Euthanasia and Physician-Assisted Suicide

Background Document 2024

The Ethical Committee of the Finnish Medical Association

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Preface

This document has been compiled by the working group established by the Ethical Committee of the Finnish Medical Association as background information for the decision-making processes of the Medical Association concerning euthanasia and physician-assisted suicide. The Supervisory Board of the Finnish Medical Association has initiated this investigation. The working group consisted of the chair of the Ethical Committee, Marjo Parkkila-Harju, member Kalle Mäki and secretary Mervi Kattelus from the Ethical Committee. The background document was reviewed in the Ethical Committee.

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Abstract

The questions about good care at the end-of-life are current and under development. Along with these, there have been repeated discussions about allowing euthanasia and physician-assisted suicide. In its statements and ethical guidelines, the Finnish Medical Association (FMA) has been negative towards the legalization of euthanasia and physician-assisted suicide. There are countries where these actions are allowed. In order to evaluate the basis of the Finnish Medical Association's position, it has been appropriate to do a background study of the arguments presented for euthanasia and physician-assisted suicide and their counter-arguments, the questions of patients approaching death and the treatment available, the legislation of different countries regarding euthanasia and physician-assisted suicide, and how these have worked in practice. In this background investigation, the topic has been examined in the light of human rights, social ethics and medical ethics, and an overview of the views of some key medical associations has been made. A summary has been made of the studies and opinions of the members of the FMA. Similar survey work in the Nordic countries has recently been carried out by the Norwegian Medical Association and Denmark's Det Etiske Råd, and a few years ago by Sweden's Statens Medicinsk-etiska Råd. In the light of the collected material, the prerequisites for euthanasia and physician-assisted suicide as well as possible risks have been evaluated to support the formation of the position of the Finnish Medical Association.

1. Introduction

1.1. Background

The Supervisory Board and the Council of the Finnish Medical Association (FMA; Suomen Lääkäriliitto, SLL) have addressed the issue of euthanasia and physician-assisted suicide multiple times. The FMA conducted surveys among its members on this topic most recently in 2017, 2020, and now in 2023, in collaboration with Tampere University. The Ethical Committee of the FMA has particularly considered this topic during the revision of the “Lääkärin etiikka" (Physician’s Ethics) book, where the related text was also reviewed and approved by the FMA’s Delegate Committee. The Delegate Committee took a stance on this matter in 2016 and 2020, stating that the FMA considers it crucial to ensure the availability of high-quality palliative care and end-of-life care for every patient. The FMA has not supported the legalization of euthanasia or the requirement that physicians, as a professional group, be obligated to perform procedures aimed primarily at hastening the death of a patient (physician-assisted suicide).

When rejecting a citizen's initiative on euthanasia, the Finnish Parliament noted the need for broad public discussion and thorough ethical analysis on the subject. The FMA has also recognized the need to compile material on this topic, particularly from an ethical perspective, to serve as a basis for ongoing discussions. The Council of the FMA has discussed the topic, and as a result, the Supervisory Board has deemed it appropriate to prepare a background report on euthanasia and physician-assisted suicide and related issues for the FMA's discussions and the formation of its stance. The background report has been prepared by the FMA’s Ethical Committee.

The approaching end of life raises many thoughts, questions, and emotions. Illness brings concerns about potential suffering at the end of life. The approach of death is a physical, existential, and psychosocial process, with the value of life being at its core.

Alleviating suffering is a central task of the physician in palliative care and end-of-life care during the end of life. How well can this be done? Is the value of human existence and life measurable in terms of suffering? The highest human right is the right to life, but how does this relate to the right to self-determination? What do the fundamental values of medical ethics say? Can it be considered that existing means of alleviating suffering are sufficient, both for physical, psychological, social, and existential suffering, or is there significant suffering that cannot be substantially alleviated by the available means? What would be the characteristics of such suffering? Would it be justified in such a situation to deliberately end a patient's life so that they would no longer have to suffer? Could ethical and legal frameworks be created for such actions that would not allow misuse or expose vulnerable individuals to these actions? What would happen to the role and ethics of the medical profession, or the doctor-patient relationship, if the intentional killing of a patient or assisting in suicide were allowed? Would patient safety be endangered? What would happen to public trust in healthcare?

1.2. Basic Concepts and Terms

The concepts used to describe treatments and procedures at the end of life are defined here to ensure they are understood precisely. Words have different connotations and ethical content, so it is important how terms are used. It is essential that the terms describe the intention or purpose of the action. A term should be used to describe only one specific intent, to avoid conflicting meanings.[1]

According to the definitions in the "Lääkärin etiikka" (Physician's Ethics) book[2]:

- **Palliative care** refers to comprehensive care aimed at preventing and alleviating suffering and promoting the quality of life for patients suffering from life-threatening or terminal illnesses, as well as their loved ones. It addresses physical, psychosocial, and existential suffering.
- **End-of-life care / hospice care** refers to the care of a dying patient, that is, care for patients approaching death during their final weeks or days. Death is seen as the natural endpoint of life. The goal is neither to prolong nor shorten life but to help the patient live as well as possible until death.
- **Euthanasia** refers to the intentional ending of a patient's life by a physician, at the patient's voluntary and legally competent request, through the administration of drugs.
- **Withholding or withdrawing unnecessary and ineffective treatments** is part of good medical practice. The aim is not to cause the patient's death but to avoid discomfort and the prolongation of the dying process caused by unnecessary treatments.
- **Natural death** occurs when death is caused by the patient's illness, even if the death results from withholding or withdrawing treatment.
- **Physician-assisted suicide** refers to a physician intentionally providing assistance to a person for committing suicide by making medication available, which the person can take themselves, at their voluntary and legally competent request.
- **Assisted suicide** refers to the act in which someone provides assistance to another person to commit suicide.
- **Palliative sedation** refers to the reduction of a patient's consciousness through medication. Sedation can be intermittent, with varying depths, or continuous, particularly in the final stages of life. The goal is to alleviate unbearable suffering that cannot be relieved by other treatments, without hastening the patient's death.
- **Double effect** refers to a situation where a treatment, in addition to its intended therapeutic effect, may have a negative side effect, which may shorten life. For example, a medication may relieve pain but also shorten life.

There are other terms used regarding end-of-life care, which are not standardized, and may be interpreted in multiple ways. Some of these terms may also be seen as euphemisms used instead of established terms to create a more positive image of the procedure. The use of terminology influences how issues are perceived.

When using non-standardized terms, it is advisable to define their content in the context of use. Such terms include:

- **Kuolinapu** (**Aid in dying**) may refer to euthanasia or physician-assisted suicide, or both. It can also be understood to mean end-of-life care where death is not hastened. It can also refer to withdrawing treatment with the explicit purpose of hastening death. The definition of this term was changed by the Finnish language authority (Kielitoimisto) in the fall of 2023 to include the first two meanings, whereas previously it referred to the latter two. The term is often used as a translation of ***assisted death*** (English) and *dödshjälp* (Swedish). In some cases, it is also translated as *assisted dying*.

- **Lääkäriavusteinen lääkkeellinen kuolema (Physician-assisted death through medication)** is an unestablished term referring to both euthanasia and physician-assisted suicide.
- **Lääkäriavusteinen kuolema (Physician-assisted death)** refers to both euthanasia and physician-assisted suicide. This is a synonym to *physician-assisted dying*.
- **Lääkkeellisesti avustettu kuolema (Medically assisted death)** is also an unestablished term. It has been used to refer to a situation where the patient takes a lethal substance themselves. The meaning of "assisted" in the term depends on the context, and without further clarification, it may also be understood to mean euthanasia.

Instead of using non-standardized terms, this report employs established definitions unless the referenced text suggests the use of other terms. Consistent use of established definitions should be encouraged, as otherwise, the diversity of terms may lead to confusion about what is actually meant.

The term **passive euthanasia** should not be used, as it is conceptually contradictory and causes confusion. The term has been used to refer to withholding or withdrawing unnecessary and ineffective treatments. Euthanasia is always an active procedure, so the word passive cannot be attached to it. In euthanasia, death is caused by an active intervention, i.e., medically, and this essential aspect is not included in the word euthanasia in the term passive euthanasia.

In English, the term **non-voluntary euthanasia** is used to describe the termination of a person's life without their consent. This term is also contradictory, as the definition of euthanasia always includes the patient's request. The European Association for Palliative Care (EAPC) states that this is considered murder.[3]

Terms should describe as clearly as possible the intention of the action. From terms describing end-of-life procedures, it should be clear whether the intent is to allow death or to intentionally cause death.[4]

Such emphasis on the importance of intention and its categorization has been made by the British Medical Association (BMA)[5]: *"the BMA believes that there is a fundamental difference between avoiding treatment that cannot provide an overall benefit to the patient and deliberate killing." "…it is not only the nature of an act but the intention, purpose, or objective behind it that is a key factor in end-of-life decisions."*

The Finnish Penal Code contains several terms to describe the intentional termination of human life. The different terms specifically describe the different intentions behind the act.

1.3. The Relationship Between Palliative Care, End-of-life Care, Euthanasia, and Physician-Assisted Suicide

The key international definitions of palliative care and hospice care have been provided by the World Health Organization (WHO)[6], the International Association for Hospice & Palliative Care (IAHPC)[7], and the European Association for Palliative Care (EAPC)[8].

International definitions of palliative care and hospice care do not include euthanasia or physician-assisted suicide. These are explicitly distinguished from palliative care and end-of-life care. Moreover, it has been stated that organizations providing palliative care and end-of-life care should

not be involved in performing euthanasia or physician-assisted suicide. The Finnish Medical Association (FMA) has similarly stated that euthanasia is not a part of healthcare.[9]

In practice, however, in all countries that have accepted euthanasia and/or physician-assisted suicide, the medical profession is responsible for carrying out these processes.

1.4. Core Arguments

1.4.1. General Arguments in Favor of Euthanasia and Physician-Assisted Suicide

Two basic arguments have been presented in favor of allowing euthanasia and physician-assisted suicide, one concerning self-determination and the other concerning unbearable suffering.

- Euthanasia and physician-assisted suicide should be allowed so that individuals can exercise their right to self-determination. The physician should respect the patient's autonomy. Helping the patient to carry out these actions is seen as acting in the patient's best interest and as a compassionate act of doing good.
- It is argued that there is unbearable suffering that cannot be substantially alleviated by other means. The patient should be the one to decide what constitutes unbearable suffering.
- Medical ethics are interpreted in such a way that the principle of alleviating suffering justifies ending life to stop suffering.
- Since individuals are not obligated to live, they should be able to be helped in ending their life voluntarily.
- Euthanasia or physician-assisted death takes away only that part of life that no longer benefits the patient. That part is no longer "worth living" because it includes unbearable suffering and, relatedly, the loss of autonomy and functioning.
- Individuals should have the right to a dignified death without losing their dignity due to illness at the end of their lives.
- The possibility of euthanasia or physician-assisted suicide gives patients a sense of security that they will not have to endure unbearable suffering due to severe illness or accident.
- According to the principle of democracy, reference is made to surveys conducted among citizens, which show that the majority supports the legalization of euthanasia and physician-assisted suicide, and therefore, this should be done. Similarly, reference is made to surveys conducted among physicians, which show a gradual increase in support for euthanasia.
- Euthanasia and physician-assisted suicide should not be prohibited because some oppose them. Those who oppose them should not be allowed to prohibit them for those who do.
- Euthanasia and physician-assisted suicide are not alternatives to good end-of-life care but rather both are needed.
- Since there are countries where euthanasia and physician-assisted suicide are legalized, they could also be implemented in Finland. It is believed that sufficiently precise criteria and safety mechanisms can be defined in legislation and guidelines.

- There is no slippery slope phenomenon where the criteria for euthanasia and physician-assisted suicide expand inappropriately. Rather, there has been a better understanding of them, and accordingly, existing conditions have been applied. Euthanasia has expanded because awareness of euthanasia has increased.

1.4.2. General Arguments Against Euthanasia and Physician-Assisted Suicide

There are several arguments against allowing euthanasia and physician-assisted suicide.

- Euthanasia is not in accordance with medical ethics. The role of the physician is to maintain and promote health, prevent and treat diseases, and alleviate suffering. The physician should do good (beneficence)[10] and avoid harm (primum non nocere / nonmaleficence). Physicians must respect humanity and life in all their actions. Euthanasia and physician-assisted suicide contradict both medical ethics and the physician's role, and the killing of a patient through euthanasia or assisting in suicide has not been seen as justified to alleviate suffering.
- The right to life is a more fundamental right than the right to self-determination. Self-determination is a right that is limited in many ways. It cannot be used to justify taking the life of another person or obligating someone to assist in such an action.
- Life has intrinsic value. Allowing euthanasia and physician-assisted suicide creates a situation where society begins to judge whose life is worth living and whose is not. This diminishes respect for human dignity. Life should not be valued based on suffering.
- Euthanasia or physician-assisted suicide are not autonomous acts because they require the involvement of another person. Therefore, autonomy cannot be the primary justification.
- The criteria underlying euthanasia and physician-assisted suicide, such as "unbearable suffering," cannot be defined precisely enough to build reliable and safe legislation. Research has shown that countries allowing euthanasia or physician-assisted suicide have failed to achieve this.
- The “safeguard criteria” for euthanasia and physician-assisted suicide work only in an ideal world. In practice, assessments based on these criteria lead to errors with fatal consequences: the intentional death of a patient whose life should not have been ended.
- Euthanasia and physician-assisted suicide pose a threat, particularly to vulnerable individuals, such as those with disabilities. They may create social pressure for these individuals to request such actions. The law always sends a social message. Legalization can lead to unpredictable developments and create new problems.
- In countries that have allowed euthanasia and/or physician-assisted suicide, the laws and criteria have been expanded to apply to increasingly new patient groups beyond the original intent, realizing the slippery slope phenomenon. Intentionally caused death becomes a normalized practice.
- Whatever initial criteria are accepted for euthanasia or physician-assisted suicide, there will always be those who advocate for expanding the criteria and who influence public opinion, physicians, and lawmakers in that direction.

- Euthanasia and physician-assisted suicide give society the right to interfere with an individual's life and impose an obligation on the medical profession that is outside the scope of their role. Euthanasia and physician-assisted suicide are not palliative care.
- Palliative care and end-of-life care can address physical, psychological, and psychosocial problems at the end of life quite effectively. There is no need to legalize euthanasia or physician-assisted suicide. Palliative care and end-of-life care are evolving fields that continually adopt new treatment methods to manage previously difficult symptoms, as has happened with palliative sedation.
- Palliative care and end-of-life care should first be brought to an appropriate level in terms of both quality and accessibility, and only then can the need for legalizing euthanasia and physician-assisted suicide be evaluated. Otherwise, euthanasia and physician-assisted suicide might be used to replace palliative care and end-of-life care.
- Against the legalization of euthanasia and physician-assisted suicide, it is pointed out that physicians with special qualifications in palliative medicine and others who work closely with dying patients believe that these practices should not be legalized. Professional expertise is essential.
- The legalization of euthanasia and physician-assisted suicide reduces trust in physicians and healthcare in general and mentally burdens the work of physicians.
- There have been reports of complications in carrying out euthanasia and physician-assisted suicide. In some cases, the patient did not die as expected, instead suffering from complications or, in the case of physician-assisted suicide, may even survive in a problematic state.
- Euthanasia and physician-assisted suicide may take away a phase of life that could have ultimately been meaningful to the individual.
- In all countries that have allowed euthanasia, it remains a crime. The laws only define when it is not punishable. This reveals the nature of the act, which is not fundamentally acceptable.

These arguments include both value-based and practical considerations.[11]

1.5. Task Assignment

This background document has compiled key materials related to questions concerning euthanasia and physician-assisted suicide. The subject is examined both generally and from the perspective of medical ethics, outlining the practices related to these actions, and an evaluation of the arguments supporting different viewpoints.

2. Issues to be Solved Faced by Patients Approaching Death

2.1. Key Medical, Psychosocial, and Existential Issues of Dying Patients

The condition of a patient approaching death can be examined from the perspective of treating underlying diseases as well as addressing psychosocial and existential issues. Palliative care and hospice care take all of these perspectives into account.

Problems at the end of life have been mapped through research. A meta-analysis reviewed patient groups with advanced cancer, AIDS, heart disease, COPD, and kidney disease. The three most common symptoms at the end of life were pain, breathing difficulties, and abnormal fatigue. These symptoms affected more than half of the patients. In total, 11 common symptoms were identified, which were fairly evenly distributed across all these patient groups.[12]

These 11 symptoms were pain, depression, anxiety, confusion, abnormal fatigue, breathing difficulties, sleep problems, nausea, constipation, diarrhea, and anorexia. Some of the diseases in the study sample have a fluctuating course, which means that planning palliative care and transitioning to palliative care must be adjusted accordingly.[13]

Of the somatic problems at the end of life, pain is generally well-managed when the appropriate means are available.[14] Breathing difficulties, along with fears of suffocation, seizures, and central nervous system metastases, pose more significant challenges in treatment. In addition to the diseases mentioned in the study, paralysis symptoms, particularly in ALS/MND patients, can also present major issues.

The *Good Medical Practice* guideline for palliative care and hospice care[15] and the textbook on palliative care (*Palliatiivinen hoito*)[16] describe appropriate treatment methods for these symptoms. The theme issue of the *Duodecim* journal on palliative care also discusses these.[17] When treatment strategies and care plans are established in a timely manner, they enable good palliative and end-of-life care.[18] Disease-specific indicators help in this.

Among patients receiving palliative care, approximately 25% experience diagnosed depression, 10% suffer from anxiety disorders, and about 15% have adjustment disorders. These conditions are more prevalent than diagnosed, even from an existential perspective. For terminally ill patients, depression symptoms are present in approximately 1/3 – 2/3 of cases, and about 1/3 of patients experience anxiety. Mental health issues, such as depression and anxiety, as well as feelings of hopelessness and loneliness, can exacerbate the suffering caused by the approach of death.

Regarding psychosocial issues, when approaching death, concerns arise about letting go of certain aspects of life, anxiety about increasing limitations, and experiences of life's meaning and relationships with others, as well as perhaps unresolved matters in relationships. Existential questions also come to the forefront.

Death can be experienced as an existential threat since it ends a person’s existence from a medical perspective. This can cause existential anxiety, especially if the patient’s worldview and understanding of existence are unclear. Key questions include, ‘what will happen to me at death?’, and ‘what lies beyond death?’ There are effective treatments and forms of support available for psychosocial and existential suffering.[19]

The *Good Medical Practice* guideline for palliative and end-of-life care also outlines treatments for mood disorders, including non-pharmacological options. In addition to therapies, *Dignity Therapy*, which addresses the meaningfulness of life, is one of the available interventions. Psychosocial

support is an essential part of end-of-life care. In hospice settings, volunteers are a significant source of support. There are also individuals who have received special *death doula* training to support those nearing death. A separate guide was created for supporting existential questions.[20]

The presence of family and friends can play a crucial role in how meaningful and dignified the patient perceives their end-of-life experience. They can provide significant emotional support in processing the feelings and thoughts that the approach of death evokes in the patient. Support from healthcare staff to the patient's loved ones and friends is often welcomed, as their own feelings and concerns are also heard and validated.

