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ETHICAL AND LEGAL ASPECTS OF THE RIGHT TO DIE WITH DIGNITY

ABSTRACT
The issue of euthanasia presents a contact area of ethics, law, and politics. This text provides a contribution to the expert public debate on the introduction of euthanasia into Serbian legislation. It does so first by clarifies the term – *euthanasia* (as a right to die with dignity). Further, it considers the *obligations* of other persons that arise from this right and the conditions under which they present a restriction on *personality rights*. By citing examples from the fields of ethics and law, the text states that the distinction between active and passive euthanasia is in fact a product of inadequate deliberation during the implementation of this differentiation.

KEYWORDS
euthanasia, mercy killing, active euthanasia, passive euthanasia, suicide, responsibility, ethics, law

1. Introduction

The immediate cause for the creation of this text is the Preliminary Draft of the Civil Code of the Republic of Serbia that contains a provision allowing the *right to die with dignity*. It refers to the Article 86 from the first book of the Preliminary Draft which regulates the *personality rights*:

> The right to euthanasia, as a right of an individual to consensual, voluntary, and dignified termination of life, can be exceptionally realized if the stipulated humane, psycho-social, and medical conditions are fulfilled.
>
> The conditions and the procedure for the realization of the right to euthanasia are stipulated by a special law.
>
> The abuse of the right to euthanasia, for obtaining unfounded material or other benefits, represents the basis for criminal liability.
>
> *Note:* Due to the complexity of realization of the right to euthanasia that, apart from legal, has medical, psychological, and social aspects, the Commission[1] shall subsequently definitively declare their stand on the basis of arguments of experts

1 The Commission for drafting the Civil Code was formed on the basis of the Decision of the Government of the Republic of Serbia (the "Official Gazette of the RS", No. 104 from 17th November and 110 from December 2006 - correction) in order to codify civil law and draft the text of the Civil Code.

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> from different fields and professional activities, taking into consideration the proposal of the text of the special law that is prepared after the public debate on the Preliminary Draft. Upon the potential adoption of the proposal, the appropriate amendment of the Criminal Code (*Preliminary Draft of the Civil Code of the Republic of Serbia 2015, Article 86*) would be conducted.

As stated in the *Note*, if this provision is adopted, in the proposed or a different form, it will initiate passing of a special law, which shall regulate the mentioned right in detail, which implies the amendment of the Criminal Code of the Republic of Serbia (the "*Official Gazette of the Republic of Serbia*", No. 85/2005, 88/2005 - corr., 107/2005 - corr., 72/2009, 111/2009, 121/2012, 104/2013, 108/2014, 94/2016, and 35/2019). This definitely refers to the Article 117 of the Criminal Code – "Mercy Killing", in which this crime is punishable by imprisonment from six months to five years (compare Banović, Turanjanin, Ćorović 2018: 237–287).

On the basis of the formulation from the Criminal Code, we can draw two significant conclusions:

1. The right to euthanasia, i.e. the "right to die with dignity" is not considered in detail in the domestic law, that is, the legislator did not take into consideration all aspects of the act for which legal sanctions are envisaged in the Article 117: *mercy killing* is not the same as, for instance, passive euthanasia, and that is why the intention from the Note of the Preliminary Draft of the Civil Code of Serbia is correct, stating the necessity of an opinion of experts in this field;

2. The possibility of imposition of a relatively lenient sentence for *mercy killing*, i.e. a large range between the minimum and maximum stipulated punishment, indicates that the legislator took into consideration that euthanasia is *de facto* implemented in our country, outside the legal framework, and that there are cases in which its implementation is tolerated, because it is the consequence of the will of the patient himself/herself. Particularly for that reason, there is a need for regulating this area that would bring the right to die with dignity into the field of *de iure*.[2]

In this text, we will try to contribute to the expert discussion on the right to die with dignity, primarily by, on the basis of relevant expert literature, indicating at the difference between different forms of *euthanasia*, as well as at the experience of other countries in legal regulation of this area.

On the other hand, we will indicate at the sociological and ethical discussions on euthanasia, which have a significant impact on legal views on the right to die with dignity, being convinced that political, ethical, and legal levels intertwine in this area, more significantly and intensely than when it comes to abortion or the death penalty.

Our assumption is that taking a stand whether the right to die with dignity should be legally allowed primarily implies that the following should be clearly defined: (1) what this right exactly refers to (which form of euthanasia), (2) what the obligations of other persons arising from this right are, and (3) under which

2 More on the difference between euthanasia *de facto* and *de iure* in Keown 2002: 73.

conditions the rights of other persons deny the right (of a patient) to die with dignity, and under which conditions the obligations of other persons, arising from the mentioned right, represent the limitation of their *personality rights*.

2. Types of Euthanasia

The term *euthanasia* originates from Greek and it literally signifies "good death", a peaceful and easy process of dying, devoid of pain and suffering. Gregory Pence says that euthanasia "usually means the killing of one person by another for merciful reasons" (Pence 2015: 31). That means that during euthanasia, the agent of death is not the ill person that is exposed to severe suffering, but the other person. Even in the case when the person that will undergo euthanasia explicitly demanded it to be done, while they were conscious and reasonable, the bare act of taking their life implies a decision and action of another person. That frequently requires an assessment on whether the suffering is severe and unbearable, and whether there is any hope that the condition of the person whose life will be taken can be rehabilitated. Suicide, as opposed to that, implies that the executor is the person that desires to end their own life – even in the cases when that execution requires the assistance of other persons. Then, rational assessment is on the side of the person asking for assistance in order to end their life.

