc. with widely disparate legal codes share social and cultural commonalities concerning MAD-E.[1–5,25,26] Yet, in these countries, there have been ongoing remarkable debates and discussions about changing the law and a call for the consideration and adoption of MAD-E. Australia, New Zealand, Spain, and Portugal passed legislation laying the groundwork for the legalization and adoption of euthanasia in 2021.[3–6] In Norway and Sweden, proponents of PAS have called for a parliamentary inquiry into its legalization, while opponents have highlighted risks and pitfalls.[1–7,20–22] It is not excluded that we may see some of these countries adopting and legalizing MAD-E in the next few years. MAD-E remains widely illegal around the world; most African, Asian, and Middle Eastern countries do not even open debates or have legal provisions on MAD-E.[3–7,20–26] As we already stated, very few countries have strictly adopted this practice, mostly in Europe and North America. Nevertheless, certain countries, such as India and South Africa, have opened the debate on the right to die with dignity, and we may see new countries being added to the list of countries that legalized MAD-E.[3–7,20–26]

Ethical considerations

The ethical perception of MAD-E is profoundly complex. However, justification for MAD-E has been largely based on principalism and mainly the principle of autonomy, or "the right to die".[1–7,20–26] Many authors decry what they see as an outmoded medical paternalism and see MAS-E as an extension of the patient engagement continuum, as a component of a patient-centred care approach, and also as a natural humane response to suffering.[8–19] Central to the debate is the principle of autonomy, respecting a patient's right to choose their fate, especially when facing terminal illness and intractable suffering.[8–19,25,26] Proponents argue that granting a dignified and pain-free end through assisted death is a compassionate response to unbearable suffering.[8–19,25,26] Conversely, opponents cite the sanctity of life principle, viewing MAD-E as an unacceptable breach of the ethical duty to preserve life.[1–19,25,26] Healthcare professionals often find themselves at the crossroads of this ethical quandary. Balancing patient autonomy with the Hippocratic Oath "do not harm" presents a profound moral conflict.[1–19,25,26] Varied personal beliefs and the legal implications in different jurisdictions further intensify this dilemma. Furthermore, the principle of autonomy is not a self-evident, absolute, stand-alone truth. This concept was first introduced as one of four pivotal moral and ethical principles in the medical practice, including beneficence, non-maleficence, autonomy, and justice aimed at shaping a set of norms broadly recognized and valued by individuals who are earnestly engaged in ethical considerations.[1–3,25,26] Ethical frameworks provide diverse lenses through which to view MAD-E.[1–3,25,26] In exploring the ethical dimensions of MAD-E, it is crucial to delve into the philosophical foundations that govern its application. This includes thoroughly examining different ethical theories such as deontology, which emphasizes duty and rules, utilitarianism, which focuses on the greatest good for the greatest number, and virtue ethics, which considers the moral character of the individuals involved. By analyzing MAD-E through these distinct lenses, we can better understand the complex moral landscape it inhabits.[1–3,25,26] For instance, utilitarianism may justify it as a means to reduce overall suffering, while deontological ethics might oppose it on the grounds of intrinsic moral principles.[20–25] Virtue ethics, focusing on character and intentions, could offer a more individualized assessment of each case. This diversity in ethical reasoning reflects the depth and complexity of the issue, necessitating a thoughtful, case-by-case approach supported by an open, multi-disciplined, and without-prejudice ethical framework.[1–3,25,26]

MAD-E domains and clinical applications

In jurisdictions and countries where MAD-E is legal, its application is tremendously subject to strict regulations and specific requirements and conditions to ensure that it is performed in alignment with the ethical guidelines in place of the context and with proper safeguards. Patients must typically meet stringent criteria, including terminal and incurable illness, unbearable suffering, clear, unfailing capacity, and consistent expression of the wish to die.[1–7] The process involves thorough medical evaluations, psychological assessments, committee board bioethical review and, often, mandatory waiting periods.[1–7,25,26] Clinical applications and domains of MAD-E are subject to continuous debate, legal scrutiny, and potential revisions based on societal values and evolving ethical standards and often involve rigorous and specific clinical criteria and administrative procedures.

End-of-life care and terminal illness: Medical-assisted death and Euthanasia (MAD-E) is an end-of-life care service typically considered for individuals suffering from a terminal illness with a prognosis of imminent death. To qualify, the patient's condition must involve unbearable and untreatable suffering. Terminal illnesses include a wide range of diseases and conditions, such as advanced-stage cancer, Amyotrophic Lateral Sclerosis (ALS), AIDS, End-Stage Renal Disease (ESRD), advanced heart failure, advanced pulmonary fibrosis, and certain neurodegenerative diseases like advanced Alzheimer's, Parkinson's, Huntington's, and other severe neurodegenerative illnesses.[1–8] In some contexts and jurisdictions, euthanasia may also apply to severe, resistant, and uncontrollable psychiatric disorders, such as severe mania and schizophrenia.[2]

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Informed consent: The patient must demonstrate unfailing capacity and provide voluntary, well-considered, and informed consent to end their life through MAD-E. This consent must be given by a competent individual free from external pressure or coercion.

Medical supervision: MAD-E is usually carried out under the supervision of medical professionals. The involvement of doctors ensures that the procedure is conducted consistently with medical, ethical, and legal requirements.

Multiple consultations: The process of MAD-E often involves multiple consultations with different healthcare professionals and legal experts to assess the patient's condition and capacity, confirm the diagnosis, and ensure that all legal criteria are met.

Documentation and reporting: Comprehensive documentation review and reporting are typically required to ensure transparency and accountability in applying MAD-E. This includes detailed records of the decision-making process, consultations, and the actual procedure details and specifics.