Palliative sedation is used as symptom management, particularly when other treatments no longer provide the desired relief.[21] The most common reasons for its use include delirium and the associated agitation, shortness of breath, pain, and convulsions. It can also be used temporarily for psychological symptoms, although there is no consensus on its use for this purpose. The depth of sedation is adjusted so that it is not deeper than necessary to alleviate the symptoms. Continuous sedation is used only for patients with a life expectancy of hours or days. When used according to recommendations, palliative sedation does not hasten or delay death but supports the progression of the end of life as peacefully as possible toward natural death.[22] It helps improve the quality of life at the end of life.

The use of palliative sedation varies depending on the level of the care unit. It is possible to use it even at the basic level of care. Internationally, palliative sedation is used in approximately 7–18% of palliative care patients. There are no detailed statistics yet on the use of palliative sedation in Finland.[23]

The Finnish Institute for Health and Welfare (THL) launched palliative care procedure codes in 2022.[24] With the implementation of these codes, data collection will begin, providing a more detailed picture of end-of-life care.

Hospices have encapsulated their experience with end-of-life care in the saying: *"When there is nothing more to be done, there is still much to do."* Experience has shown that, for many patients, the desire for an intentional hastening of death subsides with good hospice care.[25]

2.2. Reasons Behind Requests for Euthanasia or Physician-Assisted Suicide

According to the 2022 statistics of Oregon's oversight body, the reasons behind the requests for physician-assisted suicide that have been carried out are as follows:[26]

1. Less able to engage in activities making life enjoyable (88.8%)
2. Losing autonomy (86.3%)
3. Loss of dignity (61.9%)
4. Burden on family/friends/caregivers (46.4%)
5. Losing control of bodily functions (44.6%)
6. Inadequate pain control, or concern about it (31.3%)
7. Financial implications of treatment (6.1%)

These statistics align with research showing that pain is not the primary reason for requesting physician-assisted suicide, nor are physical symptoms the main concern. Instead, depression, hopelessness, psychological stress, and psychosocial reasons are key factors.[27] A similar statistic is available from Canada.[28]

In the Netherlands, a study was conducted on "unbearable suffering" among patients with an expected remaining lifespan of no more than six months. The results were similar to those described above. The main resource for coping with their situation was described as receiving love and support.[29]

The reasons behind requests for euthanasia or physician-assisted suicide have been analyzed, and attempts have been made to identify characteristics of the individuals making such requests that could help group them.[30] [31]

Meta-analyses have shown that requests for euthanasia are often the result of the interaction of multiple factors, which together create a feeling that one must escape from unbearable suffering. Fears and feelings of losing self-control / connection with oneself are central. This does not necessarily mean a desire for death, but rather a desire to escape an intolerable situation, which could also be achieved if the underlying problems were alleviated. The individual may not see any other options apparent or immediately available to them, leading them to focus on euthanasia as a solution.[32] [33]

Different countries have varying practices regarding which patients are deemed eligible for euthanasia or physician-assisted suicide. The presence of an illness alone does not solely justify these actions; the criteria defined by the country’s legislation must also be met.

The following section describes some key criteria proposed for determining who may be eligible for euthanasia or physician-assisted suicide.

2.3. Problems in Defining and Applying Concepts

In countries that have legalized euthanasia and physician-assisted suicide, legal safeguards are in place to ensure that euthanasia or physician-assisted suicide is carried out only for the groups defined by legislators. These safeguards are based on concepts and assessment criteria that, on one hand, have been seen as subject to interpretation or problematic to implement precisely. These concepts and assessment criteria have been examined in the following sections.

2.3.1. Unbearable Suffering

A key argument for euthanasia and physician-assisted suicide is that there is "unbearable suffering" that cannot be "substantially alleviated." What is "unbearable suffering"?[34] How are the criteria defined, and who determines them? Pain and suffering can be assessed objectively to some extent using pain scales, but the assessment is also significantly based on the patient's own description.[35] It has been noted that it is very difficult to define what constitutes "unbearable suffering."[36] A literature-based meta-analysis did not find a universally accepted definition or criteria for "unbearable suffering."[37]

Elements of unbearable suffering have been considered to include medical factors, psychological and emotional internal factors, as well as interaction-related factors, social and existential factors.[38] These may include not only the symptoms and pain caused directly by the illness, but also for example, frailty of old age, fear of future suffering, functional limitations, negative emotions, feeling of loss of identity or autonomy, exhaustion, loneliness, feeling of being a burden, loss of things that make life enjoyable, hopelessness, and being tired with life.[39] Unbearable suffering includes anxiety resulting from threats to one's existence and integrity.[40]

No country that allows euthanasia or physician-assisted suicide has a precise definition of "unbearable suffering" in its legislation. The responsibility for definition and assessment has been left to the medical profession and supervisory bodies or courts. Therefore, practical problems in defining and interpreting, and the responsibility for solutions, have been left mainly to physicians. This allows for subjective interpretations that may significantly differ from the legislator's intentions.

2.3.2. Essential Alleviation

When suffering can be "essentially alleviated", it is considered that there is no longer a justification for euthanasia or physician-assisted suicide. As with "unbearable suffering". legislations have left open how criteria are to be defined and who determines them. There is no uniform definition for "essential alleviation". Responsibility for defining this has also been left to the medical profession and supervisory bodies where they exist, or ultimately to courts.

Palliative medicine specialists generally agree that pain can be alleviated to a great extent in palliative care.[41] Ultimately, palliative sedation is an effective alleviator of suffering in the final phase of life. Can it be considered to provide "substantial relief"? How many patients truly experience suffering that cannot be essentially relieved?

An issue arises with patients who refuse adequate treatment that would substantially alleviate their symptoms and suffering. Should such suffering, caused by a refusal of treatment, be considered a legitimate reason for euthanasia or physician-assisted suicide?

2.3.3. Terminal Illness

Many slowly progressing diseases eventually lead to death and are recorded as the cause of death. However, it is challenging to determine which diseases could justify euthanasia or physician-assisted suicide on this basis. Some diseases, such as type 1 diabetes, can with good treatment be managed to achieve remission or a condition where the disease is no longer life-threatening.

2.3.4. Imminent Death

Diseases can be statistically predicted in terms of their likely timeline to death. However, even statistically, there can be significant variation. Practice has shown that it is difficult to predict individual outcomes due to this variation.

In Oregon, 3–10% of patients approved for physician-assisted suicide lived longer than the below six-month life expectancy for the procedure expected. Thus, they were erroneously granted the right to the procedure.

2.3.5. Decision-Making Capacity

A general requirement for euthanasia and physician-assisted suicide is the patient’s decision-making capacity. This usually also requires adulthood, although there are exceptions. Severe illnesses are generally considered to impair decision-making capacity. Especially with psychiatric illnesses, it is very challenging to assess decision-making capacity, as is with dementia patients, too. How is the line drawn between suicidal tendencies and a request for euthanasia or physician-assisted suicide that meets the criteria? For minors, it is particularly difficult to assess whether a child is mature enough to make an informed decision. Can a surrogate decision-maker even be appropriate in such cases?

2.3.6. Is the Decision Based on One's Own Will?

In many countries, euthanasia or physician-assisted suicide must be requested in writing, and the request must be repeated. This is intended to ensure that the request reflects the patient's own will. On the other hand, it has been noted that societal expectations affect people's will. If a person feels like a burden to others, they may consequently request the intentional ending of their life. This is, according to Oregon's statistics, one of the main reasons for requesting physician-assisted suicide. But is this truly what the patient ultimately wants? It has been acknowledged that it can be difficult to assess how independent and genuine a patient's request is. Is an advance euthanasia directive, similar to an advance healthcare directive, justified? What if a person changes their mind after losing legal capacity?

2.3.7. Is the Decision Based on Informed Consent?

Physicians evaluating a request for euthanasia may not necessarily be required to have expertise in palliative care. Nevertheless, they have an obligation to inform the patient about palliative care possibilities and symptom relief that can be achieved with it. How is the patient's right to informed decision-making guaranteed if the receiving physician does not have knowledge of all treatment possibilities? Not all countries necessarily require consulting physicians to have specialist knowledge. It has been pointed out that a patient can make an informed decision only if they have been offered all available options for alleviating their symptoms and have access to those options.[42] [43]

2.3.8. Can the Terminology be Defined with the Precision Required by Legislation?

A significant problem is how to monitor and regulate a law based on concepts like "intolerable suffering" and the absence of "substantial alleviation" when these terms are not precisely defined in legislation. The ambiguity of the other aforementioned assessments and definitions leads to similar problems.[44]

From a legal standpoint, the question is whether laws, regulations, and other instructions and safeguards, such as assessments and professional standards, can ensure patient safety in such a way that errors do not occur. This is particularly important because it concerns the intentional causing of death, and mistakes cannot be corrected afterward.

When life and death are at stake, the Finnish Constitution requires precise regulation. For the core concepts and assessments used as the basis for euthanasia and physician-assisted suicide, the precision required by the Constitution has not been demonstrated to exist.

2.4. The Spectrum of Diseases in Oregon among Those Who Opted for Physician-Assisted Suicide

Here, as an example, are statistics from the U.S. state of Oregon for 2022 on the diseases that patients had when they used prescription medications to end their lives.[45]

Characteristics	2022 (N=278)		2021 (N=255)		1998-2020 (N=1,921)		Total (N=2,454)	
	N	(%)[1]	N	(%)[1]	N	(%)[1]	N	(%)[1]
Underlying illness								
Cancer	**178**	**(64.0)**	**158**	**(62.0)**	**1,420**	**(73.9)**	**1,756**	**(71.6)**
Lip, oral cavity, and pharynx	6	(2.2)	3	(1.2)	41	(2.1)	50	(2.0)
Digestive organs	45	(16.2)	36	(14.1)	378	(19.7)	459	(18.7)
Pancreas	*16*	*(5.8)*	*9*	*(3.5)*	*125*	*(6.5)*	*150*	*(6.1)*
Colon	*5*	*(1.8)*	*8*	*(3.1)*	*98*	*(5.1)*	*111*	*(4.5)*
Other digestive organs	*24*	*(8.6)*	*19*	*(7.5)*	*155*	*(8.1)*	*198*	*(8.1)*
Respiratory and intrathoracic organs	32	(11.5)	24	(9.4)	303	(15.8)	359	(14.6)
Lung and bronchus	*31*	*(11.2)*	*23*	*(9.0)*	*284*	*(14.8)*	*338*	*(13.8)*
Other respiratory and intrathoracic organs	*1*	*(0.4)*	*1*	*(0.4)*	*19*	*(1.0)*	*21*	*(0.9)*
Melanoma and other skin	0	(0.0)	5	(2.0)	44	(2.3)	49	(2.0)
Mesothelial and soft tissue	7	(2.5)	6	(2.4)	34	(1.8)	47	(1.9)
Breast	13	(4.7)	12	(4.7)	129	(6.7)	154	(6.3)
Female genital organs	17	(6.1)	15	(5.9)	106	(5.5)	138	(5.6)
Prostate	14	(5.0)	16	(6.3)	89	(4.6)	119	(4.8)
Urinary tract	6	(2.2)	9	(3.5)	54	(2.8)	69	(2.8)
Eye, brain, central nervous system	14	(5.0)	5	(2.0)	59	(3.1)	78	(3.2)
Brain	*14*	*(5.0)*	*5*	*(2.0)*	*53*	*(2.8)*	*72*	*(2.9)*
Eye and central nervous system	*0*	*(0.0)*	*0*	*(0.0)*	*6*	*(0.3)*	*6*	*(0.2)*
Thyroid and other endocrine	0	(0.0)	1	(0.4)	7	(0.4)	8	(0.3)
Ill-defined, secondary, and unspecified sites	8	(2.9)	6	(2.4)	50	(2.6)	64	(2.6)
Lymphoma and leukemia	9	(3.2)	16	(6.3)	86	(4.5)	111	(4.5)
Other cancers	7	(2.5)	4	(1.6)	40	(2.1)	51	(2.1)
Neurological disease	**27**	**(9.7)**	**35**	**(13.7)**	**207**	**(10.8)**	**269**	**(11.0)**
Amyotrophic lateral sclerosis	15	(5.4)	22	(8.6)	146	(7.6)	183	(7.5)
Other neurological diseases	12	(4.3)	13	(5.1)	61	(3.2)	86	(3.5)
Heart/circulatory disease	**32**	**(11.5)**	**29**	**(11.4)**	**105**	**(5.5)**	**166**	**(6.8)**
Respiratory disease [e.g., COPD]	**27**	**(9.7)**	**19**	**(7.5)**	**109**	**(5.7)**	**155**	**(6.3)**
Endocrine/metabolic disease [e.g., diabetes]	**4**	**(1.4)**	**5**	**(2.0)**	**19**	**(1.0)**	**28**	**(1.1)**
Gastrointestinal disease [e.g., liver disease]	**4**	**(1.4)**	**3**	**(1.2)**	**17**	**(0.9)**	**24**	**(1.0)**
Infectious disease [e.g., HIV/AIDS]	**2**	**(0.7)**	**0**	**(0.0)**	**14**	**(0.7)**	**16**	**(0.7)**
Other illnesses	**4**	**(1.4)**	**6**	**(2.4)**	**30**	**(1.6)**	**40**	**(1.6)**

Oregon Death with Dignity Act, Data Summary 2022 Table 1

3. The State of End-of-Life Care in Finland

3.1. Development of Palliative and End-of-Life Care

The Ministry of Social Affairs and Health (STM) has played a central role in the development of overall framework for end-of-life and palliative care.[46] In 2016, STM established an expert working group, which in 2017 published recommendations for organizing palliative care and end-of-life care.[47] According to the report, approximately 30,000 people in Finland need palliative care at the end of life each year, and even more require it at earlier stages of illness. The primary illnesses requiring this care include cancers (accounting for 40% of cases), as well as advanced heart, lung, kidney, and liver diseases, neurological disorders, and memory disorders.

In response to the Finnish Parliament's mandate, STM established another expert working group in 2018, tasked with addressing end-of-life care, self-determination, hospice care, and the legislative needs surrounding euthanasia.[48] STM also established a sub-working group for the development of palliative care and end-of-life care.

This sub-working group, acting as a palliative care expert group, conducted a survey of the state of end-of-life care and palliative care and produced an interim report in 2019 with suggestions for improving the quality and availability of these services.[49] In its final report in 2019, the group made a key recommendation to establish a national care organization model for palliative and end-of-life care, as well as setting quality criteria for various levels of care.[50]

Following this, the Finnish Institute for Health and Welfare (THL) initiated the *Palliative Care and End-of-life Quality Information* project. The aim of this project was to define the necessary information and data sources for monitoring the quality of palliative and end-of-life care and to make suggestions for the required data collection. The project resulted in the production of national quality recommendations for end-of-life and palliative care by the palliative care expert group in 2022.[51] [52] THL maintains up-to-date information on organizing[53] and developing[54] palliative care on its website.[55]

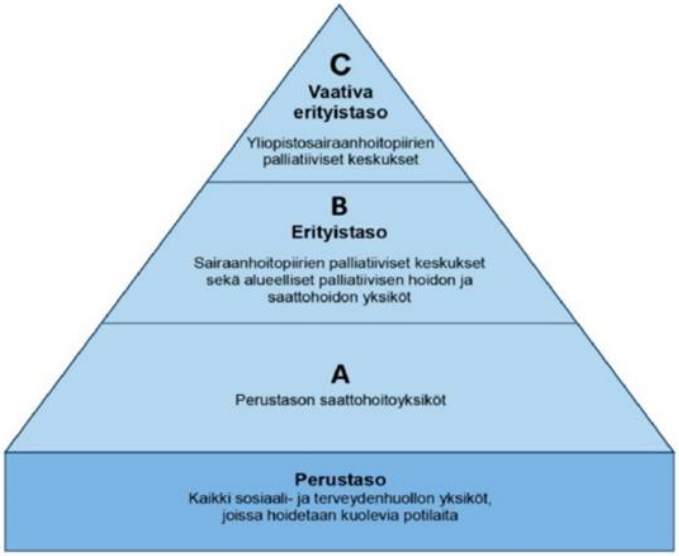
Palliative care and hospice care have developed rapidly in recent years. The cornerstone of this development has been the creation of a three-tiered care system, the establishment of care pathways, the formation of palliative care centers, and the growth of home hospital services. This care system has been built based on recommendations, but its progress is competing for resources within regional healthcare systems.

The legislative changes recommended by STM's expert working group on end-of-life care have not yet been implemented at the legislative level. These changes would secure the status and further development of palliative care. The construction of the palliative care and end-of-life care system is still ongoing. Progress has been made in education through the EduPall project.[56]

The discipline of palliative medicine has been established at Tampere and Helsinki, and palliative care education has been integrated into the curriculum at all five medical faculties for undergraduate students.

A textbook on palliative care[57] has been published, and the Good Medical Practice guidelines for palliative care and end-of-life care has been developed.[58]

Kuvio 1. Palliatiivinen hoito ja saattohoito toteutetaan perustason lisäksi kolmella eri tasolla: A – alueelliset perustason saattohoidon yksiköt kuten terveyskeskussairaaloiden saattohoitopaikat, B – erityistason palliatiivisen hoidon keskukset ja kotisairaalaverkosto ja C – yliopistosairaan vaativan erityistason palliatiiviset keskukset (Saarto ym. 2019b).



Palveluketjun keskiössä ovat palliatiiviset erityistason kotisairaalat. Kotisairaalat tukevat perustason yksiköitä, joihin kuuluvat myös sosiaalitoimen ikääntyneille ja vammaisille henkilöille tarkoitetut palvelut, psykiatrisen hoidon ja/tai asumisen tukea tarvitsevien henkilöiden asumispalvelut ja pitkäaikaissairaalahoidossa olevat psykiatriset potilaat. Palliatiiviset erityistason kotisairaalat toimivat siltana perus- ja erityistason yksiköiden välillä. Palliatiiviset kotisairaalat vastaavat kotisaattohoidosta. Palliatiivisiin keskuksiin perustetaan erityistason avohoidon poliklinikat ja vuodeosastot / saattohoitokodit. Keskukset vastaavat 24/7 konsultaatiotuesta (Kuvio 2.).

Figure 1

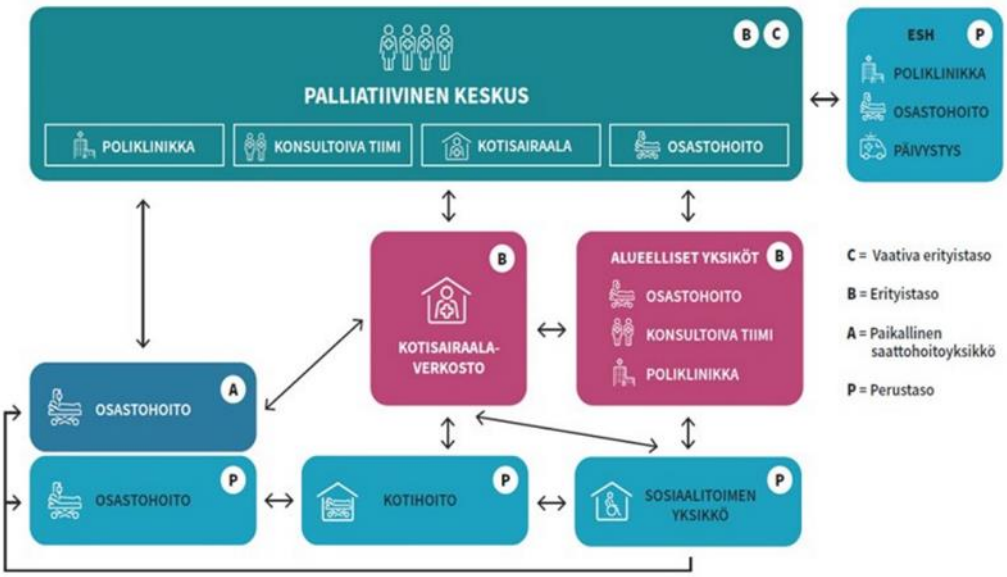
Palliative care and end-of-life care are implemented at three different levels in addition to the basic level: A - regional basic level end-of-life care units, such as hospice beds in health center hospitals, B - specialized level palliative care centers and home hospital network, and C - university hospital palliative centers of demanding specialized level (Saarto et al. 2019b)

Figure 2

At the heart of the service chain is the palliative care home hospital network, which supports the basic units in the area and operates under the guidance of the palliative care center (Saarto et al. 2019b).