However, Pence's differentiation is hardly applicable to the so-called "borderline cases", such as the one given by Helga Kuhse describing the euthanasia of Mary F. who was injected with a lethal injection at her own request (Kuhse 1991: 295) or the cases presented by Singer when describing Kevorkian's "suicide machine". Taking into consideration these cases, we propose the following conceptual distinction: the term *euthanasia* signifies taking a life of a person that is known to be certain to die in near future, in order to reduce their suffering (with or without their consent), while the term *suicide* refers to the cases in which persons are not directly vitally endangered, but who take their own life single-handedly or with assistance of other persons.

The examples in which terminally ill persons resort to suicide, not to save themselves from severe physical suffering, but to spare their loved ones of worries and financial expenses for treatment and care, requires a supplementation to the previous distinction: in the case of euthanasia (1) the rational assessment of the condition of the patient is made by other persons, regardless of whether the severely ill person directly expressed a wish to end their physical suffering by taking their life, whereas in the case of suicide, the rational assessment and action is always performed by the person wishing to end their life. From that it follows that (2) euthanasia, apart from the ethical, also presents an issue of legal *right* (of the patient, family, or physicians to terminate their life) and that suicide is *par excellence* an ethical issue.

Therefore, in ethics, but also in legal norms of some countries, assisted suicide is not treated as euthanasia, unlike *physician-assisted suicide*, which will be further discussed later.

If euthanasia is neither a *homicide* by the decision of others (family or social community), nor a suicide (from non-medical reasons, or reasons that are not medically objective), that means that euthanasia implies a relation between the will of the person that wishes to die in the situation that can be medically justified, and other persons, which need to contribute to the realization of this decision by their actions or inactions.

When closely determining the term of euthanasia in a modern context, it is necessary to primarily make a distinction between *active and passive euthanasia.*

Active euthanasia implies the administration of medical therapy with the intention of terminating someone's life. By its form, active euthanasia can be direct and indirect. In the first case that implies the shortening of the life of a terminally ill patient by injecting opiate that will drive away the pain and by administering a lethal injection, usually potassium-chloride, which stops the heartbeat (when the patient is already deeply sedated).

In the legislations of many countries, active euthanasia is equal to the criminal acts of murder or negligent homicide. In our legislation, the *Criminal Code of the Republic of Serbia*, Article 118 "Negligent Homicide" envisages the same sanctions for causing the death of another person by negligence as for mercy killing (the Criminal Code of the Republic of Serbia 2019, Article 118). That means that the action of this criminal act is the same as with homicide, with the difference that its subjective feature is the motive of mercy, which causes the different determination of the sanction in comparison to the other acts of life deprivation (Banović, Turanjanin, Ćorović 2018: 237–287).

Indirect active euthanasia implies the termination of life of a patient occurring by the "incidental effect" of a medical treatment, the aim of which is to relieve the pain. Terminal sedation is a form of indirect euthanasia.

At the first glance, indirect active euthanasia can be qualified as negligent homicide. However, the German Medical Association took a clear stand that the quality of life achieved by relieving the pain needs to have an advantage over the quality of life in general (Klajn-Tatić 2007). Although such a determination certainly has in mind the definition of health by the United Nations, the mentioned attitude is taken into consideration during court proceedings in which physicians are tried for bringing their patients into terminal sedation. However, these proceedings are rare, and in many countries, not only in Germany, this type of euthanasia is *de facto* applied, even though it is not approved by positive legal regulations.

Passive euthanasia, on the other hand, implies that the diseased in the terminal phase of the disease is cancelled the treatment that keeps them alive, which after a shorter or longer period leads to death. That implies that patients are not administered food, water, oxygen, artificial respiration, medication, transfusion, or dialysis - without which the patient is not able to survive (Radišić 2008: 145).

This type of euthanasia is allowed in many countries. In our legislation, this type of euthanasia could be sanctioned by the Article 117 of the *Criminal Code of Serbia*, and it could be treated even more severely if there is a suspicion of the existence of the explicit will of the diseased to be treated in this manner.

The degree to which domestic legislation is vague and imprecise when it comes to this type of euthanasia is shown by the obvious discrepancy between the *Law on Patients' Rights* (the "Official Gazette of the Republic of Serbia" No. 45/2013 and 25/2019 - other law) and the *Criminal Code.* Namely, the Article 17 of the *Law on Patients' Rights* takes over the previous provision of the Article 33 of the *Law on Healthcare of the Republic of Serbia* from 2005. The Article 17 of this Law stipulates:

> A patient, capable of reasoning, has the right to refuse the proposed medical measure, even in the case when that measure saves or maintains his/her life.
>
> The competent healthcare professional is obliged to point out to the patient at the consequences of their decision to refuse the proposed medical treatment and to ask for a written statement from the patient that needs to be kept in the medical documentation. If the patient refuses to give the written statement, an official note needs to be made on that.
>
> In the medical documentation, the competent healthcare professional writes the information on the consent of the patient, or their legal representative, to the proposed medical measure, or the refusal of that measure (the Law on Patients' Rights 2019, Article 17).

According to this definition, passive euthanasia is practically allowed, although the stated provision of the *Law on Patients' Rights* actually does not envisage that, by denying treatment, based on the expressed will of the patient, a physician in hospital conditions contributes to the faster lethal outcome (and, thereby, to the shortening of the duration of suffering).

On the other hand, the *Code of Medical Ethics of the Medical Chamber of Serbia* (the "Official Gazette of the Republic of Serbia", No. 104/2016) explicitly prohibits just active euthanasia, permitting in curative procedures, by inaction, according to the will of a patient, acceleration of the lethal outcome, which in a certain way contradicts the provisions of the *Criminal Code of Serbia*. The mentioned definition of euthanasia in the *Code of Medical Ethics of the Medical Chamber of Serbia* will be discussed later in this paper.