Age restrictions: Some jurisdictions may have age restrictions for eligibility to MAD-E, and in some cases, minors may not be eligible for euthanasia.

MAD-E application challenges

Applying MAD-E poses various challenges for patients, families, and healthcare providers. These complex challenges often involve ethical, legal, emotional, and psychological considerations. There are some challenges associated with the application of euthanasia that should be considered:

Ethical dilemmas: As we already mentioned, MAD-E raises profound ethical questions related to the sanctity of life, autonomy, and the role of healthcare providers in facilitating the end of life and might be very challenging. Therefore, in clinical settings where MAD-E is legal, the application of MAD-E for some people may pose a challenge to diverse ethical and religious beliefs, leading to conflicting perspectives on the morality of MAD-E.[1–7,25,26]

Informed consent: Ensuring genuine and informed consent for MAD-E from the patient is challenging. Factors such as the patient's mental state, unfailing capacity assessment, potential family influences, and the gravity of the decision require careful consideration.

Patient-centred care challenges: Families may face emotional distress and moral dilemmas when requested to support, engage, or participate in the decision-making process related to MAD-E. Disagreements among family members regarding the decision can sometimes lead to added stress, frustration, and even conflicts.[1–3,9–19] This challenge can be prevented and mitigated according to the approach of patient engagement and patient-centred care, which stipulates that patients' families and their loved ones, through early engagement in the MAD-E process, consulted and informed of the evolution of the patient care process in all its phases including at the end-of-life care and MAD-E.[1–3,9–19]

Healthcare provider challenges: Healthcare providers involved in MAD-E may experience emotional and psychological distress as they navigate their professional duty to provide care while also participating in a procedure that ends a patient's life. This can trigger them to question their own moral beliefs, professional obligations, and the potential legal implications of their involvement. Healthcare providers may also experience the emotional burden of assisting in a patient's death, even when legally and ethically permissible, which can be challenging, necessitating support from health systems. Navigating the legal requirements and ensuring regulation compliance can be complex and overwhelming for healthcare providers. Moreover, healthcare providers may face legal and professional consequences if procedures are not followed properly and precisely according to legal and bioethical guidelines.[1–4,20–23,26]

MAD-E societal and public health implications

Long-term and societal implications: MAD-E remains a controversial topic, and public opinion can vary widely. Healthcare providers, patients, their families, and all parties involved in the MAD-E process may face judgment or stigma from the public, peers, or their professional communities based on simply their involvement in the MAD-E process.[1,7,15–19,24–26] The long-term impact of MAD-E widespread on societal values, perceptions of life, and the doctor-patient relationship might be jeopardized.[10–19] This may affect trust between healthcare users and healthcare providers in certain healthcare system settings and influence how society views the sanctity of life.[24–26] Also, certain concerns about the potential for abuse, coercion, or exploitation of MAD-E as long-term impacts might emerge. Also, striking the right balance between respecting individual autonomy and protecting vulnerable individuals is a persistent and real medical and social challenge.[9–19] Open and effective communication among healthcare providers, patients, and families is crucial. Discussing euthanasia can be emotionally charged and may strain relationships if not handled with psychosocial diligence.[1,7,15–19,24–26]

Public health implications: From a public health perspective, MAD-E raises existential and critical questions. Its impact on overall suicide rates and societal attitudes towards death and dying is a matter of ongoing research and debate within public health institutions. Some fear the normalization of suicide, while others argue for the autonomy and dignity it can provide to those suffering immensely.[1–7,10–13,15–20] An essential element in this discourse is the role of palliative care. Effective palliative care can alleviate suffering, potentially reducing the demand for MAD-E.[22–27] However, its availability and quality vary significantly, highlighting a gap in end-of-life care that needs consideration and addressing. A comprehensive public health approach to MAD-E involves not only clinical, ethical, and legal considerations but also a commitment to continually improving palliative care and mental health services for patients at the end of life.[22–26] The issue of MAD-E is therefore addressed through a participatory approach in which all stakeholders concerned should actively be involved through a holistic continuum which recognizes the complexity of the issue and the need for multifaceted strategies to support patients at the end of life.[9–19]

Conclusion

The debate over MAD-E intertwined with profound legal, ethical, clinical, societal, and public health considerations, calls for continued dialogue and multidisciplinary research. New perspectives emerging from cultural shifts, technological advances, and evolving healthcare paradigms underscore the need for ongoing, nuanced debates. Discussions about MAD-E must be open and bias-free, guided by a robust ethical framework to approach this complex topic respecting human dignity and a genuine commitment to understanding patients' aspirations and multifaceted dimensions of people's end-of-life. Given the complex nature of these challenges, ongoing dialogue among stakeholders, including patients, families, healthcare providers, ethicists, policymakers, and social experts, is essential to address MAD-E concerns and develop guidelines that fairly balance individual autonomy, patient-centred care, and ethics with societal

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values. Finally, as we look towards the future, further research should be undertaken to address the following areas: 1) Cross-cultural ethical analysis; 2) Legal framework and policy analysis; 3) Longitudinal studies on Social Impact; 4) Public opinion and media representation studies.

Ethics approval and consent to participate

As this study involved no human participants, human data, or human tissue, consent was not at issue. As the manuscript does not include details, images, or videos relating to an individual person, consent to publish is not at issue.

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KB and BC organized the paper and developed the main conceptual ideas. EA and NJ collected the relevant data and bibliographic sources. KB and BC processed the writing and editing of the manuscript. KB and BC reviewed and reinforced the paper overview. All authors have read and agreed to the published version of the manuscript.

Conflicts of interest

The authors declared that there are no conflicts of interest.

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