Figure 1 and 2. STM: Elämän loppuvaiheen asiantuntijatyöryhmän raportti. STM 2021:3

Kuvio 2. Palveluketjun keskiössä palliatiivisen hoidon kotisairaalaverkosto, joka tukee alueen perustason yksiköitä ja toimii palliatiivisen keskuksen ohjauksessa (Saarto ym. 2019b).



3.2. The Importance of Palliative Care and End-of-Life Care

Research shows that good end-of-life care significantly reduces patients' requests for intentional hastening of death through euthanasia or physician-assisted suicide. In Oregon, shortly after physician-assisted suicide was legalized, a study was conducted to investigate how the palliative care measures received by patients influenced their attitudes towards requesting physician-assisted suicide. Among those who had requested physician-assisted suicide and then received at least one type of essential palliative care for their symptoms, nearly half (46%) changed their minds and no longer wished to pursue physician-assisted suicide.[59]

Similarly, a study on cancer patients revealed that poor-quality care correlated with increased interest in euthanasia. This also indicates that receiving high-quality palliative care reduces the desire for euthanasia.[60]

Proponents of euthanasia and physician-assisted suicide argue that, even when palliative care is of high quality, there will always be individuals whose suffering is unbearable, and who therefore would need the intentional termination of their life.

Those who are critical or cautious about euthanasia and physician-assisted suicide argue that there are treatment options within palliative care and end-of-life care that, when applied correctly and sufficiently, work effectively. In such cases, there is no need to intentionally end a patient's life.[61]

A group of physicians with special expertise in palliative care, who are key players in the palliative care offered in university hospitals, sent an open letter to members of the Finnish Parliament during the processing of the euthanasia citizens' initiative. In the letter, they stated: *"Hospice care has the potential to manage even severe suffering if all available options are accessible to all citizens."*[62]

With a living will, a patient can express how they wish to be treated in critical situations or at the end of life when they are no longer able to express their wishes. In a living will, a person can state that they do not want life-prolonging treatments if they would only prolong suffering without the hope of recovery. Advance directives are binding for doctors and other healthcare personnel. Through a living will, patients can alleviate fears that their end-of-life care preferences will not be respected. The directive can be changed at any time.[63]

Finland's National Advisory Board on Social Welfare and Health Care Ethics (ETENE) believes that the need for euthanasia can only be assessed after ensuring that hospice care across the country is brought to an appropriate, high level.[64]

4. Human Rights and Social Ethics

4.1 Human Rights Conventions

Human rights are fundamental rights that protect humans and human life. They are universal, inalienable, and indivisible, presented as value-based norms. Human rights are in force regardless of whether an individual invokes them. No one can nullify or revoke human rights, not even with the individual's own consent.[65]

Human rights are described in international human rights conventions, the most important of which are the United Nations (UN) *International Covenant on Civil and Political Rights* (ICCPR)[66], the *International Covenant on Economic, Social, and Cultural Rights* (ICESCR)[67], and the UN *Convention on the Rights of Persons with Disabilities* (CRPD)[68]. In Europe, the key document is the *European Convention on Human Rights* (ECHR) and its additional protocols.[69] Finland has ratified these UN conventions, the European Convention on Human Rights, and the *Council of Europe's Convention on Human Rights and Biomedicine.*[70] [71]

4.2 The Right to Life and Self-Determination

According to the main international human rights conventions, the right to life is a human right that serves as the foundation for other human rights. States that have committed to these agreements are obliged to secure and protect this fundamental right through legislation and other means. The realization of this right indicates a commitment to respecting human dignity. The right to life does not mean maintaining life for as long as possible but ensuring a dignified life.[72]

The UN International Covenant on Civil and Political Rights states in Article 6: *"1. Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life."* It is significant that the right to life is described as an inherent right, which is not stated about other rights. The dignity of life is intrinsic and not defined by circumstances.

The right to life is explicitly mentioned in Article 2 of the European Convention on Human Rights: *"1. Everyone's right to life shall be protected by law. No one shall be intentionally deprived of his life..."* This same issue is stated in Section 7 of the Constitution of Finland: *"Everyone has the right to life, personal liberty, integrity, and security."*

The right to self-determination is a fundamental right also protected by international human rights conventions, and it is also safeguarded in many ways by the Finnish Constitution. One of the key principles of the Patient Act is to support the patient's right to self-determination, although the patient cannot directly demand specific procedures be performed on them.

The European Court of Human Rights' decisions on respecting self-determination are primarily based on Article 8 of the European Convention on Human Rights: *"1. Everyone has the right to respect for his private and family life, his home, and his correspondence."*

A key question concerning euthanasia is whether the right to self-determination can override the duty to protect human life. Does a person have the right to decide about their death to the extent that they can request someone else to assist them in ending their life or carry out that act? This has been described as the "right to die." Self-determination is not an absolute right; it is restricted by legislation in various ways. Self-determination can only be realized when balanced with other rights, which may take precedence.

From the perspective of prioritizing human rights, it has been argued that protecting life is such a fundamental human rights principle that it should not be abandoned, even in favor of self-determination.[73] On the other hand, it has also been stated, for example, by the German Federal Constitutional Court, that no one is obliged to live.[74]

Philosopher Immanuel Kant argued that using self-determination to end one's own life destroys self-determination itself. He considered this contradictory, illogical, and a negation of self-determination as a human value, thus deeming it immoral.[75] [76]

4.3 The European Court of Human Rights

The European Court of Human Rights (ECHR) delivers rulings on cases concerning the European Convention on Human Rights. The court has stated that the right to life is the highest of all fundamental rights:
"The right to life is an inalienable attribute of human beings and forms the supreme value in the hierarchy of human rights."[77]

In the case of *Pretty v. the United Kingdom* (No. 2346/02), the ECHR ruled that from Article 2 of the European Convention on Human Rights cannot be derived *"right to die"* either with the help of another person of a public authority.[78] The court also stated that the view expressed in the Council of Europe Parliamentary Assembly Declaration 1418 (1999) supports this. The court found that the legal prohibition on assisting suicide served the legitimate aim of protecting vulnerable individuals. The prohibition on assisting suicide justified limiting the right to self-determination:
" Article 2 cannot, without a distortion of language, be interpreted as conferring the diametrically opposite right, namely a right to die; nor can it create a right to self-determination in the sense of conferring on an individual the entitlement to choose death rather than life. The Court accordingly finds that no right to die, whether at the hands of a third person or with the assistance of a public authority, can be derived from Article 2 of the Convention."

The ECHR has stated in its decision (*Haas v. Switzerland 31322/07*) that states are not obliged to create the conditions for physician-assisted suicide, i.e. an individual does not have a "right to die". At the same time, the ECHR has stated that states have exercised a wide margin of appreciation in the European Convention on Human Rights issues of protection of life (Article 2) and the right of an individual to end their own life (Article 8), although most states still emphasize the protection of life.[79]
"Council of Europe member States were far from having reached a consensus as regards the right of an individual to choose how and when to end his life."
"The vast majority of member States, however, appeared to place more weight on the protection of an individual's life (Article 2) than on the right to end one's life (Article 8). The Court concluded that the States had a wide margin of discretion in that respect."

The role of the European Court of Human Rights has evolved to secure certain minimum requirements for the realization of human rights and to set standards for this.[80]

The ECtHR has for the first time had to take a direct position on the relationship between euthanasia and the European Convention on Human Rights in its judgment Mortier v. Belgium 78017/17.[81] The ECtHR has stated that although Article 2 of the European Convention on Human Rights cannot be interpreted as a right to die, the right to life it guarantees cannot be interpreted as such as an obstacle to the conditional decriminalization of euthanasia.

The judgment states that the UN Human Rights Committee has taken a similar position, as long as the legislation contains sufficient safeguards to ensure that the action is based on the patient's free, informed, precise and unambiguous decision, made without pressure or abuse. The official summary of the case states[82]:
"The right of an individual to decide how and when his or her life should end was one aspect of the right to respect for private life. The decriminalisation of euthanasia was intended to give individuals a free choice to avoid what in their view might be an undignified and distressing end to life.

While it was not possible to derive a right to die from Article 2, the right to life enshrined in that provision could not be interpreted as per se prohibiting the conditional decriminalisation of euthanasia."

In the same decision, the ECtHR also stated that although Belgian law was not actually violated in the case, and the legislation was not found to be deficient (voting result 5–2), the actions of the Belgian Euthanasia Supervisory Commission did not meet the requirements of Article 2 of the European Convention on Human Rights on the protection of human life, nor did the actions of the Belgian judiciary.

Belgium was found to have breached its duty of care[83] by having a member of the euthanasia monitoring committee who had himself performed euthanasia and then was on the monitoring committee deciding whether the act was in accordance with the regulations. It was also found that special safeguards should be implemented when psychiatric criteria are used. Belgian legislation has been found to be indeterminate in the rules according to which violations of euthanasia legislation are punished.[84]

4.4 The Parliamentary Assembly of the Council of Europe

The Parliamentary Assembly of the Council of Europe is a key institution that sets guidelines for social ethics. Its decisions are not legally binding. It drafted the European Convention on Human Rights.

The Parliamentary Assembly of the Council of Europe condemns euthanasia (Resolution 1859 (2012)).[85]
*"Euthanasia, in the sense of the intentional killing by act or omission of a dependent human being for his or her alleged benefit, must always be prohibited***.**"

It has also taken a separate negative position on euthanasia of children in its statement on Belgian euthanasia legislation (Written declaration 567(2014), doc. 13414).[86]

The Parliamentary Assembly of the Council of Europe does not consider a medical will that includes euthanasia or physician-assisted suicide to be valid (Resolution 1418 (1999), doc. 9404).[87] The declaration requires the recognition that the wish of a terminally ill patient to die never constitutes a legal obligation for another person to carry it out, nor does the wish provide legal justification for carrying out procedures that intentionally cause death.
"9 c. by upholding the prohibition against intentionally taking the life of terminally ill or dying persons, while:

1. recognising that the right to life, especially with regard to a terminally ill or dying person, is guaranteed by the member states, in accordance with Article 2 of the European Convention on Human Rights which states that "no one shall be deprived of his life intentionally";

2. recognising that a terminally ill or dying person's wish to die never constitutes any legal claim to die at the hand of another person;

3. recognising that a terminally ill or dying person's wish to die cannot of itself constitute a legal justification to carry out actions intended to bring about death."

These decisions of the Parliamentary Assembly of the Council of Europe show that the European Court of Human Rights' interpretations of the European Convention on Human Rights do not correspond to the protection of respect for human life that the Parliamentary Assembly of the Council of Europe, which drafted the European Convention on Human Rights, would like it to be.

The key decisions of the European Court of Human Rights regarding physician-assisted suicide and euthanasia and the interpretation of human rights have been described[88] and evaluated in several publications and reports.[89] [90] [91]

Since each country has its own constitution and moral concept, this is also reflected in the decisions of the European Court of Human Rights in that it has not sought to fully harmonize the practices of states. States have been left with their own discretion.[92]

5. Country-Specific Legislation

5.1 Finnish Legislation

In Finnish legislation, euthanasia is not permitted. Assisting in suicide is not strictly prohibited, but the legal status of such an act is unclear. Healthcare personnel have a special responsibility to protect individuals under their care based on statutory principles, so legal consequences for such actions are likely.

The most important Finnish laws to be evaluated in the examination of euthanasia and physician-assisted suicide are listed below.

5.1.1 The European Convention on Human Rights (63/1999)[93]

Particularly Article 2 (Right to life) and Article 8 (Right to respect for private and family life).

Article 2
"Right to life:

1. *Everyone's right to life shall be protected by law. No one shall be intentionally deprived of his life, except in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law."*

- **Article 8**
"Right to respect for private and family life:

1. *Everyone has the right to respect for his private and family life, his home, and his correspondence.*
2. *There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety, or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others."*

5.1.2 The Constitution of Finland (11.6.1999/7319)[94]

In particular, Chapter 2 Fundamental Rights 7§

7§ Right to life, liberty and security of person

Everyone has the right to life, liberty and security of person.

No one shall be sentenced to death, tortured or otherwise treated in a manner that violates human dignity.

No one shall be deprived of his or her personal integrity or liberty arbitrarily or without a basis provided for by law. A penalty involving deprivation of liberty shall be imposed by a court. The legality of other deprivations of liberty may be reviewed by a court. The rights of a person deprived of his or her liberty shall be protected by law.

5.1.3. The Reasons for the Constitutional Reform

Perustuslakivaliokunnan mietintö n:o 25 hallituksen esityksestä perustuslakien perusoikeus-säännösten muuttamisesta (Report No. 25 of the Constitutional Law Committee on the government's proposal to amend the fundamental rights provisions of the constitution)**. 1994 vp-PeVM 25-HE 309/1993 v**[95]

In the 1994 fundamental rights reform, the Constitutional Law Committee of Parliament defined the provisions by which citizens' fundamental rights may be interfered with: Provisions restricting fundamental rights must be at the level of law, not in lower-level provisions such as decrees. Legal texts must be precise and sufficiently sharp-edged, and they must ensure the legal protection of the person subject to the measures. Measures must always be proportionate to the matter or legal interest pursued (principle of proportionality) and socially acceptable. Restrictions must be necessary to achieve an acceptable purpose. A restriction of a fundamental right is permitted only if the aim cannot be achieved by means that interfere less with the fundamental right (principle of least interference). The restriction must not go further than is justified, taking into account the weight of the social interest underlying the restriction in relation to the legal interest being restricted (PeVM 25/1994, p.5). (see also Lääkärin etiikka (Physician's ethics) 2021, pp. 52–53).[96]

5.1.4 The Criminal Law (39/1889)[97]

Especially Section 21. Euthanasia as manslaughter or murder (RL 21:1 and RL 21:2).
Physician-assisted suicide possibly as manslaughter (RL 21:8 and RL 21:9).
In ETENE's position on euthanasia in 2017, the Criminal Code is understood as follows:
"Regardless of what someone asks another person to do to them, ending a person's life is a punishable act in Finland, according to the Criminal Code, either manslaughter, killing or murder. Suicide is not a crime in Finland, and assisting in suicide is not a separate criminal offense. However, assisting another person to die can meet the characteristics of a crime if other laws are violated, such as laws regarding dangerous substances or instruments. In practice, assisting in suicide can be punished as manslaughter, abandonment or neglect of rescue operations. According to the current legislation, euthanasia would be classified as killing another person if the serious illness of the deceased and the unbearable suffering they experienced were considered exceptional circumstances defined in the law, if they were considered a motive for the perpetrator's act or if they were interpreted as mitigating circumstances affecting the assessment of the act. According to the Criminal Code, the penalty for killing is four to ten years in prison."[98]

In Finnish law, there is no explicit prohibition on assisting in suicide, nor are there any legal cases of healthcare personnel acting as an assistant in such an act. One legal case concerns a person who acted as a caregiver and received a sentence. The act was sentenced as manslaughter due to mitigating circumstances.[99]

5.1.5. The Health Care Act (1326/2010)[100]

Especially sections 1–3, which describe the purpose of the law and what is meant by healthcare.

5.1.6. The Act on Health Care Professionals (559/1994)[101]

Especially section 15 Professional ethical obligations:

The aim of the professional activities of a healthcare professional is to maintain and promote health, prevent diseases, and cure the sick and alleviate their suffering. In their professional activities, a healthcare professional must apply generally accepted and empirically justified procedures in accordance with their training, which they must strive to continuously improve. In their professional activities, a healthcare professional must impartially take into account the benefits and possible harms of their professional activities for the patient.

A healthcare professional has a duty to take into account the provisions on the rights of the patient.

5.1.7 The Act on the Status and Rights of Patients (785/1992)[102]

Especially 5–8§ determine the legally binding nature of an advance directive. The scope of the law is described in 2§.

6§ describes the patient's right to self-determination. The patient must be treated in agreement with they wishes. The patient's autonomy is strongest when he/she refuses treatment. The law allows the patient to refuse treatment or to continue it, even when it concerns life-sustaining treatment. In cases of refusal, the patient must be treated in another medically acceptable way, if possible. The patient does not have the right to demand any treatment; the provision of treatment is determined on clinical grounds.

If the patient is unable to express their will, the patient's legal representative or close relative or other close person must be consulted before an important treatment decision is made, in order to determine which treatment would best correspond to the patient's wishes. If the patient's wishes cannot be clarified, the patient must be treated in a way that can be considered in their best interests.

2§ defines health and medical care as *"measures taken to determine the health status of a patient or to restore or maintain his or her health, which are performed by health care professionals, or which are performed in a health care unit;"*

This definition excludes euthanasia and physician-assisted suicide from the scope of health and medical care. A corresponding description is given in 15§ of the Health Care Professionals Act (see above) and 2§ and 3§ of the Health Care Act.

5.2 Legislation in the Nordic Countries

Norway: The law in Norway does not allow euthanasia or assisted suicide (Lov om straff (straffeloven) §275–279).[103]

Denmark: Similarly, Danish law does not permit euthanasia or assisted suicide (Straffeloven §237, 239, 240, and when evaluating the act, §82 and 83).[104]

Iceland: Icelandic legislation does not allow euthanasia.

Sweden: In Sweden, euthanasia is not permitted, but there is no specific prohibition against assisting suicide. Healthcare personnel are subject to the Patient Safety Act (patientsäkerhetslagen 2010:659)[105], which requires that health care be conducted according to science and established experience. It is possible that a doctor assisting in suicide could face penalties. Other key laws include the European Convention on Human Rights, the Penal Code

(brottsbalken 1962:700), the Health and Medical Services Act (hälso- och sjukvårdslagen 2017:30), and the Patient Act (patientlagen 2014:821).[106] [107]

5.3 Countries Allowing Euthanasia or Physician-Assisted Suicide

The number of countries that have permitted euthanasia or physician-assisted suicide has gradually increased and now represents about 7% of all states. As of early 2024, four countries had allowed only physician-assisted suicide, in addition to 11 U.S. states. Eleven countries have permitted euthanasia, all of which also allow physician-assisted suicide. These are primarily in Western cultural areas. No countries in Asia or Africa have legislated to permit these practices.

Countries that allow physician-assisted suicide only include Switzerland (since 1942, but practically since the 1980s)[108], Italy (with a constitutional court ruling in 2017 that assisting in suicide is not always a crime; no formal law), Austria (Supreme Court ruling in 2020[109], law in 2022)[110], Germany (2017 and 2020 rulings by the Federal Constitutional Court[111] [112]; no formal law but conditions in the penal code (2021) allow for non-punishment[113]), and 11 U.S. states or territories: California, Colorado, District of Columbia (Washington, D.C.), Hawaii, Montana, Maine, New Jersey, New Mexico, Oregon[114], Vermont, and Washington.