Physician-assisted suicide, unlike *assisting in suicide*, can certainly be treated as euthanasia. This type of euthanasia implies the explicit request of the patient to be subjected to lethal treatment, and a physician assists the patient in that, by, for instance, indicating which medical devices will cause a rapid and painless death, or by supplying the mentioned devices. In this case, the patients themselves are the agents of termination of life, but the activities of another person are necessary in order to achieve the deprivation of life, which is why this is a specific form of euthanasia.

Physician-assisted suicide is allowed in Belgium, Switzerland, the Netherlands, Luxembourg, Albania, Colombia, as well as in the American states – Oregon, Montana, and Washington. In European Union, this issue has not been resolved in a unique manner, and the practice is that every country is allowed a margin of appreciation when it comes to euthanasia (Simović, Simeunović-Patić 2017: 317–336).

According to the criminal legislation in Serbia, this type of euthanasia is treated as *incitement to suicide and aiding in suicide:*

1) Whoever incites another to suicide or aids in committing suicide and this is committed or attempted, shall be punished with imprisonment from six months to five years.
2) Whoever assists another in committing suicide under provisions of the Article 117 hereof, and this is committed or attempted, shall be punished with imprisonment from three months to three years.
3) Whoever commits the act specified in the paragraph 1 of this Article against a juvenile or a person in a state of substantially diminished mental capacity, shall be punished with imprisonment from two to ten years.
4) If the act specified in the paragraph 1 of this Article is committed against a child or a mentally incompetent person, the offender shall be punished in accordance with Article 114 hereof.
5) Whoever cruelly or inhumanely treats another who is in a position of subordination or dependency and due to such treatment the person commits or attempts suicide that may be attributed to negligence of the perpetrator, shall be punished with imprisonment from six months to five years (the Criminal Code of the RS, Article 119).

Even though assistance in suicide, which includes the physician-assisted suicide, is connected in the Criminal Code of the RS with "manslaughter" from the Article 115 ("manslaughter in a heat of passion"), it is punishable with a significantly more lenient sentence, although, unlike with "negligent homicide" (Article 118), it involves a *decision* of other person to provide assistance in suicide (which presupposes the assistance of a physician in the described conditions).

By closely defining the term of euthanasia, we have stated that it implies deprivation of life based on the decision of the patient. Scientific discussions, but also legal documents, talk about the distinction between voluntary and involuntary euthanasia.

Strictly observed, both cases involve euthanasia based on the will of the patient, just in the case of involuntary euthanasia, the patient, before losing consciousness or other capacities to express their decision, clearly expressed their desire to be submitted to euthanasia at certain circumstances of the terminal stage of the disease, but the immediate decision, now, based on the will of the patient, needs to be made by someone else, usually a person the patient authorised for that.

However, in legal and medical practice, there are cases in which a patient is terminally ill, with no hope of being cured, and their condition significantly burdens the life of people taking care of them, in the sense of creating severe financial deprivation. And, nevertheless, according to our opinion, the deprivation of life of a patient, without their clearly expressed will stated in the time when that was possible, does not constitute euthanasia, but a form that contains all elements of the criminal act of homicide.

This case, also, needs to be differentiated from the condition occurring in the case of the brain death, when the decision of the family on turning off the devices that keep the patient alive is legitimate and allowed, and within the framework of domestic legislation.

3. Ethical Dilemmas and Their Legal Context

3. 1. Moral Justification of the Patient's Decision

The patient's decision to terminate their life in an active or passive form, due to the terminal condition that is accompanied by unbearable suffering differs from suicide precisely in the matter of the attitude towards the physician, i.e. the person that needs to perform a type of euthanasia.

However, if we just focus on the patient's decision from the position of moral absolutism, we encounter certain dilemmas. Thus, in the Kant's text *Metaphysic of Morals*, in the part discussing suicide (§ 6), taking one's life is considered unacceptable, because in that manner one annihilates "the subject of morality in one's own person" (Kant 1996: 177). In other words, for Kant, the inadmissibility of suicide arises from the fact that the decision on the termination of life opposes to the moral autonomy that separates the humans from the causality chain of nature, giving *dignity* to their existence, i.e. "a life independent of animality and even of the whole sensible world" (Kant 2015: 129), and that means "to root out the existence of morality itself from the world", although it is "an end in itself", as stated in *The Metaphysics of Morals*.

The same as with mutilation, in order to realize certain dispositions that would generate good profit (castration that increases vocal abilities) or in order to sell organs of one's own body, suicide according to Kant supposes a hypothetical imperative, i.e. placement in a state of subordination to an external purpose, which means abandoning the self-purpose *produced* by the practical mind.

Nevertheless, apart from the causality issues accompanying the stated paragraph of *Metaphysics of Morals*, Kant's relation to suicide, if applied to moral justification of the patient's request for undergoing euthanasia, faces a problem indicated by a special medical condition: *dementia*. Demented persons do not dispose with that "value of *intelligence*" of the self-purposeful mind, and they are not capable to rise above the life "independent of animality" with their moral autonomy (Budić 1998). This issue is exacerbated by the fact that a dementia patient is not able to consciously perceive the condition in which they are, and thereby not able to make the stated decision, which raises the issue of permissibility of involuntary euthanasia in that case.

On the other hand, the illness itself, as an expression of natural causality, significantly impacts the mind autonomy that Kant in the *Critique of Practical Reason* calls "intelligence". In the work *The Magic Mountain*, Thomas Mann gives a convincing description of a sick condition, in a monologue of Settembrini: "A human being who is first of all an invalid is *all* body;

therein lies his inhumanity and his debasement. In most cases he is little better than a carcass...” (Mann 1987: 117).