Countries that permit both euthanasia and physician-assisted suicide include the Netherlands (1994; in 2002[115] also for children, initially restricted, then in 2024 for all children[116]), Belgium (2002[117] [118], also for children in 2014[119]), Luxembourg (2009)[120], Colombia (2014 ,with court approval acknowledged as early as 1997)[121], Canada (2016)[122], New Zealand (2021)[123], Spain (2021)[124], Australia through state-level decisions (effective from 2019-2023)[125] (Victoria 2019[126], Western Australia 2021, Tasmania 2022, Queensland 2023, South Australia 2023, New South Wales 2023, Northern Territory, whose euthanasia law was in force 1996—97),[127] Portugal (2023)[128], Cuba (2023)[129], and Ecuador (2024 with a court ruling, no formal law yet)[130]. However, the law in Portugal has not yet been implemented, as it awaits the newly elected government in spring 2024. In Belgium, physician-assisted suicide is not directly mentioned in the law but is permitted in practice. In Canada, nurses can also participate in performing euthanasia or assisted suicide.

The adoption of legislation allowing euthanasia or physician-assisted suicide has often not been a straightforward process. It has sometimes involved the rejection of laws that were not yet ratified, as happened several times in Portugal by the Constitutional Court.[131] Euthanasia was approved in the Northern Territory of Australia in 1995,[132] but the law was already repealed by another law in 1997. One reason was the growing distrust of the population in health care. In the USA, bills allowing physician-assisted suicide have repeatedly been presented in different states, but only a few states have enacted them.

In some countries, the court has interpreted the constitution or other key law and issued a permissive ruling on euthanasia or physician-assisted suicide, in which case the legislators have had to start drafting legislation to regulate practical activities. This has happened, for example, in Canada, Colombia and Ecuador.

In different countries, the implementation requires the fulfilment of different preliminary criteria. The implementation of the monitoring of the actions also varies.

The legalization of euthanasia has been rejected in several countries. This happened in France in 2016,[133] in England & Wales in 2015, and in Finland in 2018[134].

The constitution plays a significant role in what can be provided for in the legislation of the country in questions regarding euthanasia and physician-assisted suicide.

It should be noted that in no country has euthanasia *per se* been legalized, but it remains a criminalized act, which is not punished only if the set criteria are met.

5.4 Laws in Countries Allowing Euthanasia or Physician-Assisted Suicide

5.4.1 Examples of Laws Allowing Physician-Assisted Suicide

In countries where only physician-assisted suicide (PAS) is allowed, laws require that the individual is adult and capable of making the decision. A serious illness and the suffering that it causes are key criteria.

In **Austria**, the illness must be serious, incurable, and terminal, and it must cause continuous symptoms and suffering that significantly affect the quality of life. A 12-week waiting period is required after the patient's initial request, which can be shortened to two weeks if death is expected to occur very soon.

To carry out assisted suicide in Austria, the individual must receive a Sterbeverfügung, a permit valid for one year, issued by a notary or the patient's attorney after a reflection period. Two physicians must confirm the patient's decision-making capacity, and that the decision was made voluntarily. One of these physicians must be a palliative care specialist. The patient must be informed about the availability of psychotherapy and suicide prevention counselling. A written definite medical statement is required from the physician, and it will be archived. After the waiting period, an authorized pharmacy dispenses the medication, which the patient must ingest independently; no one is allowed to assist.

In **Switzerland**, assistance in suicide is allowed as long as it is done with unselfish motives. The patient must be competent and able to ingest the drugs or activate an infusion of the lethal substance. The person assisting in taking the medication does not have to be a physician. A formal pre-report is not required, but assisting organizations require a physician's statement and prescription.

In the United States, the legislation on physician-assisted suicide in different states is relatively similar. Following the state of **Oregon's** model, laws require reporting to a supervisory body when a patient receives permission and a prescription for PAS. The principle of personal autonomy is a central justification in U.S. legislation.[135]

According to Oregon's Death With Dignity Act, the requirements for prescribing life-ending medication include:

1. The patient must be an adult.
2. Two oral requests must be made at least 15 days apart, except when death is expected within that time.
3. A written request must be signed by two witnesses, one of whom cannot be a relative.
4. Two physicians must confirm that the patient has a terminal illness with a life expectancy of six months or less.
5. The attending and consulting physicians must assess that the patient is capable of making the decision.

6. If the patient has or is suspected of having a mental illness, a psychiatrist must evaluate that it is not impairing the decision.
7. The patient must be informed about alternatives to physician-assisted suicide, such as palliative care.
8. The patient is advised to discuss their decision with family.

The patient must self-administer the medication voluntarily. The law does not require supervision during ingestion — once the medication is dispensed, the patient is on their own. The application of the law has been expanded in 2022 so that residency in Oregon is no longer required to access the law.

5.4.2 Examples of Laws Allowing Euthanasia and Physician-Assisted Suicide

The Netherlands was the first country to enact a law permitting both euthanasia and physician-assisted suicide. Prior to the law, such actions could be permitted through court decisions upon request. **Belgium** followed to adopt a similar law, although it does not explicitly mention physician-assisted suicide, which is nevertheless permitted in practice.

In the Netherlands euthanasia is not punished when the following conditions are met:

1. The patient has made a voluntary and well-considered request.
2. The patient is experiencing unbearable suffering with no hope of recovery.
3. The physician has informed the patient of the condition and prognosis.
4. The physician and patient see no reasonable alternatives.
5. An independent physician has been consulted and has provided a written opinion confirming the patient's voluntary and well-considered request and the lack of reasonable alternatives.
6. The physician performed the euthanasia or assisted suicide in accordance with accepted medical standards.

A written request is not mandatory but can be submitted in advance.

If a competent 16–18-year-old made a written request before losing the ability to express their will, the request may be taken into account. A euthanasia request from a competent 16–18-year-old may be considered after discussion with their parents or guardian. For 12–16-year-olds, a competent request may be accepted if the parents or guardian agree. Euthanasia has also been carried out for children under 1 year old.[136] Since February 2024, a regulation permits euthanasia for children aged 1–12.[137]

Euthanasia must be reported to the Regional Euthanasia Review Committee (RTE).[138] After discussions with this committee, the Royal Dutch Medical Association has issued more detailed guidelines, which have changed over time. The Euthanasia Review Committee also issues its own guidance and annual reports.

Other countries that allow euthanasia, such as Belgium and **Luxembourg**, have similar criteria. Generally, euthanasia and PAS are only permitted for adults and citizens of that country, with a written request required. Belgium also permits euthanasia for minors. In most of these euthanasia permitting countries, advance directives for euthanasia are not accepted, except in the Netherlands where it is permitted by a Supreme Court precedent decision.[139] In Belgium, advance directives are valid for five years.

In **Spain** the person, in addition to being a competent adult , must be a citizen, a permanent resident, or have lived in Spain for more than 12 months. The patient must have a serious, incurable, or debilitating disease that causes unbearable suffering.

The patient must submit two requests at least 15 days apart, and documentation must be retained. After the first request, the doctor and patient discuss possible treatments. If the patient maintains their wish, they submit a second written request. Approval for euthanasia or PAS must be sought in advance from an oversight body, where two experts review the application. If they disagree, the whole committee evaluates the case.

Canadian criminal law stipulates that euthanasia or physician-assisted suicide (termed MAID – Medical Assistance in Dying)[140] can only be carried out by a health care professional, which includes specially trained nurse practitioners. There are requirements, which must be met.

Requirements include:[141]

1. The person must be eligible for health services in Canada.
2. The person must be an adult and competent in matters related to their illness.
3. The patient must have a grievous and irremediable medical condition causing intolerable physical or psychological suffering.
4. The request must be voluntary, without external pressure.
5. The patient must provide informed consent after being advised of all care options, including palliative care.

Previously, the illness had to be terminal, and death was expected in the near future — this requirement has been removed (though not yet in force), meaning that mental health conditions will also qualify under MAID in the future.

The health care professional must then ensure that the “protective measures” are met. These are defined separately for those whose death is expected in the near future and those whose death is not imminent.

If death is foreseeable:

1. The preconditions have been met.
2. Written, dated request after being informed of diagnosis about grievous and irremediable medical illness or injury.
3. One independent witness at signing (used to be two).
4. Confirmation that the patient understands they can withdraw the request at any time.
5. The consulted health care professional has provider written confirmation that the eligibility criteria have been met.
6. All involved professionals must be independent.
7. Patients with communication difficulties must be supported every possible way in understanding their health condition and expressing their wishes.
8. Just before administration of life-ending drugs, the patient must be offered the chance to withdraw consent again and it has been ensured that the patient gives their consent to the completion of the actions.

If death is not foreseeable, in addition to the above criteria:

A 90-day assessment period before implementation.

The consulting provider must have special expertise in assessing the patient's condition in question. There must be thorough discussion with the health care professional consulted of all alternatives for relieving suffering, and the patient must have considered them.

Canadian legislation does not define in more detail what is meant by terms such as “grievous and irremediable medical condition” and “physical or psychological suffering that is intolerable”.

In Canada, health care providers are obliged to report all euthanasia and assisted suicides that have been carried out. The Ministry of Health collects the data.[142]

In many countries, a mandatory waiting period is required between the patient's request and the performance of euthanasia or physician-assisted suicide (PAS). Repeated requests and witness confirmation may also be required.

In general, advance requests made before the appearance of severe symptoms are not accepted. However, the Netherlands has more permissive criteria for accepting such requests. In Belgium, it is also possible to make an advance directive.

Countries that permit euthanasia and PAS have also criminalized violations of their respective laws. In the Netherlands, only intentional non-compliance is punishable. Thus, actions taken in good faith or due to negligence may not lead to penalties. Oregon's legislation follows a similar principle. In Belgium, the burden of proof in case of alleged errors in euthanasia procedures has been shifted to the prosecutor. Therefore, the physician is not obligated to prove that the procedure was lawful.[143]

5.5 Comparisons of Legal Requirements Across Different Countries

The British Medical Association (BMA) has created comparison tables between countries or states that have only permitted physician-assisted suicide and those that have also permitted euthanasia. The comparison includes Switzerland, Oregon, the Netherlands, Belgium, Canada, and New Zealand. A map of countries allowing PAS and euthanasia was also included, though it is now outdated.[144] Similar tables have been created by others,[145] including the Norwegian Medical Association, which has compared key countries.[146]

Finland’s Ministry of Social Affairs and Health (STM) commissioned an expert group to consider end-of-life care, self-determination, palliative care, and euthanasia. The report of the expert group made a review of legislation of several countries related to euthanasia and PAS.[147] Similar legislative summaries are available online on several websites.[148] [149] [150] [151] [152]

5.6 The Relationship Between Law and Ethics

The World Medical Association (WMA) has declared in its statement on the relationship between law and ethics that when these are in conflict, physicians should work to change the law. In such circumstances, ethical responsibilities are considered to take precedence over legal obligations.[153]
”When law is in conflict with medical ethics, physicians should work to change the law. In circumstances of such conflict, ethical responsibilities supersede legal obligations.”

This topic is also addressed in the Finnish publication Lääkärin etiikka (Physician's Ethics), which explains that:

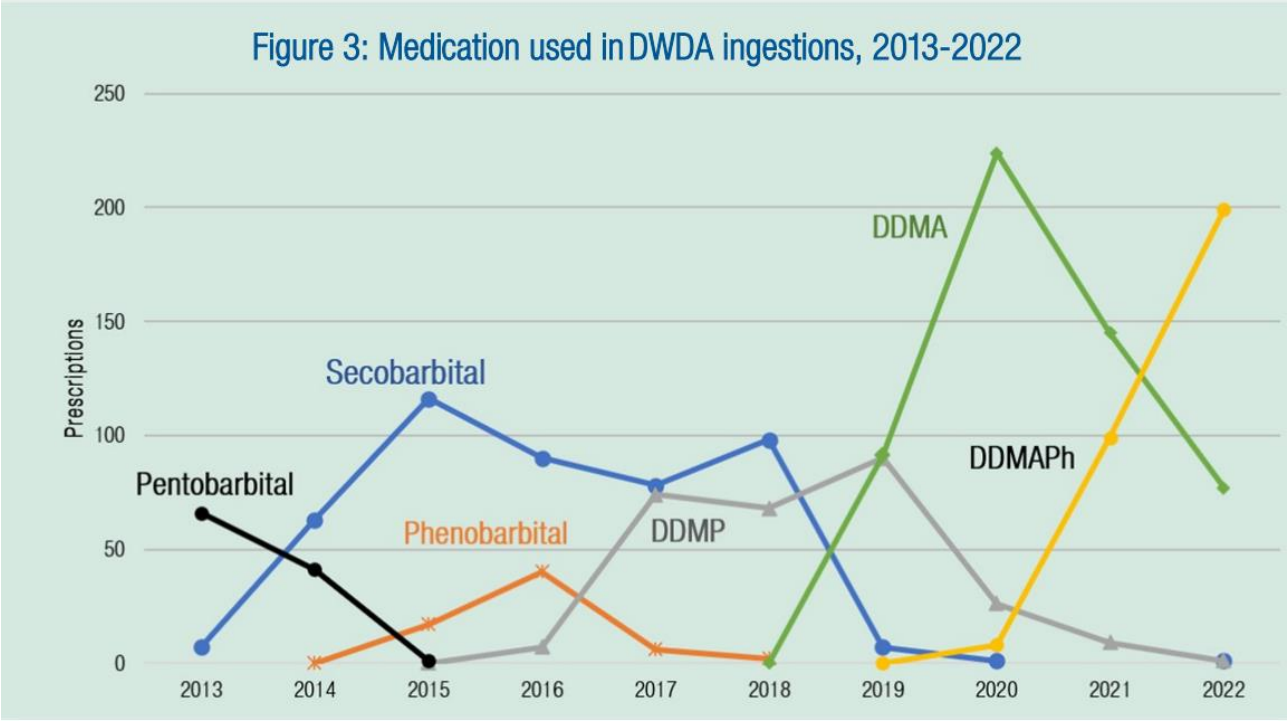
Norms can be legal, ethical, or social. They reflect social and moral values and set standards of behaviour. International declarations such as those by the WMA, though not legally binding, set ethical standards that often offer more specific guidance than legal texts. The ethical content of the norm comes from the thinking about right and wrong.[154]

Laws and ethical norms should not conflict. The relation between law and medical ethics is bilateral. The law sets limits within which ethical choices can be made and ethics sets limits on what actions are voluntarily taken even within the law. When legislating, lawmakers must consider the impact on the medical profession. Following medical ethics helps maintain public trust in physicians, especially when law and ethics diverge or contradict.[155]

6. Practices

6.1. Substances and Methods Used in Euthanasia and Physician-Assisted Suicide

In **Oregon**, the medications used for PAS are listed in the annual report from the Oregon Health Authority.[156] Patients take the medications orally.



Oregon Death with Dignity Act, 2022 Data Summary

DDMAPh = diazepam, digoxin, morphine sulfate, amitriptyline, and phenobarbital.
DDMA = diazepam, digoxin, morphine sulfate, and amitriptyline.
DDMAPh is used in over 70% of cases and DDMA in about 28% of cases.

According to data from 2001–2022, time until death using DDMAPh ranged: Average 105 minutes, median 42 minutes, range 5 minutes to 68 hours.

In **the Netherlands**, the Royal Dutch Medical Association (KNMG) provides guidelines for the medications used in euthanasia and PAS.[157] [158] Loss of consciousness is induced first (e.g., with thiopental or propofol). Then a neuromuscular blocker (e.g., rocuronium or atracurium) causes paralysis of breathing muscles and leads to death by suffocation. Midazolam may be administered first for sedation.

Death usually follows quickly after intravenous administration. A Canadian study reported a mean time of 9 minutes to death.[159]

However, complications sometimes occur, even the awakening of the patient. Most common complications are seizures, awakening from coma, vomiting, pain caused by the used drugs, in

some cases technical problems, and even delayed death.[160] In euthanasia, complications occur in 0.9–4.5% of cases;[161] in PAS vomiting could be in up to 10% of cases and regaining consciousness is reported in up to 4% of cases, along with significantly delayed death. In both euthanasia and PAS it is difficult to be sure that the patient is really unconscious before the effect of the muscle relaxant.[162]

No medication has an officially approved indication for causing death in humans. Thus, this is off-label use, which does not have official registered approval. This is an overdose and a combination that produces the desired effect in the target person. The effect is essentially a drug poisoning in relation to the official use of the drug. This is a pathological cause of death. The products used have been selected for use quite empirically, and as can be seen, the product combinations have varied significantly.

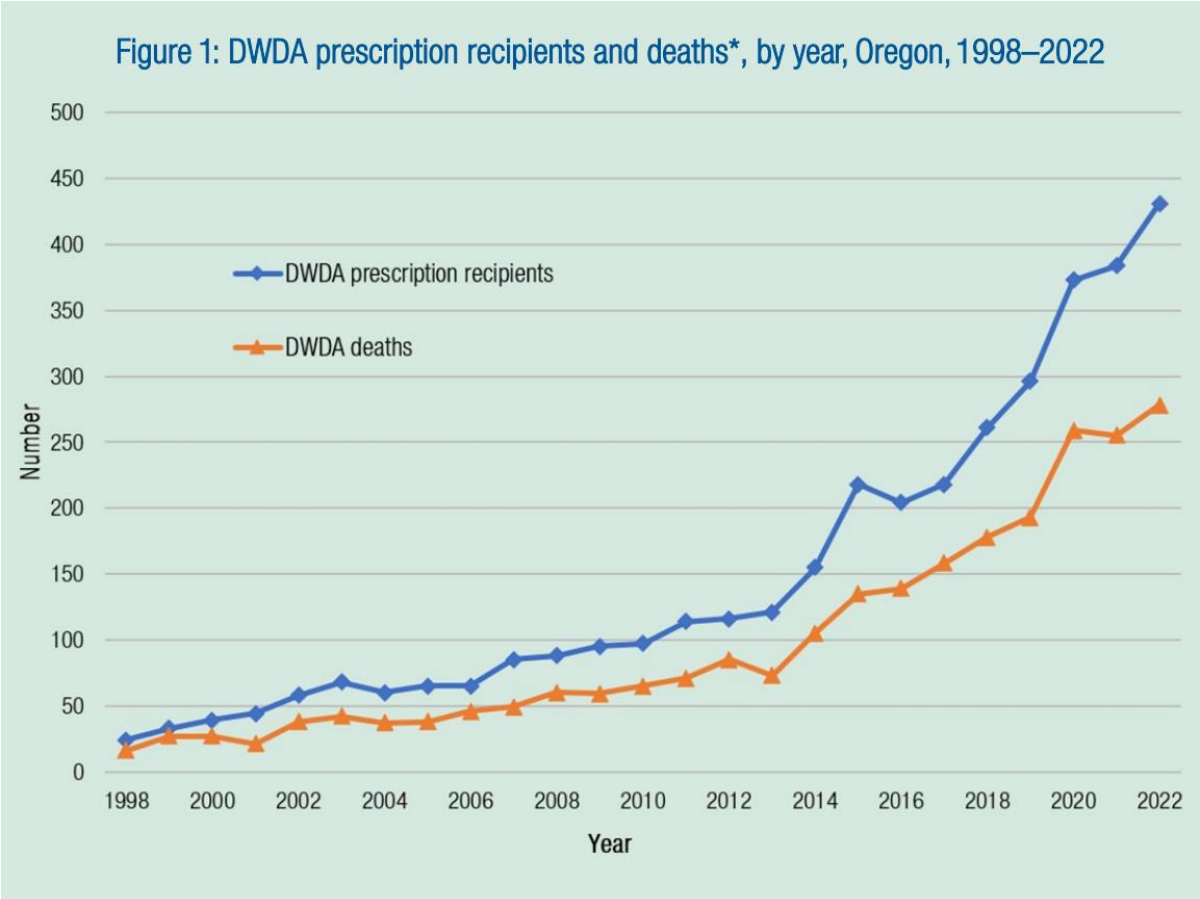
6.2. Implementation Practices in Countries Allowing Euthanasia or Physician-Assisted Suicide

Examples include the practice of physician-assisted suicide in Oregon, USA, and the practices of the Netherlands and Canada, which also allow euthanasia. Countries that have allowed euthanasia and physician-assisted suicide keep statistics on these procedures. Statistics show that the number of procedures is constantly increasing.