Therefore, what if the nature with its causality has already reduced an ill person to the state of their “animal existence”, if they, suffering unbearable pains, actually do not dispose with moral autonomy, since their condition does not allow any self-regulation, but supposes constant submission to physiological processes, in a vicious circle which one cannot leave?

Understanding life as a value by itself, precisely for the reason it provides *experience*, because it represents the *possibility* of overcoming the factual situation was also developed by Nagel in his deprivation theory:

> First, the value of life and its contents does not attach to mere organic survival: almost everyone would be indifferent (other things equal) between immediate death and immediate coma followed by death twenty years later without reawakening. And second, like most goods, this can be multiplied by time: more is better than less. (Nagel 1970: 74)

Nagel’s attitude is opposed to the mentioned attitude of the German Medical Association, according to which a life without pain is more significant than the mere living. But, can it be claimed, on the basis of that, that the request of a patient to be submitted to euthanasia is morally unacceptable? Can one defend, on the basis of this “objectively” established value of life, the attitude that in the case of a terminal disease, the only justified imperative is the one represented by Dr Rank, one of episodic characters in Ibsen’s play *A Doll’s House*, who considers that every wretched day is still incomparably better than the cessation of every feeling?

The question of moral responsibility of a patient can also be asked in the context of the Christian understanding of “sanctity of life”. If a patient refuses the so-called “disproportionate actions”, such as a painful medical treatment, their decision cannot be characterised as a suicide. In a figurative sense, the refusal to continue the life with the treatment that presupposes pronounced discomfort can be understood as the mentioned “disproportionate action”, according to which, at least when it comes to voluntary passive euthanasia, the patient would be absolved of moral responsibility for such a decision (Kuhse 1991: 299).

According to that, passive euthanasia would be morally allowed, i.e. a patient is not morally responsible if they do not want to undergo a treatment that assumes a significant risk or is uncertain when it comes to its outcomes. Thus, in that sense, the patient actually does not wish to die, but between the offered options chooses “inaction” as the one that would, in their opinion, produce the most acceptable conditions for the continuation of life (even if that involves daily pain and other difficulties). However, it does not mean that it would be morally permissible to refuse the medical treatments that would certainly prolong life and that belong to “proportionate” means.

The issue of euthanasia, however, differs from the issue of suicide by the fact that euthanasia supposes moral relation not only towards self (at least

towards self as towards the other), but also towards the others. In causality issues on the problem of suicide, Kant touches on the area of euthanasia, giving an example of a man bitten by a rabid dog who, aware that it is an incurable disease, commits suicide so as not to bring misfortune to other people in his rabid state (Kant 1993: 223). In a somewhat different context, the question can be raised if the demand of a patient to undergo euthanasia is justified in the case when the patient considers that their condition will cause harm to other people, who they want to spare, i.e. whether this demand can be universalised in this or in a similar context.

In the context of this paper, however, legal and political context of the issue of euthanasia also emerges, arising from ethical dilemmas. Euthanasia implies a role of a physician, regardless of whether they will administer a lethal injection or allow a patient to die. In the deontological context, the *request* from the other person to realise this decision presupposes the use of that person as a *means*, and not as a *purpose*, which implies the denial of their moral autonomy.

The moral right of a physician to decide whether they will act according to the will of their patient, regardless of whether they deal with active or passive euthanasia, is usually overlooked in the legal observation of this issue. Ethically observed, a physician cannot be denied the right to a moral decision, and the action of the patient requiring euthanasia would be morally unjustified in that case. In other words, as shown by libertarian debates, the consent (wish) of the patient, in the narrow sense, is not a sufficient condition for the violation of the *inalienable* right to life, and, in the broad sense, their decision is completely irrelevant, because the justification of euthanasia must be endorsed by an appropriate medical association (McConnell 2000a: 43). Starting from the Locke's distinction between the inalienability of the right to life and the possibility of losing that right, Moser (2017: 449), following in the footsteps of McConnell, considers that a patient cannot "alienate" the said right, although it can be taken away from them under certain circumstances.

Thus, in the legal and ethical context, certain *norms* need to be established, on the basis of which it would be decided on the right or liabilities of the persons expected to actively or passively influence the termination of life of a patient in the terminal stage of an illness.

3.2. Justification of the Patient's Decision

Euthanasia implies that another person causes the death of a patient, for the sake of the patient, i.e. according to their request, in case of a terminal stage of an illness. Passive euthanasia, in that sense, assumes that the patient's life is not ended by, for instance, administering a lethal injection, but that the lethal outcome is accelerated by ceasing or giving up on the administration of a medical treatment.

The fact that medical practice and legal regulations in the world, except in the Netherlands, prohibit active euthanasia and allow the passive one, is mostly based on the conclusion that the first case more directly causes the fatal

outcome. On the other hand, when it comes to giving up on a treatment that would prolong life, in numerous scientific papers, the nature of the illness itself is taken as the agent leading to the lethal outcome. Therefore, withholding, i.e. inaction, is not the direct cause of death, but the illness.

On the basis of that, the prevalent opinion is that active euthanasia is inhumane, because it implies taking someone's life, which contradicts the proclaimed tasks of the medical profession.

However, not only when it comes to the field of ethics, but in the legal context, as well, the distinction between the passive and active euthanasia is entirely problematic. That can be clearly perceived if we take a look at the Article 67 of *The Ethical Codex of the Medical Chamber of Serbia:*

> Deliberate shortening of a life is contrary to medical ethics.
>
> It is forbidden to undertake actions that actively shorten the life of a dying patient.
>
> In the event when the postponing of the inevitable death of a dying patient would present just inhumane prolongation of suffering, a physician can, in accordance with the freely expressed will of the patient capable of reasoning on refusing the further measures for prolonging life, limit the further treatment to efficient alleviation of the patient's suffering (The Codex of Medical Ethics of the Medical Chamber of Serbia 2016, Article 67).