6.2.1. Oregon, USA

The Oregon law on physician-assisted suicide, the Death With Dignity Act (DWDA), requires that when a physician writes a prescription for this purpose, they must report it to the oversight body, the Oregon Health Authority (OHA), which is obligated to collect this data and maintain statistics. The agency does not conduct independent assessments to determine whether the patient met the legal criteria but relies entirely on the reports that physicians are required to submit. [163] [164]

The latest statistics, from the Oregon Death with Dignity Act 2022 Data Summary[165], show that in 2022, there were 278 physician-assisted suicides, compared to 255 the previous year. Of the 431 patients who received a prescription for this purpose that year, 57% also used it to commit suicide. There is no information on the use of the medication for 101 patients. About 6% of patients lived more than six months after the prescription was written, longer than the criteria required. Approximately 0.6% of all deaths in Oregon resulted from physician-assisted suicide. Of the patients, 25% received the prescription without the reflection period described by law, based on the grounds that their life expectancy was less than 15 days. Chapter 2 above describes the patients' diagnoses and the reasons they reported for their requests.



*As of January 20, 2023

Oregon Death with Dignity Act, 2022 Data Summary

In the early years of data collection, information was gathered for three years on how many doctors the patient saw before obtaining the desired prescription. During those years, 59% of patients had visited multiple doctors. It is possible that "doctor shopping" occurs in a model like Oregon's. In the USA, organizations that promote physician-assisted suicide have also been willing to assist patients in finding a doctor who is sympathetic to their request for a prescription for physician-assisted suicide.[166]

Oregon law does not set competency requirements for doctors assisting in the implementation of physician-assisted suicide. Nevertheless, they are required to inform patients of all palliative care options. Oregon law only requires psychiatric consultation in cases of mental health issues. The specialties of doctors who have performed physician-assisted suicides are not recorded in the statistics. The median duration of the patient-doctor relationship was five weeks in 2022 before the procedures leading to physician-assisted suicide began.

Approximately 20–25% of cancer patients are depressed.[167] About 80% of those requesting physician-assisted suicide or euthanasia are cancer patients.[168] However, only 1.1% of those approved for physician-assisted suicide in Oregon in 2022 had seen a psychiatrist for evaluation.[169] This figure has been significantly lower in recent years than it was previously.[170] This suggests either that doctors are not adequately identifying mental health issues[171] or that they are not necessarily giving them the attention required by law.

Oregon's law has been interpreted to mean that even if good care could stop the progression of the disease, the patient is still entitled to physician-assisted suicide if the untreated disease is expected to lead to death within six months.[172]

According to the report, a doctor or another person was present when the patient ingested the medication in 44% of cases. There is no information about the remaining cases. From earlier years, there are known cases where patients have woken up. In one case, a patient lived for another couple of years after a failed physician-assisted suicide attempt (in 2018). Side effects have also included vomiting, among other things.

The Oregon Health Authority keeps the reports it receives confidential, and even researchers do not have access to them. The reports are destroyed about a year after the annual report is published. As a result, it is not possible to evaluate the accuracy of the reports on an individual level through research.[173] [174] The lack of transparency raises concerns about whether patient safety is truly ensured and whether the law is being followed or if violations occur. A notable weakness of the Oregon model is the lack of government oversight during the process and the lack of transparency in reviewing practices. The law, however, provides significant protection for physicians.[175] [176]

The problems with the Oregon model have led to critical views of it.[177] [178] In the USA, there are practices where patients can also be given lethal injections upon request, even though euthanasia is not legal.[179]

6.2.2. The Netherlands

In the Netherlands, euthanasia has been practiced for a long time. The criteria for non-prosecution and non-punishment were shaped by practices that emerged from court cases in the 1980s.

In the Netherlands, administrative regulations in 1990 required that euthanasia cases be reported to the local coroner. However, nearly half of the cases were still unreported in 1993. Euthanasia was not necessarily recorded as the cause of death; instead, a more natural cause might be listed.[180] As a result, legislation was created to control existing practices related to euthanasia and physician-assisted suicide, which came into effect at the beginning of 1994. At that time, death resulting from actions that hastened death could no longer be recorded as a "natural death"; instead, it had to be reported to the local coroner, who would then report it in writing to the prosecutor. The prosecutor would evaluate on a case-by-case basis whether to bring charges. Initially, the law applied only to somatic illnesses, but through court rulings, the practice expanded to include mentally ill patients as well.[181]

At that time, actual euthanasia and physician-assisted suicides accounted for about 2% of all deaths, with euthanasia occurring six times more often than physician-assisted suicide. The deliberate use of excessively high doses of painkillers to hasten death occurred in 6% of cases where such medication was used, with awareness of the potential double effect. Additionally, according to the so-called Remmelink study[182], nearly 1% (approximately 1,000 patients) of all deaths each year occurred due to hastened death without the patient's consent.[183] [184] The ethics of these actions were questioned, and the Van del Wals study raised the question of how doctors could act in this way. Appeals to patient autonomy were no longer valid.[185]

At that time, palliative care was inadequate, and its availability did not meet the level of need.[186]

A new law on euthanasia and physician-assisted suicide came into effect in the Netherlands in 2002. This law set the conditions under which euthanasia would not be punished (see chapter 5 above). The central principle was to support patient autonomy. However, euthanasia and physician-assisted suicide remained crimes under the penal code, with corresponding penalties. These conditions were intended as safeguards to ensure that euthanasia and physician-assisted suicide were limited to carefully considered cases. The legislation required that the request be voluntary, informed, and that the patient had long-lasting "unbearable suffering", but it did not define how these should be verified. Notably, there was no requirement for a terminal illness or a written request from the patient.

The law established oversight committees with broad decision-making power to determine whether euthanasia or physician-assisted suicide was conducted according to the law (Regional Euthanasia Review Committee, RTE). The assessment is based on the euthanasia report that the doctor is legally required to make. The oversight committee must forward cases where it believes the criteria were not met to the prosecutor. The composition of the oversight committee is specified by law. These committees publish an annual report on their activities.

The oversight committees established by law meet behind closed doors. The grounds for their decisions are not described. In effect, the oversight committee wields power similar to a court of law. Their decisions guide the interpretation of the law, which has expanded over time to include new groups as a result of these decisions. This has been made possible by the very loosely written euthanasia law. The oversight committee has interpreted the law in a way that allows what is not explicitly forbidden in the law. This has particularly concerned the interpretation of what constitutes "unbearable suffering". A patient's refusal of appropriate medication has been considered to meet the criterion that there is "no foreseeable relief" from the suffering. The legislation has been criticized.[187]

UN human rights observers pointed out during the drafting of the law that, based on previous experience, there is doubt as to whether the euthanasia law would be used only in extreme cases and with all the required care. The Netherlands received a recommendation to review its legislation in light of these observations and to ensure that its provisions form adequate protection against misuse, including undue influence on decision-making by outsiders.[188]

When UN human rights observers reassessed Dutch legislation in 2009, they reiterated their concerns about the law. Although the law required a second physician's assessment, there was no longer any assessment by a judge or an equivalent impartial authority to ensure that the euthanasia decision was not the result of undue influence or misunderstanding. The human rights observers repeated their demand for a review of the legislation in light of what the UN human rights convention says about the right to life.[189]

To support the practical interpretation of the law, the Dutch Medical Association (KNMG) issued guidelines in 2011, which KNMG said to expand the prevailing understanding of the requirements for euthanasia. In the guidelines, the "unbearable suffering" required by law was interpreted to always include a medical factor, such as a disease or a combination of illness and ailment. Psychological or existential suffering was also considered to fall under medical grounds. Vulnerability, including loss of functionality, loneliness, and loss of autonomy, was deemed to lead to unbearable suffering and should be considered in connection with a euthanasia request. Problems with vision and hearing, mobility issues, falls, fatigue, bedriddenness, exhaustion, and loss of physical condition and dependency on others were also considered medical problems.[190]

The KNMG has trained a network of so-called SCEN doctors, who can be consulted for the legal requirement of a second opinion and other advice. Additionally, in 2012, the KNMG issued practical guidelines for performing euthanasia and physician-assisted suicide, including the substances to be used.[191] [192] The Regional Euthanasia Review Committees adopted these guidelines as the basis for their own evaluations.[193]

The Regional Euthanasia Review Committees began in 2018 publishing an occasionally updated "Euthanasia Code," which explains how doctors should proceed in the process of euthanasia and physician-assisted suicide to have it approved by the oversight committee. The latest guidelines are from 2022.[194] They were developed in consultation with the KNMG, the prosecutor's office, and other key stakeholders. These are in line with the KNMG guidelines, updated in 2021.[195] Both contain a very broad interpretation of what constitutes "unbearable suffering", following the directions set out by the KNMG in 2011, and emphasizing the individual's experience of their own suffering. Unbearable suffering can also include fear of future deterioration in condition. The consulting doctor does not necessarily need to contact the patient; they can make their assessment based on other grounds if needed.

The so-called Groningen Protocol was published in 2007, describing the criteria for when the life of severely ill children under one year of age can be intentionally ended with medication.[196] [197] The Dutch Paediatric Association has approved the protocol. This, too, was about bringing existing practice under common criteria.[198] The KNMG issued a publication on severely ill newborns in 2013.[199]

The public prosecutor in the Netherlands has stated that a physician will not be punished for euthanizing a child under one year old if four conditions are met, and these conditions align with the Groningen Protocol: 1. The suffering is hopeless and unbearable. 2. The parents agree to the act. 3. Another doctor has been consulted. 4. The child's life is ended properly. The doctor is required to report the act to both the public prosecutor and the Regional Euthanasia Review Committee. The act remains criminalized, but according to established legal practice, it is not punished.[200]

The Groningen Protocol has been criticized with the same arguments as those used against performing euthanasia. How can "unbearable suffering" and "expected quality of life" be defined? Criticism has been expressed by, among others, the American Medical Association and the American College of Pediatrics.[201] [202]

According to the annual report of the Regional Euthanasia Review Committees, the total number of reported euthanasia and physician-assisted suicide cases in the Netherlands has been continuously increasing. The number has multiplied since the early years of the current euthanasia legislation, reaching 8,720 in 2022. According to the 2022 oversight committee statistics, these accounted for 5.1% of all deaths, a 13.7% increase from the previous year. There were 8,501 physician-assisted euthanasia cases, 186 physician-assisted suicides, and 33 combined cases. There were 282 dementia patients and 115 psychiatric patients. The oversight committee felt that 13 of the reported cases did not meet the criteria. It is important to note that these numbers only include reported cases.[203]

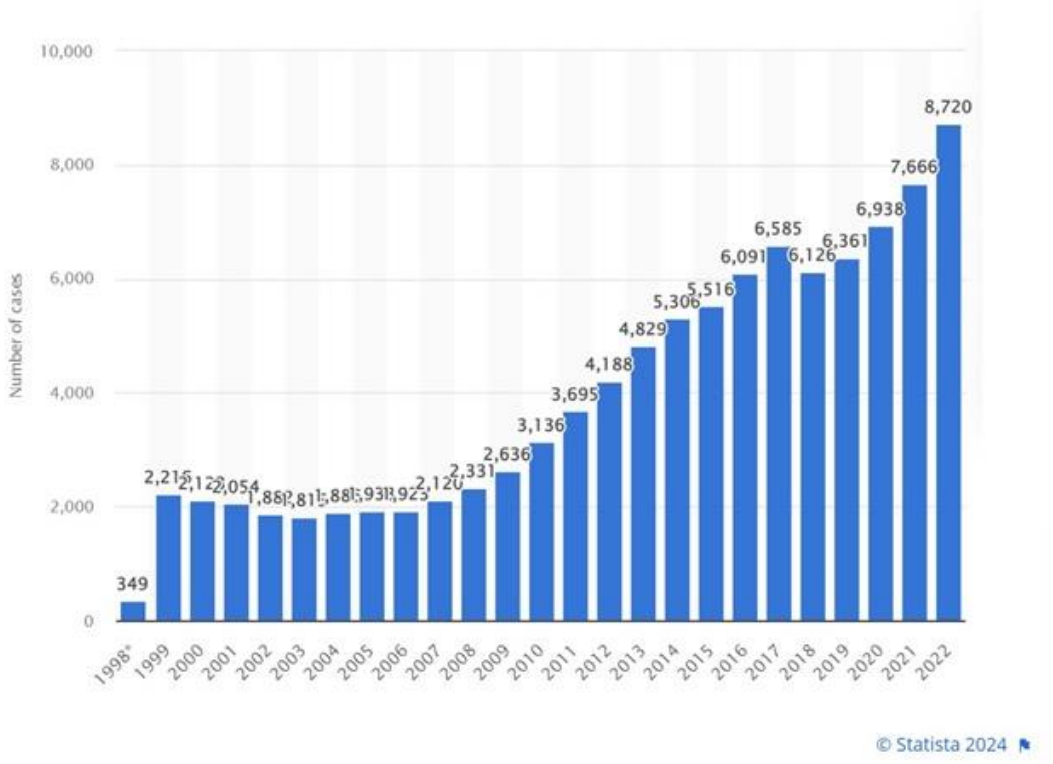
Of all euthanasia and physician-assisted suicide cases, 97.4% were euthanasia, 2.1% were physician-assisted suicides, and in 0.38% of cases (33 cases), the patient did not die from the drugs provided for physician-assisted suicide, and the doctor had to perform euthanasia. In the

Netherlands, organs are harvested for transplants from patients who died through euthanasia and physician-assisted suicide.

Most of the physicians who reported performing euthanasia and physician-assisted suicide were general practitioners (7,013, or 80.4%). Other significant groups included geriatricians (316), other specialists (264) and registrars (125), as well as other doctors (967).

Euthanasias and physician-assisted suicides reported to Regional Euthanasia Review Committees in the Netherlands 2000–2022

diagram: Statista Research Department[204]

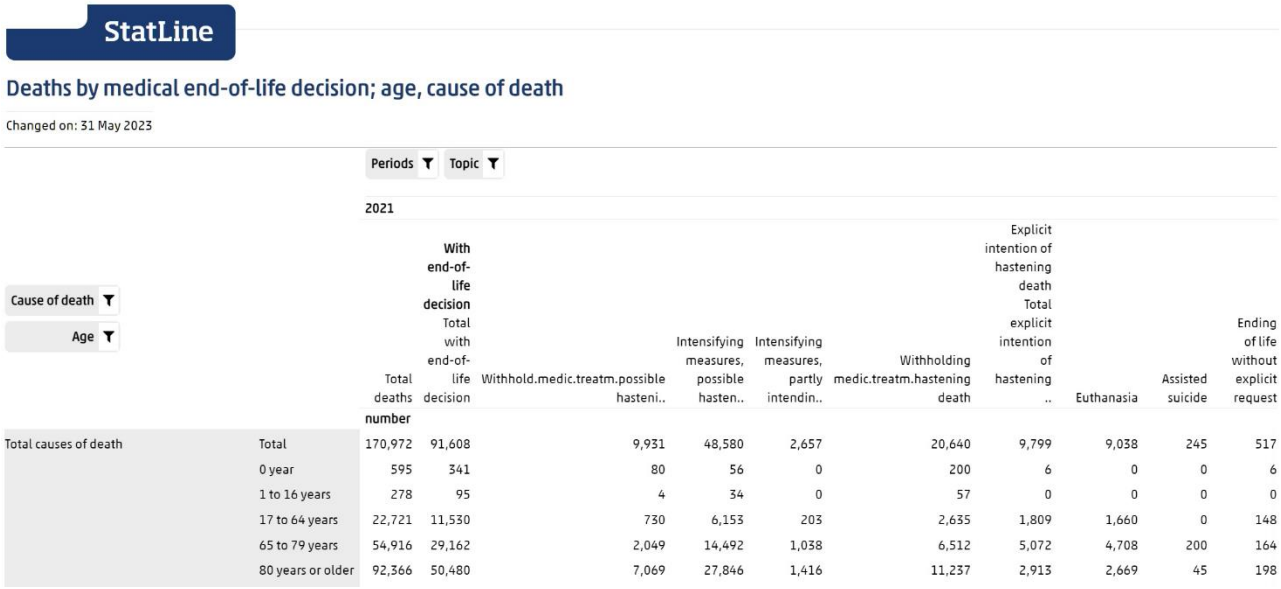


An assessment of euthanasia practice in the Netherlands has been carried out approximately every five years on behalf of the state, the most recent was published in 2023. The assessment is based on physicians' reports submitted to the Regional Euthanasia Review Committees and an assessment of these committee's decisions on them. In addition, some surveys have been conducted. Individual patient cases have not been opened for a more systematic assessment. According to the report, only 77–83% of euthanasias have been reported during the period of euthanasia legislation, the rest have not been reported. The report draws attention, among other things, to the increase in the number of euthanasias and the increased use of continuous palliative sedation. It was used for 23% of patients in 2022, compared to 5% in 2005. The report contains recommendations for further action.[205]

The problem has become that a significant number of euthanasias, about a fifth, are not reported to the Regional Euthanasia Review Committees. As a result, their legality is never assessed. Failure to notify is already against the law.

In the Netherlands, it is also a practice that in some cases a patient's life can be intentionally ended with medication without the patient's consent (non-voluntary euthanasia). This action is at the discretion of the physician and is called life-terminating treatment or life ending without explicit request. These are not considered euthanasia, as they do not require the patient's consent.

According to **StatLine cause of death statistics**, in 2021 there were 517 *endings of life without explicit patient request*, 20,640 *withholding or withdrawing medical treatment with the explicit intention of hastening death*, 2,657 *intensifying measures to alleviate pain or other symptoms partly intending the possible hastening of death*, and 48,580 *intensifying measures to alleviate pain or other symptoms while taking into account the possible hastening of death*. The cause of death statistics shows that the number of euthanasias (9,038) differs significantly from what was reported to the Regional Euthanasia Review Committees in the corresponding year (7,459).[206]



StatLine

Deaths by medical end-of-life decision; age, cause of death

Changed on: 31 May 2023

Periods: 2021 | Topic

Cause of death	Age	Total deaths	With end-of-life decision: Total with end-of-life decision	Withhold.medic.treatm.possible hasteni..	Intensifying measures, possible hasten..	Intensifying measures, partly intendin..	Withholding medic.treatm.hastening death	Explicit intention of hastening death: Total explicit intention of hastening ..	Euthanasia	Assisted suicide	Ending of life without explicit request
		number									
Total causes of death	Total	170,972	91,608	9,931	48,580	2,657	20,640	9,799	9,038	245	517
	0 year	595	341	80	56	0	200	6	0	0	6
	1 to 16 years	278	95	4	34	0	57	0	0	0	0
	17 to 64 years	22,721	11,530	730	6,153	203	2,635	1,809	1,660	0	148
	65 to 79 years	54,916	29,162	2,049	14,492	1,038	6,512	5,072	4,708	200	164
	80 years or older	92,366	50,480	7,069	27,846	1,416	11,237	2,913	2,669	45	198

diagram: StatLine.

The Dutch practice of continuous palliative sedation leading to death has raised concerns that the procedure is being used to circumvent the euthanasia regulations.[207] The same concern has been raised about procedures that are recorded as intensive procedures that are partly intended to hasten death or that may have this effect.[208] A worrying feature has emerged in that 42% of patients were not asked whether they wanted intensive symptomatic treatment, the purpose of which is to shorten life. In their case, the matter was not discussed with their relatives or consulted with another physician.[209] [210] [211]

Similar practices exist in Belgium, and a study conducted there has yielded similar results. In the cases described in the study responses, some of the euthanasias were carried out without the patient's consent as required by law. Of these intentional terminations of life without a formal request, 77.9% were carried out medically, without even discussing it with the patient.[212]

In Belgium, the acceptance rate of euthanasia requests increased from 56.3% in 2007 to 76.8% in 2013, and the total number of euthanasias had also increased.[213] In parts of Belgium, only about half of euthanasias were reported.[214]

In the Netherlands, the organization Nederlandse Vereniging voor een Vrijwillig Levenseinde - NVVE was founded in 1973. It has actively advocated first for the legalization of euthanasia, then for the expansion of the grounds for euthanasia, and has also promoted the implementation of euthanasia and physician-assisted suicides. In 2012, the organization founded a network clinic, the Levenseindekliniek (End of Life Clinic), which has mobile units. They go to those who request euthanasia but do not know of a physician who would carry it out. However, a large proportion of euthanasias carried out by mobile units have been carried out on patients who have not given the reason that their own doctor has refused to perform euthanasia in principle, but because the doctor had considered that euthanasia could not be performed on the patient in question for various reasons. Euthanasias carried out by doctors at these clinics have been on a sharp rise.[215]

In the Netherlands, the assumption for euthanasia to be performed would be a stable and confidential relationship with the physician to whom the euthanasia request could be addressed. However, the physician in the NVVE mobile units met the patient on average only three times before the patient received the drugs that led to his death. During the corona epidemic, remote connections were introduced for patient meetings. Levenseindekliniek has operated since 2019 under the name Expertisecentrum Euthanasie.[216] In 2022, approximately 14.2% of all euthanasia deaths were performed by a physician affiliated with the Expertisecentrum Euthanasie organization. That year, there were 115 euthanasias performed for psychological reasons, of which 65 (56.5%) were performed by physicians from this organization, and 42.7% of dementia patients were euthanized by physicians from the organization. With only a few visits to the patients, the question has arisen as to how thorough an assessment of the condition of these patients could be made as a basis for euthanasia.[217]

A study of 66 psychiatric patients who underwent euthanasia from 2011 to 2014 revealed that in 11% no independent psychiatrist was consulted at all and in 41% a psychiatrist who was not an official consultable psychiatrist was used. The consultants did not agree with the referring physician's assessment that the conditions for euthanasia were met in 24% of cases, but euthanasia was still carried out. In 27% of cases, the euthanasia process was carried out by a physician who was not previously known to the patient, 78% of whom were physicians from the Levenseindekliniek mobile teams established by the NVVE, which promotes euthanasia. Of the 66 patients studied, 37 were in a situation where they had refused the treatments offered, although they had a previous treatment history. Several also had previous suicide attempts. The most common psychological problem was depression, but there were also psychoses, eating disorders, reduced cognition and prolonged grief. Questions have been raised about how reliable the Dutch practice is.[218] [219]

In 2019, a case of euthanasia carried out on a 74-year-old dementia patient in the Netherlands came to light, in which it was a case of carrying out a previously submitted euthanasia request when “the time is right”. The doctor agreed with the family on the time of implementation. That day, the doctor mixed a sleeping pill into the patient’s coffee, but the patient was awake when the procedure began and strongly resisted it. When the family held the patient steady, the physician carried out the euthanasia by administering a lethal injection.[220] [221]

The case went to the Supreme Court, which issued an acquittal. This provided an opportunity to expand the existing euthanasia code so that, based on a previously submitted euthanasia request,

the doctor can also carry out euthanasia for dementia patients. The doctor can, at his discretion, take into account circumstances in the grounds for carrying out euthanasia.[222]

Euthanasia advocates have also produced model instructions on how to make a request for euthanasia and how to behave when meeting a physician, so that the request is more likely to be accepted.[223]

Euthanasia opponents have drawn attention with concern to the continuous increase in the number of euthanasias.[224] [225] This has been seen as a result of the expanded criteria, which have led to euthanasia being approved for ever new, milder reasons.[226]

The Dutch Ministry of Foreign Affairs has prepared a question-and-answer publication on euthanasia.[227]

6.2.3. Canada

In Canada, euthanasia and assisted suicide became permissible following a court ruling. In its 1993 decision, the Supreme Court of Canada had stated that the best way to effectively protect the lives and vulnerable individuals in society is to prohibit assisted suicide without exception.[228] However, in early 2015, the Supreme Court of Canada, in its *Carter v. Canada* decision, ruled that euthanasia and assisted suicide are permissible under certain conditions.[229] Around the same time, the province of Quebec was enacting a law permitting euthanasia, which came into effect at the end of 2015.[230] Canada's criminal law was amended in 2016 to align with the Supreme Court's decision.[231] [232]

The Canadian Medical Association (CMA) had opposed euthanasia in its statements in 2007 and 2013. However, in its statement to the Supreme Court in the 2014 *Carter v. Canada* case, the CMA changed its ethical stance to accept both the practice of euthanasia and the right to oppose it.[233]

The sections of Canada's criminal law concerning euthanasia and assisted suicide (Medical Assistance in Dying, MAID)[234] [235] were amended in 2021. The background for this was the decision in the *Truchon case* by the Quebec Superior Court in 2019, which found that the legal requirements for euthanasia, such as *"reasonably foreseeable death"* and end of life, were unconstitutional. As a result, Bill C-7 was introduced and, when it came into effect, immediately removed these conditions from the legislation. The requirement for two witnesses to the patient's written euthanasia request was also removed, leaving only one witness, who could also be a health care worker. The law also eliminated the 10-day reflection period before euthanasia could be performed. The legal reform removed restrictions so that it became possible to obtain euthanasia or assisted suicide for purely psychological reasons, although this part of the law was set to take effect in March 2023 and included additional conditions for this group.[236] [237]

In early 2023, a bill (Bill C-39) was passed to further delay the implementation of legislation that would remove barriers to euthanasia or assisted suicide for purely psychological reasons by another year.[238] In early 2024, the government proposed extending the law's implementation until 2027 (Bill C-62),[239] which was approved in February 2024.[240]

Legislative work is supported by committee reports.[241] [242] In Canada, these have discussed expanding euthanasia legislation to include minors. Disability organizations have expressed concern about this.[243] Proponents of euthanasia have wanted to extend this possibility as well.[244]

The Council of Canadian Academies has conducted studies at the request of the government on expanding the MAID legislation to new groups of people. The reports highlight key risks associated with the expansion. The expansion to include mentally ill patients is viewed cautiously in light of experiences from countries where this practice is in place.[245] Drug addicts have also been considered as potentially falling under the category of mentally ill.[246] A government-appointed expert group concluded in its report that the MAID legislation should be extended to include mental health patients.[247]

The number of euthanasia and assisted suicide cases in Canada has risen faster than in any other country that permits these practices. In Canada, the percentage of deaths resulting from euthanasia is nearing the levels seen in the Netherlands and Belgium. The number of euthanasia cases in those countries has already been surpassed.[248] In Canada, this development has taken only a few years. One reason behind this has been seen as the loosening of legislative criteria and the lack of uniform, structured evaluation criteria.[249] Euthanasia proponents view the expansion of practices as a deeper understanding of euthanasia.[250]

Health Canada publishes an annual report on MAID activities.[251] The 2022 report states that 13,241 euthanasia or assisted suicide cases were performed in Canada, accounting for 4.1% of all deaths. This represented a 31.2% increase from the previous year. There were 16,104 MAID requests, of which 13,102 resulted in death as requested, meaning 81.4% of requests were approved. However, the number of reported MAID deaths was higher at 13,241, explained by additional information from legal authorities (139 deaths). MAID was performed for 463 individuals whose death was not expected in the near future.

Of the requests, 3,002 did not result in euthanasia or assisted suicide. Of these, 298 individuals withdrew their request (1.9%), 560 were deemed unsuitable for the procedure and their request was rejected (3.5%), and 2,144 died before MAID could be implemented (13.3%).

The main reasons for requesting euthanasia or assisted suicide were the loss of ability to engage in meaningful life activities (86.3%) and the loss of ability to perform activities of daily living (ADL) (81.9%).

MAID was most often performed by a physician (92.7%), with the remaining cases carried out by trained nurse practitioners (9.4%). The largest group of doctors performing MAID were family medicine practitioners (67.7%), followed by palliative care physicians (8.0%), anesthesiologists (4.1%), internists (3.2%), emergency medicine physicians (2.6%), oncologists (1.2%), psychiatrists (0.8%), and other physicians (3.0%).

The required second assessor for MAID eligibility was a physician in 92.7% of cases and a trained nurse practitioner in 7.3% of cases.

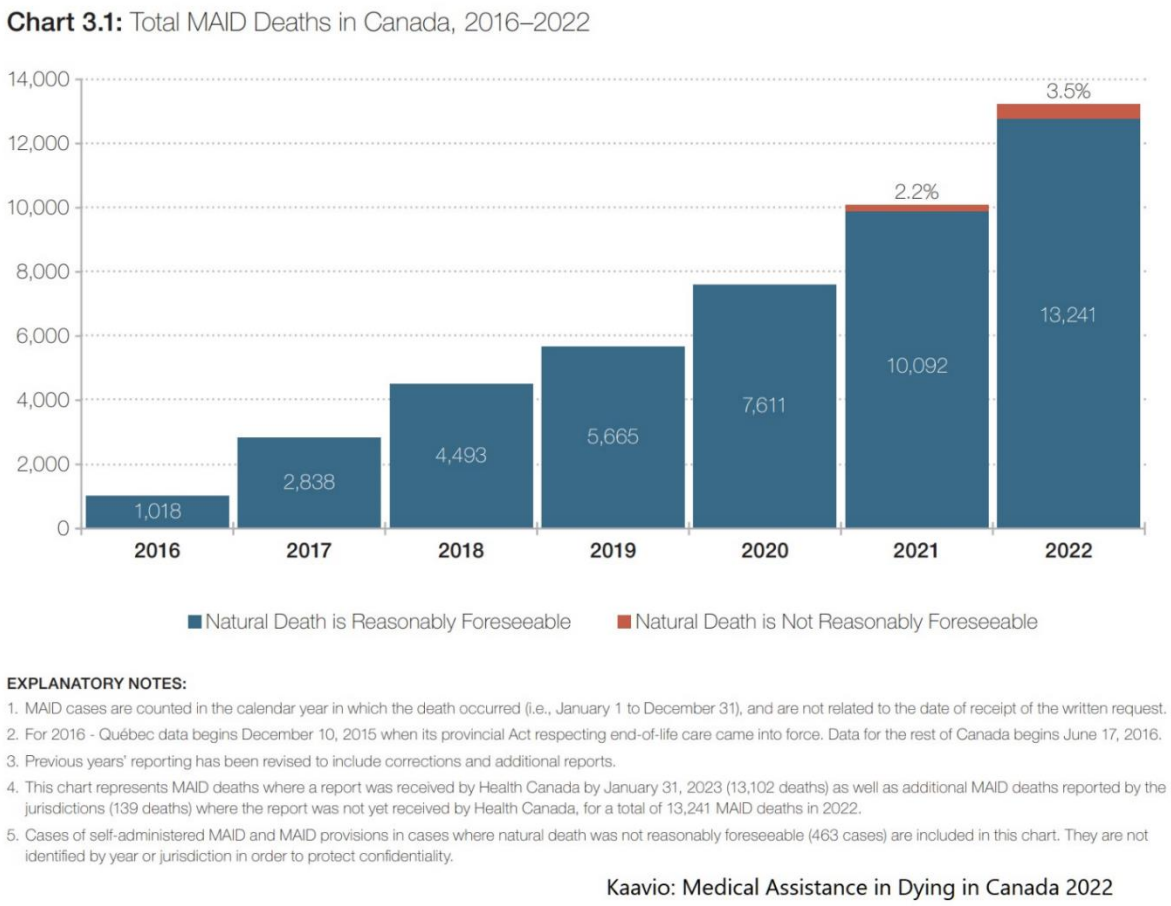


Diagram: Medical Assistance in Dying in Canada 2022

In Canada, health care professionals can recommend euthanasia and assisted suicide to patients. There is no legal or regulatory prohibition against this, unlike in New Zealand. The Canadian Association of MAID Providers and Assessors (CAMAP), which has received significant government support for training in the implementation of MAID legislation, strongly recommends that euthanasia or assisted suicide be offered as an option to all patients who may meet the MAID criteria when discussing potential treatments for serious illness.[252] Some patients have found this offensive. In Canada, there is no requirement that appropriate treatments be tried first before offering life-ending procedures.[253]

Although MAID legislation requires a discussion with the patient about different treatment options, these options may not necessarily be available to the patient. For euthanasia or assisted suicide to be an informed choice, there must be a real possibility of accessing palliative care. In Canada, access to palliative care is not at the required level.[254]

Euthanasia and assisted suicide are classified as healthcare procedures under Canadian law, so they must be state-funded, and access to them must be guaranteed to all citizens. Death has been medicalized. Palliative care does not have the same status and therefore is not guaranteed state funding or access for everyone. Some have argued that euthanasia and assisted suicide are end-of-life care, and funds intended for palliative care have been allocated to them.[255]

The Canadian Institute for Health Information produces up-to-date reports on palliative care.[256]

There has been particular concern about the increasing number of cases where euthanasia and assisted suicide have been offered in situations where health care has been unable to provide

necessary care and support.[257] These situations may involve the prioritization of health care resources. When the requirement that the patient's life must be near its end was removed from the law, it opened the possibility of considering suffering related to disability as a justification for euthanasia and assisted suicide. Canadian disability organizations have been particularly concerned about this.[258] [259]

The implementation of euthanasia requires consultation after the first assessor's approval. In practice, this can be done by phone or video call. A personal meeting is not required. The legislation allows the patient to request both the initial request and the second consultation as many times as they want from different sources if the first assessor refuses to perform euthanasia. The two assessors are supposed to be independent of each other, but this is not always the case. The assessors are not required to have any special qualifications beyond basic professional competence when dealing with a patient whose death is not expected in the near future. Therefore, it has been questioned how well the legal requirement that the patient be offered the care they need is fulfilled, especially when there is no obligation to consult a palliative care specialist in cases requiring special expertise.[260]

Canadian law theoretically guarantees conscience rights for physicians. This means that physicians should not be required to refer patients to another physician in cases like euthanasia to protect their conscience rights. However, at the local level, physicians have been required to make referrals in all cases where a patient invokes MAID legislation. In Ontario, the courts have overridden physicians' conscience rights, arguing that ensuring the patient's access to further care is more important. Physicians who have refused to make referrals have faced the threat of disciplinary action, including the potential loss of their medical licenses.[261]

The Canadian Association for Suicide Prevention (CASP) has raised the question of why a referral to another physician should be made if, in the physician's judgment, the patient does not meet the MAID criteria. Wouldn't the referring physician then be acting against the principles of their profession?[262] Hospices have been pressured to perform euthanasia and assisted suicide under the threat of losing government funding if they refuse.[263]

In Canada, euthanasia and assisted suicide have become routine causes of death rather than exceptional procedures as these practices have become institutionalized. Their implementation has been extended to new patient groups, such as those with osteoarthritis, dementia, and disabilities. Refusal to accept effective treatment for suffering has been considered a justified reason for receiving euthanasia or assisted suicide. A penalty is prescribed for violating MAID legislation if the violation is intentional. Negligence does not meet this requirement. Violations of MAID legislation and guidelines have been identified, but no charges have been filed.[264]

Canada performs a significant number of organ transplants from euthanasia patients because patients are not required to give prior consent for the procedure, as is the practice in many other countries that have legalized euthanasia. For some, the possibility of organ donation has been a motivating factor in choosing euthanasia. The possibility of a planned organ transplant also affects the substances used in euthanasia.[265]

UN human rights observers have noted that Canada's euthanasia legislation (MAID) does not provide sufficient protection for people with disabilities.[266] Over 100 civil society, patient, and disability organizations have voiced similar concerns.[267]

The practices of different countries have been compared and evaluated in several publications.[268] [269]

6.2.4. Organ Donation in Euthanasia and Physician-Assisted Suicide

After euthanasia or physician-assisted suicide, organs are collected from these patients in several countries according to the DCD (donation after circulatory death) practice, and there are even recommendations for this.[270] [271] [272] This has given rise to suspicions that the practice could lead to a preference for euthanasia and physician-assisted suicide in end-of-life decisions.[273] [274] [275] On the other hand, organ donation has been seen as an altruistic act.[276] The practice has been in force at least in the Netherlands, Belgium and Canada. Canada performs the highest number of organ transplants from euthanasia patients in the world.[277]

6.2.5. Cost-Effectiveness Considerations

Cost-benefit analyses have been conducted on euthanasia and physician-assisted suicide.[278] In Canada, it has been calculated that savings of $34.7 - $138.8 million per year accrue, while the direct costs of these interventions are $1.5–$14.8 million.[279] When the range of services offers the possibility of responding to problems with several interventions, it has been thought that cost-effectiveness considerations may influence the provision of a cheaper alternative, in this case euthanasia.[280] In health care that is based on insurance, this has become more evident, even in the form of obvious abuses.[281]

6.2.6. Slippery Slope

The slippery slope phenomenon means that the application of the criteria for implementing an approved measure is expanded either by interpreting the criteria to include new actions that were not originally considered to be included, or by adopting entirely new criteria that expand the scope of the measure.

In the case of euthanasia and physician-assisted suicide, the slippery slope phenomenon, i.e. the expansion of criteria and practices beyond those originally intended, has occurred in both ways.[282] [283] [284]

In the Netherlands, the expansion of euthanasia practice in particularly vulnerable groups of people has been seen as a slippery slope phenomenon.[285] [286]

In the Netherlands, there have been repeated initiatives to extend euthanasia legislation to the elderly so that they would have access to a “death pill” when they feel that they have had enough of life. The initiatives have been promoted by the Minister of Health,[287] one parliamentary party[288] and the NVVE.

In Canada, court decisions and legislative changes have repeatedly expanded the groups that can receive euthanasia or physician-assisted suicide. The most recent significant changes have been that the patient's death no longer needs to be expected in the near future and that in 2027 euthanasia and physician-assisted suicide will be permitted for the mentally ill. Euthanasia advocates have proposed allowing it to be extended to children as well.[289] In the Netherlands, euthanasia will be extended to all children in 2024, as was previously done in Belgium.

Legislative projects are pending in the USA that are intended to expand both the target group and the group of practitioners of physician-assisted suicide, as well as the method of implementation.[290] [291]

It has been considered appropriate to critically evaluate the practices of different countries.[292] [293]

It should be noted that whatever criteria for euthanasia or physician-assisted suicide are initially accepted, there will always be groups and organizations that advocate for expanding the criteria and strive to influence decision-making in both the medical profession and legislators in this direction.