If we keep in mind that the crime of deprivation of life out of mercy implies a certain action, the question arises whether the "refusing the further measures for prolonging life", in the conditions envisaged by the cited article of the *Ethical Codex,* is a certain *action*, and whether the *inaction* can be classified as a type of an *action*.

Namely, the action of a criminal act is in the human behaviour, and the behaviour does not start in the voluntary act (Mrvić-Petrović 2008: 82), but supposes a *decision*, based on the rational connection of an activity or inactivity (action or inaction) with the consequences it causes. Moreover, if there is awareness that the *inaction* would cause a lethal outcome, then it can certainly be classified as active euthanasia.

Furthermore, giving up on the treatment can cause more suffering than active euthanasia, because the patient, deprived of the therapy, is often in a more painful terminal stage, which, although it shortens life, makes their final moments more difficult and unbearable than the condition that preceded it:

> Fixing the cause of death may be very important from a legal point of view, for it may determine whether criminal charges are brought against the doctor. But I do not think that this notion can be used to show a moral difference between active and passive euthanasia. The reason why it is considered bad to be the cause of someone's death is that death is regarded as a great evil – and so it is. However, if it has been decided that euthanasia – even passive euthanasia – is desirable in a given case, it has also been decided that in this instance death is no greater an evil than the patient's continued existence. And if this is true, the

> usual reason for not wanting to be the cause of someone's death simply does not apply (Rachels 1975: 79).

The agent of "withholding" a medical treatment that would prolong life, or of giving up on a therapy that would have the same effect, according to the wish of the patient, is therefore *the other person*, usually a physician or other medical personnel. Thus, the physician's decision to undertake a measure, with the effect of euthanasia (whereby the passive euthanasia is a product of an action, i.e. inaction), is a matter of moral choice – independent of legal assumptions that would justify or sanction these measures. Therefore, in that sense, there is no such a drastic difference between passive and active euthanasia, as it seems at the first glance:

> If a doctor lets a patient die, for humane reasons, he is in the same moral position as if he had given the patient a lethal injection for humane reasons. If his decision was wrong – if, for example, the patient's illness was in fact curable – the decision would be equally regrettable no matter which method was used to carry it out. And if the doctor's decision was the right one, the method used is not in itself important (Rachels 1994: 90).

That withholding the action in medical practice can be understood as action that directly contributes to death is shown by the cases in which the refusal of physicians to perform a medical treatment caused the lethal outcome of the illness. Even if we adopt Rachels's objections, what distinguishes passive euthanasia from the mentioned cases are two significant aspects: the patient's request on one hand, and the terminal condition that gives no hope of the possibility of life prolongation and pain relief on the other hand.

The decision of the patient, in this situation, is initial, i.e. only on the basis of that decision should it come to passive euthanasia, by which it differs from a homicide (which would, for instance, be the refusal to administer adrenalin or corticosteroids to a patient in a state of anaphylactic shock) or from a suicide by the fact that the patient is in the terminal stage of illness that is considered incurable, and there is no hope of enabling the alleviation of suffering in any other way.

The fact that this is also not assisted suicide, in which the agent would be the patient (who would just be allowed to reach the necessary means for a painless termination of life), but the other person, imposes numerous ethical dilemmas.

First of all, there is a question of the patient's adequate assessment of their condition. The patient cannot, except in rare cases, have the record on the severity of their illness. They cannot read and interpret the medical examination findings and do not possess the experience when it comes to the course of the disease, the probability, and expectations regarding its further stages. All this information is provided to the patient by a physician.

If the physician can assume that the communication of the *truth* about the patient's condition and the prospects for the further course of the disease could influence their decision on wishing to continue the medical treatment

that would maintain their life for some time, then the physician actually influences their decision by familiarizing the patient with their condition.

All this speaks in favour of the fact that the communication of the diagnosis can usually play an important role in forming the patient's decision to request the cessation of further treatment, which keeps them alive. In that sense, the patient's decision is not autonomous, but based on certain dispositions that the patient adopts from the physician. If we allow the possibility that a medical error, in case of a misdiagnosis that omits to record a serious illness, would cause the worsening of the illness, because it will lead the patient to ignore the symptoms for a long time, then it is equally likely that communicating an imminent fatal outcome would also affect the patient's reception of their own condition and even their experience of physical ailments.

The previous insight opens three ethically significant questions: (1) in what sense is the opinion of the patient *competent* (since the decision is, at least partially, made under the influence of the physician); what are, actually (2) real intentions of the patient, independently of the medical context that they get from the physician, and (3) is the opinion of the patient even *relevant* during the decision-making, in the sense that it automatically obliges the other person to abide by that decision?

In his criticism of "hard paternalism", Feinberg points at the possibility that a patient renounces their right to life (alienates the right to life) because they are not adequately informed, because they cannot understand the nature of their condition, or because they are in a manner forced to make that decision. Criticising Adam's paternalism, Feinberg clearly indicates at this danger (Feinberg 1977: 240).

Rejecting the paternalistic context, but adopting the aforementioned part of Adams' objection, Feinberg advocates "soft paternalism", the conviction that the *consent* of the patient can be considered valid under certain conditions. That leads to semantic clarification that is based on the difference between "giving consent" and "requesting", but in either case the influence of the physician or family members can play a significant role in the patient's decision.