6.2.7. Patient Safety

Laws permitting euthanasia or physician-assisted suicide have set various criteria as a prerequisite for these actions. These have also been called safety mechanisms. However, it has proven that the definition of both the underlying concepts and the criteria is not unambiguous, and the legislation has not been made precise. Monitoring mechanisms are either completely absent or possibly retrospective, meaning that there is no official supervision during the process, with some exceptions. This places patient safety in a weak position, as these are actions that are final when they cause death. There has been particular concern about vulnerable patient groups. Patient safety has not been guaranteed.[294] [295]

UN human rights monitors have issued observations specifically about the shortcomings of patient safety in the legislation of both the Netherlands[296] and Canada[297] [298]. The UN has been particularly concerned about the implementation of euthanasia for people with disabilities.[299] Belgium has been reprimanded by the European Court of Human Rights for failings in its procedures that have violated the right to life.[300]

If euthanasia and physician-assisted suicide were legalized in Finland, the supervisory authority would likely be Valvira.

In physician-assisted suicide in particular, there is no guarantee that the drugs will work on an individual level within the expected timeframe, and there is also a significant risk of side effects, such as vomiting or awakening. Thus, some deaths caused by drugs may even be inhumane.[301]

6.2.8. Suicide Prevention

From the perspective of medical ethics and practice, it has been seen as contradictory that when health care is actively trying to prevent suicide, it would also allow assisted suicide under certain criteria.

It has been recognized that allowing euthanasia and physician-assisted suicide on mental health grounds increases the risk that there will be patients among them whose condition could improve. It has also been recognized that in some mental health patients, the desire to die is itself a symptom of the illness, making it particularly difficult to identify whether the patient's request to hasten death is truly made out of free will. The Council of Canadian Academics has stated that it is very difficult, if not impossible, to reliably distinguish between preventable suicides in mentally ill patients and those for whom physician-assisted suicide or euthanasia could be allowed under certain criteria.[302]

It has been suggested that euthanasia legislation would reduce suicides among patients approaching death. Evidence to the contrary is that as euthanasia and assisted suicide have become more accepted and normalized, suicide mortality outside of these practices has increased, for example in the USA and the Benelux countries, especially among women.[303] [304]

6.3. Legislation and Its Application

Statistical data on the numbers, reasons and patients are available from several countries that allow euthanasia and physician-assisted suicide. Among the cases reported to the supervisory authorities of the countries examined in more detail in this report, the supervisory authority has relatively rarely found deviations from compliance with euthanasia legislation. Even of these, only a few have led to the case being reported to the prosecutor. When borderline cases are resolved in courts, their decisions have led to changes in the application guidelines of the legislation.

The legislation of the countries examined, and the guidelines derived from them have revealed problems in defining the criteria for euthanasia and physician-assisted suicide. There have also been problems in interpreting the criteria and making assessments. The changes in legislation and interpretations have all meant that new groups have come within the scope of euthanasia and physician-assisted suicide. At the same time, problems have emerged in that patient safety for vulnerable groups has been weakened. The expansion of practices has been justified by the right of the individual to self-determination.[305]

In the countries examined in more detail in this report, monitoring takes place after the event and is based on the self-reports of the health care professionals who carried out the measures. A problem in some countries has proven to be that not all euthanasias and physician-assisted suicides are reported and therefore not subject to monitoring. There are also medical methods used to intentionally hasten death that are not subject to monitoring by the monitoring body. These open up the possibility of circumventing euthanasia legislation.

The European Association for Palliative Care (EAPC) sees the following threats in the legalization of euthanasia:

I) pressure is put on vulnerable people; II) the development of palliative care is delayed or its value is reduced; III) the personal and professional values of physicians and other health care professionals come into conflict with the requirements of the law; IV) clinical criteria are loosening and more people are falling under the scope of euthanasia; V) the incidence of involuntary and reluctant medicalized killing is increasing; VI) society is beginning to accept killing.[306]

The number of euthanasias and physician-assisted suicides has been clearly increasing in all countries. There are organizations and political parties that are actively pushing for the expansion of these practices to new groups of people. No matter how good the safeguards for the implementation of these measures are set when the legislation is being drafted, it is obvious from the examples that they will be changed in an increasingly permissive direction over time.[307] The development of the slippery slope is obvious.

7. Ethical Analysis

7.1. Ethical Principles in Medicine

The book Lääkärin etiikka (Physician's Ethics) states: *"Medical ethics brings ethical argumentation to medical decision-making. Medical ethics raises questions about the values, rights and responsibilities of the patient and the physician and is thus involved in the physician's daily patient work throughout his or her professional career."… "Medical ethics is common for the profession worldwide and thus unites the world's physicians both as individuals and as a profession." "… traditional medical ethics – the norms and standards of the profession – still form the basis of medical ethics."* [308]

7.2. The World Medical Association's Position on Euthanasia and Physician-assisted Suicide

The World Medical Association (WMA) has expressed strong opposition to euthanasia and physician-assisted suicide in its declarations. The most important of these is the WMA Declaration on Euthanasia and Physician-Assisted Suicide.[309] The same negative position of the WMA is repeated in the WMA Declaration of Venice on End of Life Medical Care.[310]

This position is supported by the WMA Ethics manual.[311] The WMA Journal has published articles that explain the content of the WMA position.[312] [313] It is worth noting what terms the WMA uses and how they are defined.

The most recent position is based on studies conducted on different continents. Based on these, support for euthanasia and physician-assisted suicide is found almost exclusively in the Western cultural context.[314]

The WMA Declaration on Euthanasia and Physician Assisted Suicide states that medical ethics makes the WMA firmly oppose euthanasia and physician-assisted suicide. *"The WMA reiterates its strong commitment to the principles of medical ethics and that utmost respect has to be maintained for human life. Therefore, the WMA is firmly opposed to euthanasia and physician-assisted suicide."*

7.3. Freedom of Conscience

The key declarations on freedom of conscience adopted by the World Medical Association are the WMA International Code of Medical Ethics (ICoME)[315] and the WMA Declaration of Geneva[316] [317]. and on euthanasia and physician-assisted suicide, the WMA Declaration on Euthanasia and Physician-assisted Suicide[318].

ICoME states that when exercising freedom of conscience, the physician must inform the patient appropriately and at the same time inform them that they have the right to obtain a consultation from another physician on the matter, and the physician must provide the patient with sufficient information about this so that they can seek it in a timely manner.

29. ..." *The physician has an ethical obligation to minimize disruption to patient care. Physician conscientious objection to provision of any lawful medical interventions may only be exercised if*

the individual patient is not harmed or discriminated against and if the patient's health is not endangered.

The physician must immediately and respectfully inform the patient of this objection and of the patient's right to consult another qualified physician and provide sufficient information to enable the patient to initiate such a consultation in a timely manner."

The WMA Declaration on Euthanasia and Physician-assisted Suicide states, like ICoME, that a physician should not be obliged to make a referral to another physician when exercising freedom of conscience:

"No physician should be forced to participate in euthanasia or assisted suicide, nor should any physician be obliged to make referral decisions to this end."

According to the declaration of the **Parliamentary Assembly of the Council of Europe**, individuals and institutions should have the right to refuse to carry out euthanasia (Resolution 1763 (2010).[319] At the same time, it should be ensured that the patient has access to health care in accordance with the law in a timely manner.

"1. No person, hospital or institution shall be coerced, held liable or discriminated against in any manner because of a refusal to perform, accommodate, assist or submit to an abortion, the performance of a human miscarriage, or euthanasia or any act which could cause the death of a human foetus or embryo, for any reason."

The book **Lääkärin etiikka (Physician's Ethics)** discusses freedom of conscience in a couple of articles, stating that physicians have the right to their own convictions and freedom of conscience in procedures that are problematic from the point of view of medical ethics.[320] **The Board of the Finnish Medical Association** has issued a recommendation on the freedom of conscience of physicians: The Finnish Medical Association's recommendation on the freedom of conscience of physicians on the application of freedom of conscience in studies and workplaces.[321]

In countries that have accepted euthanasia and/or physician-assisted suicide, there is generally a mention of freedom of conscience, that the physician is not obliged to participate in these procedures.

7.4. The Finnish Medical Association

7.4.1. Ethical Principles of the Finnish Medical Association

The Finnish Medical Association (FMA) has expressed the key principles of medical ethics in the following documents: values[322], ethical guidelines[323] for physicians and the physician's oath[324]. These are supplemented by the book Lääkärin etiikka (Physician's Ethics)[325] and several individual guidelines. Defending humanity and ethical values is mentioned as one of the tasks of the Medical Association in the FMA regulations.[326]

The Finnish Medical Association has summarized the core issues of medical ethics as follows:

"Ethical issues are an essential part of a physician's work. A physician must always serve his or her loved ones with respect for humanity and life.

A physician has three goals in his or her job:

1. maintaining and promoting health

2. preventing diseases

3. curing the sick and alleviating their suffering

A physician's professional ethical obligations include altruism, maintaining high professional skills, adhering to the principles of medical ethics, respecting humanistic values and implementing social justice." [327]

In euthanasia, a physician has been found to have a conflict of values and obligations.[328]

The expert statement submitted by the Finnish Medical Association to Parliament on 15 February 2018 states that *"in the opinion of the association, there are no sufficient ethical grounds or practical need for the legalization of euthanasia in Finland"*[329] (see Chapter 9 for more details).

7.4.2. The Book Lääkärin etiikka (Physician's Ethics)

The book Lääkärin etiikka (Physician's Ethics) provides perspectives on medical decision-making by describing ethically justified models of solutions and factors to consider in ethical evaluation. Its goal is to present a clear, well-founded and unified view of the profession on how the basic principles of medical ethics apply to the reality of Finnish healthcare.

The foundation of medical ethics lies in values. These values form the basis for the duties and norms guiding a physician's actions.[330] In medical ethics, one can see elements of three central ethical approaches: virtue ethics, utilitarian ethics, and duty ethics.[331]

In the article "Eutanasia ja lääkäriavusteinen itsemurha" (Euthanasia and Assisted Suicide), Lääkärin etiikka (Physician's Ethics) starts from the core values of medical ethics: respect for life, protection of human dignity, avoidance of harm, and alleviation of suffering. The perspective is that from the physician's duty to respect human dignity and alleviate suffering, there does not arise an obligation for the physician to assist a person in dying or to actively end a person's life. Throughout the long history of the medical profession, it has been characterized by the absence of intentional termination of human life by medical means from its professional role. In decision-making regarding end-of-life actions, the physician's intent is central. Death should not be caused, but it may be allowed.

Good medical practice highlights the abandonment of unnecessary and ineffective treatments when there is no longer hope for recovery. The patient's right to self-determination is respected, and with it, the patient has the right to refuse treatments, even if the result is death. The main argument for supporting euthanasia and physician-assisted suicide is autonomy. However, these actions are not seen as autonomous since they always require the involvement of another person, i.e., the physician.

The right to life is seen as a human right guaranteed by human rights treaties and the Constitution of Finland, which should not be infringed upon. The right to self-determination has been considered to be of such a nature that it is already being restricted in many ways.

FMA shares the strong commitment of the World Medical Association (WMA) declarations to the principles of medical ethics and respect for human life and along with it the WMA's opposition to euthanasia and physician-assisted suicide. Physicians should have the freedom of conscience not to perform these procedures, nor should they be obliged to make referrals for them.

The patient's suffering is taken seriously. However, there may be problems underlying the wish to die that can be treated.

Euthanasia and physician-assisted suicide have been seen as an obligation that in some countries has been placed on the medical profession, which must bear collective responsibility for it.

In the light of practical examples, the practice has been seen as problematic from the perspective of a physician, in which a physician, when carrying out euthanasia or physician-assisted suicide, is in principle doing an act punishable by the Criminal Code, for which an assessment is made afterwards whether the physician is exempted from liability. This is seen as equally problematic from the perspective of patient safety and the patient's legal protection. At a practical level, ethical problems have been seen in the definition of the criteria for euthanasia and physician-assisted suicide.

In the case of euthanasia and physician-assisted suicide, the physician is seen to have an equal ethical responsibility in both, even if the legal responsibility is different. Allowing these could have unforeseen consequences and could also have a reducing effect on the trust placed in the physician. These measures have also been seen to have harmful effects that should be taken into account in occupational safety and health.

Lääkärin etiikka (Physician’s Ethics) presents the FMA's view:

"The Finnish Medical Association opposes the legalization of euthanasia. The Medical Association also opposes that physicians as a profession would be obliged to perform procedures whose primary purpose is to hasten the patient's death (physician-assisted suicide)."

7.5. Nordic Medical Associations

7.5.1. Sweden

The Swedish Medical Association (Sveriges läkarförbund)[332] is opposed to euthanasia and assisted dying but welcomes a broad discussion and the exploration of the different dimensions of the issue. The Medical Association has made an official statement. It refers firstly to point 2 of its ethical code, which states that a physician's important duty is to protect human life and that he may never take measures to hasten death: "A physician shall consider the importance of protecting human life and shall never take measures to hasten death." Secondly, reference is made to the World Medical Association's declaration on euthanasia and physician-assisted suicide, which opposes these measures.[333]

The Swedish Medical Association further justifies its position:

In its view, the duty of healthcare is to alleviate symptoms and to cure and treat illnesses. Euthanasia must not be society's response to suffering and is not compatible with the mission of healthcare.

Trust in physicians and healthcare must be protected. It is important to keep a clear "white line" between treatment and measures aimed in the opposite direction. Euthanasia in healthcare is considered to be incompatible with the goal of zero suicide rates.

Legalizing euthanasia could stigmatize and endanger the status of people with disabilities by raising the debate about whose life is "worth living".

The question of how to assess a patient's wishes for euthanasia is a complex one. In addition to the fact that it may be difficult to determine the patient's decision-making capacity, there may be risks:

- the patient feels pressured to request euthanasia in order to avoid being a burden on relatives, care or society
- the patient's wishes may arise from treatable depression
- the remaining life expectancy may have been incorrectly estimated, which may have influenced the patient's attitude towards requesting euthanasia
- the patient regrets the request for euthanasia, but does not dare to withdraw his wish

The Swedish Medical Association refers to experiences from the Netherlands, which show that the guidelines may become more permissive over time, covering more groups than initially intended, such as people with dementia or depression and minors. The aim is to improve palliative care so that everyone has a dignified, safe and painless end of life.

The Swedish Medical Association conducted a survey on the subject in 2021.[334] Its main observation is that doctors are unsure of their position.[335] A quarter could not give their opinion, slightly more supported euthanasia and physician-assisted suicide than opposed.

In Sweden, the state health care ethics body Statens medicinsk-etiska råd (SMER) (cf. ETENE) has conducted a study on assisted dying (see below in Chapter 7).

7.5.2. Norway

The Norwegian Medical Association (Den Norske Legeforening, DNLF)[336] has a prohibition on euthanasia and physician-assisted suicide in its ethical code: §5 Physicians may not provide euthanasia or assisted suicide, both of which are actions in which physicians intentionally participate in hastening death. Withholding life-prolonging or unnecessary treatment is not considered assisted dying, as the patient will die of their actual illness. The same applies at the end of life to palliative sedation, which is intended to control symptoms that cannot be alleviated in any other way.[337]

The Norwegian Medical Association received a request from its members to amend this §5 of the code at the 2023 annual meeting so that the Medical Association's position would become neutral. In support of the discussion of the matter, the Norwegian Medical Association's Ethics Committee (Rådet for legeetikk) prepared a background report. On this basis, the Ethics Committee concluded that it is not appropriate to change §5 of the Code of Ethics for Physicians.[338]

The Board of the Norwegian Medical Association (sentralstyret) has discussed the matter and decided, in accordance with the position of the Ethics Committee, to maintain the rules unchanged.

The background report prepared by the Ethics Committee extensively highlights the arguments for and against euthanasia and physician-assisted suicide. The background report discusses physician ethics and ethical guidelines and their relationship to the law, patient rights and palliative care at the end of life and opens up the key ethical questions in the field.

The central ethical theme is the treatment of euthanasia in relation to the four basic principles of medical ethics: the obligation to do good, respect for the right to self-determination, avoidance of harm and justice.

The basic arguments in favor of euthanasia are that sometimes life is not worth prolonging and that death is not a bad thing in itself, but what it takes from a person. The argument based on the right to self-determination is that a person should be able to decide whether their life is worth living. Counter-arguments include that “treating the patient’s symptoms with death” obviously also harms the patient, which goes against the principles of both doing good and avoiding harm.

From an ethical perspective, physician-assisted suicide and euthanasia are seen as similar, since in both cases the physician’s actions are intended to intentionally cause the patient’s death.

The background report is concerned that the social acceptance of euthanasia and physician-assisted suicide will put those in the most vulnerable position in an endangered position. The institutionalization of euthanasia is seen as threatening the central principle that everyone has the same human dignity, regardless of how much they suffer or how they otherwise assess their quality of life. Reference is made to a report by the Danish Ethical Council (Det Etiska Rådet) (see below in Chapter 7).[339]

The report also discusses population surveys on the subject, presents an overview of the acceptability of euthanasia and physician-assisted suicide in different countries, and opens up the legal dimensions of the subject. The text also discusses materials on why euthanasia and physician-assisted suicide are requested. The material includes several short requested perspectives on specific questions. These have been requested both for and against. Finally, the Ethics Council presents its views and conclusions, in which it concludes that the ethical rules of doctors should be maintained unchanged.

A survey of physicians in Norway on their attitudes towards euthanasia and physician-assisted suicide was conducted in 2014 and 2016, and attitudes were compared with a survey conducted in 1993. As in the 1993 survey, the majority in the new surveys oppose euthanasia and physician-assisted suicide.[340]

7.5.3. Denmark

The Danish Medical Association (Lægeforeningen)[341] opposes the legalisation of euthanasia and physician-assisted suicide. The Medical Association believes that these are ethically unacceptable. The Medical Association states that these procedures are completely different from other medical practices, as the purpose of these procedures is to cause the patient's death. This is seen as completely inconsistent with the role of the physician and the role of healthcare, as the role of healthcare is to act for the benefit of the patient by implementing prevention and patient treatment and care.[342]

The Medical Association has prepared a statement in which it justifies its position in more detail.[343]

The legalisation of euthanasia is seen as causing a fundamental change in both the relationship between doctor and patient and the relationship between citizens and healthcare. This change would be harmful and should be avoided.

The Danish Medical Association refers to the experiences of countries that have legalized euthanasia and physician-assisted suicide, where the slippery slope phenomenon has led to an ethically unsustainable expansion of practices, both in terms of quantity and in terms of the expansion of target groups. This has happened, for example, in the Netherlands, where these measures are applied to, among other things, people with dementia.

The Danish Medical Association sees the threat that enabling euthanasia and physician-assisted suicide would put pressure on vulnerable patient groups approaching death. They might feel obliged to take the measures in a situation where they see themselves as a burden on their loved ones and the healthcare system.

In 2023, the Danish Council of Ethics (Det Etiske Råd) prepared an extensive statement on euthanasia and physician-assisted suicide (see below in Chapter 7).

7.5.4. Iceland

The Icelandic Medical Association (Læknafélag Íslands)[344] has a code of ethics, **Codex Ethicus.**[345] It is based on the WMA's Code of Medical Ethics.[346] The Medical Association's position on euthanasia is negative.