Although, for Feinberg, certain conditions need to be met for the patient's decision to be considered valid when it comes to active euthanasia, we can apply them here to passive euthanasia, as well, which according to the previous arguments presents a certain type of "activity" with the aim of accelerating the lethal outcome.

The so-called Brock's safeguards that need to be fulfilled in order to claim with certainty that the patient's decision is devoid of abuse, implying that (1) the patient is competent, (2) informed on the intervention, and that (3) their consent is given freely and completely voluntary, present a relatively complex mechanism. Setting aside the legal aspect of this issue, we will focus on the ethical moment of Brock's complex principle on the basis of which the competency of the patient to make the decision on euthanasia can be verified (Brock 1992: 20).

Meeting these requirements not only legally protects the patient, ensuring that the patient makes the decision voluntarily, but also protects the physician, who is then the implementer of the freely made decision. In other words, if this ethical condition is not fulfilled, the action of the physician, whether it is euthanasia or the prolongation of life, would be paternalistic, i.e. it would deny the freedom to the patient of their own moral decision.

However, even if all Brock's safeguards are fulfilled, the question remains what if the terminal illness impacts not the patient's process of reasoning, but their value of judgement. Furthermore, it remains debatable, what the patients actually desires: cessation of pain or other suffering, or termination of life. If the cessation of pain is considered to be the primary aim, then they actually desire to experience painlessness and perceive death as the absence of the feeling of pain. But it is uncertain whether the same patient, at the point when the pain is temporarily stopped, would make the same decision. The time that needs to be allowed to the patient to consider their decision does not need to coincide with the time of stopping the pain (MacIntyre 2004).

Therefore, if this difference is adopted, stating that the patient is actually never competent enough, then moral burden falls on the physician, who should answer the question of whether imminent biological death is inevitable, and whether the suffering to which the patient is exposed can be, in the short time before the lethal outcome, stopped in any other way. In that sense, the decision of the patient, whatever it may be, remains irrelevant. Just as the consent of the patient cannot be sought when they are in shock or semi-conscious state, so in this case it cannot be sufficient. Commenting on the paternalism of Dr Campbell, McConnell indicates at the significance of the physician's decision, considering that the decision of the patient is necessary, but never sufficient:

> The second problematic aspect of Dr Campbell's argument concerns the specific recommendation that he believes follows from the fact that a request for euthanasia is not known to be voluntary. He maintains that in such cases the request should not be followed. Apparently it is permissible to act on the request only if it is known to be voluntary. But this is a very demanding standard, and one that is not at all reasonable in most areas of medicine. If a patient in great pain presents in the emergency room of a hospital and consents to recommended surgery, we do not hesitate to perform the procedure because the pain renders the consent not voluntary. It is question-begging to retort that this case is different from euthanasia because the surgery is obviously rational and in the patient's best interests. For as Dr Campbell rightly concedes, if a patient's pain is irremediable and can be ended only by hastening death, then it may well be rational for that patient to choose to end his or her life (McConnell 2000b: 218–219).

If the request or consent of the patient does not present a sufficient condition for euthanasia, then that means, in ethical sense, that a physician, who is guided by other criteria, also has a certain moral responsibility. That is why the intention of the physician is specially considered as one of the questions in the ethical consideration of the problem of euthanasia.

4. Action and Prediction in Palliative Medicine

Article 68 *The Code of Medical Ethics of the Medical Chamber of Serbia*, stating that the treatment of a dying patient is a medical obligation, in the second paragraph, emphasises that an obligation of a physician is to alleviate physical and mental suffering, that a duty of a physician is to "provide the conditions for dying worthy of a human" (the Code of Medical Ethics of the Medical Chamber of Serbia 2016, Article 68).

However, it is appropriate to ask the following question at this point: if the provision of these conditions for dying with dignity leads to the lethal outcome, is that then active euthanasia, i.e. the criminal act of mercy killing?

The decision on that implies the reconstruction of the physician's motive. However, this only seemingly solves the problem. Namely, a physician can be fully aware of the consequences of their actions, i.e. that the administration of pain relief medications will cause the lethal outcome. Does, in that case, the provision of conditions for dying with dignity, in spite of the awareness of the physician of the possible outcome of this procedure, at the same time signify active euthanasia? If the answer is affirmative, the question remains if this is direct or indirect active euthanasia.

The clarification, necessary to conceive valid legal regulations, presupposes ethical dimension here as well.

When it comes to the negative consequence towards the accident and towards the intention, here we are still in the fields of normative ethics and moral absolutism. However, when it comes to an accident, the ethical context can be perceived only on the basis of the consequence. An accident implies an unintentional event, so its moral value in that sense can be perceived just from the specific consequence, not starting from the cause, that is, from the great premise the practical syllogism is based on.

In an attempt to formulate this difference observed in examples, Quinn suggests that the distinction is made on the basis of the response to the question – *why an action is taken.* If the question is replied with "to" (question: "Why are you pushing a mower?", the answer: "To cut the grass"), then the other consequence can be considered accidental. However, if the direct answer (with "to") is avoided, then the consequence is certainly is not unintentional. Thus, using the well-known example of hysterotomy, when saving the mother implies killing the foetus stuck in the uterine canal, if we ask the doctor "Why are you killing the baby?", they would reply: "It can't be avoided if I want to save the mother" (Quinn 1989: 343), then they reply hides the intention to sacrifice of the foetus, contained in the intention to save the mother. However, when it comes to accident, the question "why" is not followed by a direct reply. Let's say that a physician has an intention to help a patient hasten their death by withholding therapy. However, the cessation of therapy caused a reduction in the patient's suffering, although there was indeed a rapid lethal outcome. The physician did not have the intention to primarily contribute to the end of suffering, because they did not know that the therapy the patient was receiving

paradoxically caused the effects it was supposed to prevent (pain reduction, for instance). Thus, the resulting reduction of pain occurred as a positive side of this procedure; although the intention of the physician was to cause the cessation of suffering by death, it appeared that the accidental cessation of pains accidentally caused peaceful death.

Therefore, the consequentialist explanation some utilitarians resort to does not assess the intention, but the procedure. The intention of the physician that decides to remove the foetus from the uterine canal not intending to kill it, and the physician who consciously does that (with intention) results in the same consequence, which can be morally qualified.

Contrary to the original version of the double effect principle, interpreters who do not start from principles, but from consequences, explain the difference between the direct production of a negative consequence and the "unintended", accidental consequence through the differentiation between the goal and the means. Therefore, it can be qualified as evil when the consequence is negative. However, if evil *is used* in the calculation of types of actions that can achieve a goal, then that is morally justified. For example, the trauma children experience during some medical treatments is negative by itself, but in the context of the achieved goal, which is recuperation, it has to be differently qualified.

The difference between deontological and utilitarian point of view becomes quite obvious if we use examples. Thus, Sophia Reibetanz gives an example of a physician facing a moral dilemma: he has only one dose of a life-saving medicine and two patients, of whom the one who does not receive the medicine will certainly die (Reibetanz 1998: 220). Deontologically observed, if the physician gives the medicine to one of the patients, he indirectly causes the death of the other one, although his action is not the direct cause of death, but the lack of the medicine is. Strictly deontologically, in that case, the physician observed one patient as a means of saving the other (not giving the medicine to one patient enables the saving of the other one). However, according to the utilitarian observation of consequences, the physician acted morally, because he saved one life, which represents the maximum of the positive outcome in the given circumstances.

On the other hand, if the patient is qualified to decide, i.e. if the necessary, but not the sufficient condition is met, and it is their decision to undergo euthanasia, the physician who needs to perform it, in the active or passive sense, also needs to go through the process of ethical decision-making. They can act by applying risky methods for relieving symptoms, but they can also consider that the patient's death is actually the only salvation from the suffering the patient is experiencing.

The difference in the intention, but also in the effect, between the listed cases is obvious. Nevertheless, the principle of double effect cannot in an unambiguous way, i.e. in principle, determine the limit within which the intention to help a vitally endangered patient turns into the intention to kill them. In the palliative medical practice, it is unlikely that we will come across cases when the intention is clearly derived from a principled position. Also, it is hard

to assume that the physician will act absolutely deontologically, and that they will not consider the final outcome, because these two perspectives are actually intertwined. Therefore, the assessment of the final outcome significantly determines the intention, as well, and the intention indicates the possible measures, which should be applied prudently (Hills 2003: 152).

In other words, if the physician should not be governed by the factual condition, but by the imperative of action, which implies at least an attempt to overcome the factual condition, then, the action cannot be morally valued neither on the basis of the deontological principle, nor the expediency of the action.

5. Conclusion: The Rights of Patients and Other Persons

When it comes to the responsibility of the patient, as well as the responsibility of a physician, ethical stands are entangled, as we have tried to show, in antinomies. In that sense:

1. Moral responsibility of the patient cannot be ignored, even though there are conditions (and that can be generally applied), when the patient is not competent or capable of making the decision.
2. However, in that case, the physician also does not have moral responsibility, i.e. their potential responsibility is entangled in antinomies of genus-species relationships, that is, of principles and their concrete actions. Even in the Aristotelian framework, it is possible to imagine a physician who has morally correct normative intentions, but who acts in such a way that it does not lead to their realization, because he/she makes *wrong assessments* (the case of Oedipus);
3. The patient, regardless of their intentions, has the right to life-long medical care, which must not be denied even in the case when they clearly want that (i.e. they must be medically cared for in cases where they are unable to do otherwise, leave the hospital, etc.);
4. The decision on the essential steps in order to reduce the suffering of the patient who is in the terminal stage of an illness always starts from the postulate that the patient is the goal, that is, that they cannot be used as a means to some other goals.

The last two theses show how ethical issues shift to the legal field. It is only then that moral *indecency* transfers into the realm of objective injustice.

The right of choice, thus, does not rest on moral, but on social, political justification. Precisely for that reason, the issue of merciful death represents one of the topics of controversy of opposing political doctrines in Western countries.

The main arbiter, on the basis of which the decision on euthanasia is actually made is the social community, which transfers the problem of moral responsibility to the field of *law*.

Along with writing the extensive *Preliminary Draft of the Civil Code of the Republic of Serbia*, the proposer conceived the basic parts of the future *Law*

on the Right to Die with Dignity, which should resolve numerous dilemmas, some of which we have pointed out in this paper. This has been done before the announced expert public debate, but certain formulations indicate that professional opinions have been consulted, primarily ethicists and physicians.

First of all, the intention of the proposer is to clearly resolve the dilemma posed by the existing laws and regulations, primarily by the *Law on Patients' Rights* and the *Ethical Codex of the Medical Chamber of Serbia.* That is clearly indicated by the working version of the formulation which states:

> In an exceptionally difficult and long-lasting medical, psychological, and social situation of the dying person, on the basis of their clearly, undoubtedly, and freely expressed will, the request on premature termination of life can be accepted in the form of dying with dignity (Working Material on the Draft Law on Dying with Dignity 2018).

Hereby, the *action* of medical personnel is indicated more clearly than in the formulations of the laws and regulations we have discussed in the paper. However, it is necessary to determine the precise criteria for determining the patient's power of judgement in the situation with long-lasting physical and psychological suffering, and, consequently, their *freedom* of expressing their will (i.e. whether the patient truly comprehends that the specific medical treatment will deprive them of their life).

Furthermore, if the said request is *accepted*, the question remains if that explicitly allows active euthanasia, which would be the logical consequence in our opinion. If the patient's wish to end suffering by terminating their life in the terminal stage of an illness is fulfilled, then the right to die with dignity assumes a rapid and effective measure, rather than sluggish, lengthy, and potentially painful methods of passive euthanasia.

On the other hand, this formulation does not specify whether the activity of the premature termination of life is direct or indirect. Although, from a legal perspective, this presents a dilemma that could be resolved to the benefit of direct active euthanasia, which most probably will not happen, due to the insufficiently prepared public opinion.

The point that causes most dilemmas, on the other hand, deals with the formulation on the manner the decision is made on the premature termination of life in the terminal stage of an illness – *who* can make that decision. The Material states:

> In case the dying patient is not conscious, i.e. they "objectively cannot clearly, undoubtedly, and freely express their will to terminate their life by dying with dignity, then such will can be, exceptionally, expressed by their legal representative or other authorised attorney".

Here, of course, it needs to be clarified whether the said legal representative obtained the authorization to decide about that while the patient was conscious and able to freely express their will and whether the terms under which they

can make that decision are clearly specified. Additionally, the question is raised regarding the conditions under which this authorisation will have legal force.

The Material also envisages the fulfilment of certain conditions so that indirect or direct euthanasia could even occur. Those conditions are threefold, and the Material names them as *medical, humane, and social*.

It should be kept in mind that determining the mentioned conditions should, apart from regulating the patient's rights, also regulate the rights of other persons. If the authorised person accepted to make the decision at certain point, it is necessary to establish the basis on which the medical personnel would have the obligation to follow that decision and, thereby, avoid the burden of ethical responsibility (pressure of conscience), which can not only jeopardize the rights of medical personnel to spiritual well-being, but can also be an immediate initiator of illness (due to stress).

That is why the formulation in the Material is definitely incomplete, since the medical criterion implies that "the competent council of doctors of the appropriate speciality, on the basis of medical documentation and direct insight, establishes that in the specific case in the near future there is no hope to achieve healing of the patient or improvement of their health, in spite of using scientific, expert, and practical experience and knowledge of modern medical science."

Collective responsibility prevents abuse, but in a sense, it liberates other persons from moral responsibility. However, a question remains: on the basis of which criteria can it be decided with merit that a condition is medically hopeless?

On the other hand, humane conditions imply that "the dying person is in such psycho-physical state that, due to physical pain and psychological suffering, has become unbearable over a long period of time".

Apart from the medical and humane, the Material envisages that the *Draft Law* cumulatively requires the fulfilment of the third condition, which is named social, "if, owing to long-lasting health and psycho-physical state of the dying person, their immediate family, or the person caring for them, experiences such severe material and social consequences that significantly endanger their material existence or future social position".

Only when all three criteria are fulfilled, on the basis of a written explanation, the competent court, in extra-judicial proceedings, should make a decision on the request for the execution of euthanasia. That means that the burden of responsibility is shared between the medical and judicial authorities. The decision of the court is considered final and enforceable, so the dilemma, which certainly needs to be resolved in the final text of the Law, remains: what if the patient changes their mind in the meantime, or a sudden and unexpected improvement occurs (or the improvement of the material state, which relieves the family or caregivers of the social burden, which the patient had in mind during the directly or indirectly made request for euthanasia).

On the other hand, it is necessary to commend the solution from the Material stating that euthanasia on the basis of the court's decision is conducted

by a team of a team of executors from the medical profession, one of which directly conducts the act of euthanasia and keeps it as a medical secret.

This solution once again speaks in favour of the necessity to clearly indicate, at the introductory parts of the text, that the euthanasia is active, i.e. that the manner of its implementation implies not just indirect, but also direct active euthanasia.

Contrary to the well distributed burden of responsibility, according to which executors from the medical profession share the responsibility with the medical commission that gives its opinion and the court that, in extra-judicial proceedings, approves euthanasia, the solution stating that one executor directly conducts euthanasia (especially if that is direct active euthanasia) presents a weak and insufficiently considered point, because it limits the right to spiritual well-being of that person, who becomes the sole and single agent, faced with the individual whose life they need to prematurely end. It is possible to design the process so that a whole group, or several groups, of certified executors perform this process, in such manner that it remains unknown which of them is the immediate cause of the premature lethal outcome.

The mentioned drafts of legal solutions, of course, will not annul the ethical problems, which seem to remain inevitable when it comes to euthanasia, abortion, cloning, or the death penalty, as contact areas of ethics and law.

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Iva D. Golijan

Etički i pravni aspekti prava na dostojanstvenu smrt

Apstrakt

Problem eutanazije predstavlja dodirno područje etike, prava i politike. U ovom tekstu, koji nastoji da pruži doprinos stručnoj javnoj raspravi o uvođenju eutanazije u srpsko zakonodavstvo, najpre je terminološki jasno preciziran sam termin – eutanazija (kao pravo na dostojanstvenu smrt). Nadalje, u tekstu se razmatra kakve su obaveze drugih lica koje proističu iz ovog prava i pod kojim uslovima obaveze drugih lica, koje proističu iz pomenutog prava, predstavljaju ograničavanje njihovih prava ličnosti. Navođenjem primera iz područja etike i prava, u tekstu se konstatuje da je razlikovanje aktivne i pasivne eutanazije zapravo proizvod neadekvatnog promišljanja prilikom izvođenja ove diferencije.

Ključne reči: eutanazija, ubistvo iz milosrđa, aktivna eutanazija, pasivna eutanazija, samoubistvo, odgovornost, etika, pravo