7.6. Views of Other Key Medical Associations

7.6.1. The Standing Committee of European Doctors (CPME)

In its statement in 2000, **the Standing Committee of European Doctors (CPME)**[347] prohibited physicians from participating in activities aimed at intentionally ending a patient's life, even if the patient himself or herself had requested this.[348]

"The doctor must not, at the patient's or anybody else's request, carry out or cause to be carried out treatment intended to result in the patient's death."

7.6.2. The United Kingdom

The British Medical Association (BMA)[349] launched in 2015 a large-scale study on end-of-life care and physician-assisted dying (ELCPAD).[350] It involved 21 discussion events attended by over 500 doctors. The members were consulted on the following questions:

- how do perceptions and reality of end-of-life care compare with models of good care?
- what are the challenges that doctors face in providing quality care at the end of life?
- what would be the impact on the patient-doctor relationship if physician-assisted dying were legalised?

The project report was published in three parts. The first part described palliative care and end-of-life care in the UK and the legislation and political climate regarding assisted dying elsewhere.[351] The second part described and analysed the discussions held in the discussion events organised in the project.[352] The third part contains the reflections and recommendations of the project.[353] The results of the project were also presented as summarised recommendations.[354]

Following this project, the BMA conducted an extensive survey and report on euthanasia and physician-assisted suicide among its members, which was completed in 2020.[355] [356] It also included open-ended questions, the answers to which were analysed.

The BMA compiled the key arguments for and against euthanasia and physician-assisted suicide that emerged. In the same context, arguments for and against the neutral position of the Medical Association have also been presented.[357]

Those in favour of a neutral position have argued that the medical profession does not have a unified view. Thus, a neutral position would reflect this fragmentation. If the position were for or against, it would not describe the situation correctly. The BMA should remain in its role as a trade union and not take a position in public, as this is a matter for society to decide, not for doctors.

Those opposed to adopting a neutral position have argued that a neutral position would be interpreted as an implicit acceptance of the legalization of euthanasia and physician-assisted suicide. The Association cannot have a neutral position on such a central issue related to the work and professional image of doctors and patients, which could expose vulnerable patients to risks. A neutral position would be a step towards legalization, as the position of the Association is important to legislators. The Association is both a trade union and a representative of the profession and therefore must take a position on important social issues that have a direct impact on doctors and patients.

The 2021 BMA Annual Representatives' Meeting (ARM), which sets the Association's views, voted by only a few votes' margin to change the BMA's position on physician-assisted dying to neutral.[358] The BMA therefore neither supports nor opposes any potential legislative changes to euthanasia or physician-assisted suicide. However, the BMA has stated that it will not remain silent on these issues.[359]

7.6.3. Germany

The German Medical Association (Bundesärztekammer, BÄK)[360] has expressed strong reservations about physician-assisted suicide becoming a common practice. This has been expressed by several specialist organisations, too.[361]

The Association considers that the involvement of a physician in assisting a patient in suicide is not a medical task. The physician's task is to protect life, prevent and treat illnesses, alleviate suffering and support the dying. The Association emphasises the importance of good palliative care at the end of life.[362]

The German Medical Association has issued guidelines on what physicians should take into account when a patient requests physician-assisted suicide. The guidelines point out that there are legal risks if a physician prescribes certain medications that can be used to commit suicide. The physician should try to find out what the patient's wish for physician-assisted suicide is based on and, if possible, address the root causes. The guideline reiterates the view that assisted suicide is not part of the medical profession. Assisted suicide is a physician's individual decision. The guideline describes the physician's responsibilities in doing so, including what criteria are relevant when the physician makes an assessment of the patient before deciding to participate in assisted suicide. The guideline also emphasizes the importance of suicide prevention in general.[363]

7.6.4. The United States of America

The American Medical Association (AMA)[364] expresses its ethical position in its **Code of Medical Ethics.[365]** The AMA states that euthanasia is not ethically acceptable.[366] Euthanasia is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks, especially to vulnerable groups:

"However, permitting physicians to engage in euthanasia would ultimately cause more harm than good.

Euthanasia is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks. Euthanasia could readily be extended to incompetent patients and other vulnerable populations.

The involvement of physicians in euthanasia heightens the significance of its ethical prohibition."

The AMA states similarly about physician-assisted suicide and emphasizes the importance of good hospice care instead of intentional acts that end life:[367]

"Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.

Instead of engaging in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life."

At the same time, the AMA refers to its position on freedom of conscience when instructing those who support assisted suicide.

The AMA has an extensive code of ethics on end-of-life care, parts of which are the statements described above.[368]

Attempts were made to change the AMA's position on euthanasia and physician-assisted suicide in December 2023 by initiatives aimed at adopting a neutral position for the AMA. The AMA rejected the initiatives and maintained its previous position (Decisions Near End of Life, H-140.966), which states that physicians should not participate in euthanasia or physician-assisted suicide.

7.6.5. Canada

The Canadian Medical Association (CMA)[369] stated in its 2014 position statement that it opposed euthanasia and assisted suicide, as it had done previously. That year, an addition was adopted alongside this position stating that the CMA supported the right of physicians to exercise their discretion, within the framework of the law, whether or not they would participate in the implementation of medical aid in dying.[370] The CMA had previously organized open discussion sessions on the issue for both the public and its members. The position was influenced by the Canadian legal case *Carter v. Canada*, which resulted in the Supreme Court of Canada ruling in 2015 that it is unconstitutional to deny the right to assisted dying.[371]

The court's decision and its implications for the profession have sparked debate among physicians.[372]

The CMA's 2017 position statement on medical assistance in dying takes only a neutral stance.[373] The position paper emphasizes patient autonomy and is pragmatic. There is little consideration of the fundamental values of medical ethics, but the use of physician discretion is emphasized.

"The CMA supports maintaining the balance between three equally legitimate considerations: respecting decisional autonomy for those eligible Canadians who are seeking access, protecting vulnerable persons through careful attention to safeguards, and creating an environment in which practitioners are able to adhere to their moral commitments."

The CMA was active in the development of Medical Aid in Dying (MAID) legislation in Canada, but was hesitant to include in it minors and those with mental health problems.[374] [375] The CMA has sought to review practices since the law came into force.[376] The CMA has supported the expansion of the legislation to allow for advance requests for assisted dying for individuals who may lose decision-making capacity before the implementation phase.[377] The CMA has taken a positive view of organ donation following euthanasia or assisted suicide.[378]

The CMA has conducted a member survey on euthanasia and physician-assisted suicide to explore views and experiences of Medical Assistance in Dying (MAID) legislation.[379]

7.6.6. The Netherlands

The Royal Dutch Medical Association (De Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst, KNMG)[380] has published several guidelines on euthanasia and physician-assisted suicide over the years.[381] [382] The most recent guidelines are included in the 2021 publication on end-of-life decisions.[383]

Euthanasia is seen as an exceptional medical procedure because it involves the termination of human life. On the one hand, the physician has a duty to protect life, and on the other hand, a duty to alleviate, prevent or end the patient's suffering, even if this means ending the patient's life at the patient's request. The physician is seen as having a conflict of duties. In such a situation, the physician may decide that respecting the patient's will is more important than protecting life and act compassionately in accordance with the patient's will.

"When faced with a situation of unbearable suffering combined with a request for euthanasia from the patient, a physician faces a conflict of duties…

When faced with a conflict of duties, the physician may decide that their duty to honour a patient's request to end their suffering outweighs the duty to preserve that patient's life…

Respect for autonomy plays an important role in justifying euthanasia."

Medical associations have taken a negative stance on euthanasia and physician-assisted suicide until legislation, or a court has permitted these procedures. The Dutch Medical Association KNMG is an exception to this, as is the BMA. Some medical associations have maintained their negative stance even after permissive legislation, such as **the Portuguese Medical Association (Ordem dos Medicos)[384]**, **the Spanish Medical Association (Organización Médica Colegial de España)[385]** and the AMA.

7.7. Views of Palliative Care Associations

The International Association for Hospice & Palliative Care (IAHPC)[386] is the global umbrella organization of palliative care organizations. In 2017, it published a position paper on euthanasia and physician-assisted suicide.[387]

The position paper states that no country should consider legalizing euthanasia or physician-assisted suicide until everyone is guaranteed access to palliative care and access to appropriate medication, including opioids for pain and dyspnea.

The position paper further states that in countries where euthanasia or physician-assisted suicide are permitted, palliative care units should not be responsible for supervising or implementing these measures. Laws and regulations should provide guidance that anyone who objects to these measures has the right to refuse to execute them.

The IAHPC has compiled the positions of the palliative care organizations of the key countries on euthanasia and physician-assisted suicide, as well as a comprehensive collection of articles on the subject.[388] [389] None of these palliative care organizations supports the legalization of euthanasia or physician-assisted suicide.

The European Association for Palliative Care (EAPC)[390] has issued a position paper on euthanasia and physician-assisted suicide, which has also been published in the Finnish Medical Journal.[391] It highlights 10 key aspects. The position paper approaches the topic from a practical perspective, encourages discussion of the topic, and leaves it up to consideration as to how matters should be resolved on a case-by-case basis. The last paragraph 10 reflects the nature of the position paper:

"10) EAPC should respect individual choices for euthanasia and physician-assisted suicide, but it is important to refocus attention onto the responsibility of all societies to provide care for their elderly, dying and vulnerable citizens. A major component in achieving this is the establishment of palliative care within the mainstream healthcare systems of all European countries supported by appropriate finance, education and research. Realizing this goal is one of the most powerful alternatives to calls for the legalization of euthanasia and physician-assisted suicide."

The Finnish Palliative Medicine Association (Suomen Palliatiivisen Lääketieteen Yhdistys, SPLY)[392] has taken a negative position on euthanasia in a statement to the Social Affairs and Health Committee of the Parliament in 2018.[393] According to it, it is seen as a difficult, or even impossible task to assess whether an individual's suffering is unbearable. In mental illnesses, assessment would be particularly difficult. Pain management and methods have developed so that severe pain can usually be controlled at least special-level pain management methods. Palliative sedation is seen as a working method if other symptomatic treatment does not help. Instead of euthanasia, legislation should ensure sufficient support for end-of-life care.

On April 8, 2024, SPLY issued a new statement in which it reiterates its negative position on euthanasia and the permission of physician-assisted suicide. SPLY, in agreement with international palliative medicine organizations, believes that euthanasia and physician-assisted suicide do not belong to palliative care. Legislative measures should be used to improve the availability of palliative care and end-of-life care services and the development of expertise.[394]

7.8. Ethical Views of Other Healthcare Professions in Finland

The ethical guidelines for nurses are based on the same basic values as doctors: *"A nurse is a nursing expert whose work aims to promote and maintain health, prevent and treat illness, and alleviate suffering."* [395]

The ethical guidelines for practical nurses state the following: *"Work in the social, health, and educational sectors is based on commonly accepted values. The regulations and ethical principles of the sector guide the activities of professionals."* [396]

7.9. Views of Disability Organizations

Disability organizations have been critical of the legalization of euthanasia. This has been raised, for example, in an expert opinion requested by the Parliamentary Committee on Social Affairs and Health from the Kynnys Association.[397] These thoughts have been summarized by social ethics professor J Hallamaa as follows:[398]

- *"Disability organizations also oppose the Euthanasia Bill The law inevitably requires a definition of when life is not worth living. If expert assistance is needed to cause death, life without value must be defined according to health criteria."*

- *"In enacting the Euthanasia Bill, society is by no means — as many advocates of the law seem to think — giving the individual the power to decide on his or her own death, but rather formulating the criteria on the basis of which the worthiness of life is weighed."*

Internationally, disability organizations have views against euthanasia and physician-assisted suicide, such as in the United States.[399] [400] Cases of discrimination and neglect of patient safety endangering people with disabilities have emerged.[401]

7.10. The Swedish National Council on Medical Ethics (SMER)

In Sweden, the **Swedish National Council for Medical Ethics (Statens medicinsk-etiska råd, SMER**)[402] (cf. ETENE) has conducted a study on assisted dying in 2017, examining legislative models and arguments for and against both euthanasia and physician-assisted suicide. The study focused on physician-assisted suicide, and in particular on the legislation in the US state of Oregon and the issues that emerged in its practical implementation. The report does not actually aim to draw conclusions, but rather to summarize essential issues and analyse the whole.[403] The report is also summarized in question-answer format.[404]

The arguments presented in the discussion are divided into value arguments and factual arguments that appear in the practices of applying euthanasia and physician-assisted suicide.

Value arguments for physician-assisted suicide and euthanasia are based on:

- self-determination
- democratic decision-making
- fairness
- the ability to regulate a practice that already exists
- arguments related to dignity

Value arguments against physician-assisted suicide and euthanasia are based on:

- the inviolability of life
- conflict with medical ethics
- loss of an important phase of the patient's life
- arguments related to dignity.

Factual arguments for physician-assisted suicide and euthanasia are based on:

- these interventions may be a last resort when symptoms cannot be controlled otherwise
- compassion for the patient
- these interventions can avoid the experience of poor quality of life and loss of human dignity at the end of life
- these interventions may reduce suicides.

Factual arguments against physician-assisted suicide and euthanasia are based on the following:

- these interventions are not needed when there is access to good palliative care
- the discussion about these interventions is conducted by healthy people, not sick people
- the care of other patients may be impaired
- trust in healthcare may decrease
- the medical assessments related to these interventions are uncertain
- patients requesting these interventions are often depressed
- it is difficult to assess with certainty whether the patient is capable of making decisions
- it is difficult to ensure that the request for these interventions is voluntary and permanent
- society's perception of people may change if these interventions are allowed
- the phenomenon of the slippery slope
- "doctor shopping"
- risks to vulnerable people
- these interventions may fail
- these interventions are a burden on healthcare staff

Arguments for and against are analysed in detail, especially factual arguments. The analysis has examined which factors support the arguments presented both for and against. The assessment recognises that there may be other arguments than those discussed and other assessment aspects than those discussed. The conclusions are not considered final and may be subject to change as new considerations emerge. The conclusions drawn from the Oregon model are not considered to be directly applicable to Sweden.

The issues raised have arisen from the debate in Sweden and the analysis has examined what kind of support can be found for them.

7.11. The Danish Council of Ethics (Det Etiske Råd)

The Danish Council of Ethics (Det Etiske Råd)[405] conducted in 2023 extensive research and prepared a statement on euthanasia and physician-assisted suicide: Det Etiske Råds udtalelse om dødshjælp (2023).[406] This was done at the request of the Danish Parliament's Health Committee, as the citizens' initiative for euthanasia[407] had collected the required 50,000 signatures to proceed to the Parliament's (Folketinget) consideration. The statement serves as background material for the Parliament's consideration of the citizens' initiative for euthanasia. The Danish Council of Ethics previously prepared a statement on euthanasia in 2012.[408]

The new statement highlights both pros and cons. As examples, the legislation of Oregon in the USA and in the Netherlands and their implementation in practice are examined. The statement refers at several points to a similar study previously conducted by the Swedish SMER.

In the ethical discussion, the arguments are divided into basic ethical arguments and basic practical-political arguments. The ethical arguments examine the reduction of suffering and the right to self-determination as the reasons for euthanasia and physician-assisted suicide. The ethical arguments against euthanasia and physician-assisted suicide examine the right to life and the integrity of life, as well as the prerequisites for autonomy and decision-making, and possible pressure from the environment.

The practical-political argumentation summarizes the conditions that have been presented for euthanasia and physician-assisted suicide to be accepted. The opposing aspects are the possibility of errors, abuse and the emergence of the slippery slope phenomenon. Arguments against euthanasia and physician-assisted suicide also include the negative consequences for vulnerable people and the negative effects on the patient-doctor relationship and palliative care.

In summary and as a position, the Ethics Council states that euthanasia and physician-assisted suicide should not be legalized. It sets forth that allowing euthanasia and physician-assisted suicide would impose unacceptable norms on society, healthcare and human perception. The possibility of euthanasia and physician-assisted suicide would decisively change the perception of old age, dying, quality of life and consideration for others.

Legalizing euthanasia and physician-assisted suicide would threaten the principle of equal respect and human dignity for all people, regardless of the amount of suffering and the assessment of quality of life. Legalizing these measures would directly or indirectly mean that some people's lives are not worth living.

The summary states that it is too difficult to determine when the desire for euthanasia is deep enough and what good reasons would be to allow euthanasia and physician-assisted suicide. It can be stated that after accessing good palliative care, many patients have given up their desire for euthanasia.

The Danish Ethics Council does not consider it possible to develop legislation that could act responsibly and at the same time protect the most vulnerable in society. Therefore, the only possible alternative is to maintain the ban on euthanasia and physician-assisted suicide. Two of the 16 members of the Council considered that further studies were needed on the matter.

7.12. The National Advisory Board on Social Welfare and Health Care Ethics, ETENE

7.12.1. ETENE Publications on the Value Base of Health Care

The National Advisory Board on Social Welfare and Health Care Ethics ETENE has described the foundations of health care ethics in several publications. These include, for example, Terveydenhuollon yhteinen arvopohja, yhteiset tavoitteet ja periaatteet (The Common Value Base, Common Objectives and Principles of Health Care)(2001)[409]; Sosiaali- ja terveysalan eettinen perusta (The Ethical Base of the Social and Health Sector)(2011)[410]; Etiikan tila sosiaali- ja terveysalalla (The State of Ethics in the Social and Health Sector)(2012)[411]. More general professional ethics material prepared by ETENE is available on the ETENE website: Lisää ammattietiikasta (More about professional ethics)[412].

The publication Sosiaali- ja terveysalan eettinen perusta (The Ethical Status of the Social and Health Sector) provides ethical recommendations for the social and health sector. In addition, it

considers, among other things, whether *"a good ethical outcome is created based on individual choice or societal guidance."*

ETENE has separately addressed issues related to the end of life, death and end-of-life care: Kuolemaan liittyvät eettiset kysymykset terveydenhuollossa (Ethical issues related to death in health care)(2001)[413]; Saattohoito – Valtakunnallisen terveydenhuollon eettisen neuvottelukunnan muistio (End-of-life care – Memorandum of the National Health Care Ethics Advisory Board)(2003)[414] and Saattohoito Suomessa vuosina 2001, 2009 ja 2012. Suunnitelmat ja toteutus (End-of-life care in Finland in 2001, 2009 and 2012. Plans and implementation)(2012)[415]. More material on the subject prepared by ETENE is available on the ETENE website: Elämän loppu (End of life).[416]

7.12.2. ETENE Statements on Euthanasia in 2011 and 2017

ETENE has prepared two positions on end-of-life care and euthanasia: Ihmisarvo, saattohoito ja eutanasia (2011, korj. 2012) (Human dignity, end-of-life care and euthanasia, 2011, revised 2012)[417] and ETENE:n kannanotto eutanasiaan (ETENE's position on euthanasia)(2017)[418].

In its position paper Ihmisarvo, saattohoito ja eutanasia (Human dignity, end-of-life care and euthanasia) in 2011, ETENE has reviewed euthanasia reflections and surveys in Finland and elsewhere, as well as the legislation in those countries where euthanasia was approved at the time. ETENE states in the position paper that no unified view has been found on euthanasia. The question behind this is what kind of measures can and should be included in good care and a death that respects human dignity. ETENE believes that there needs to be a discussion, especially about situations where even good end-of-life care cannot sufficiently alleviate suffering. At the time, the estimate was that there could be a few dozen of them per year. In addition, it should be carefully examined how hospice care could be developed to respond specifically to alleviating their suffering. ETENE believes that there needs to be a discussion about whether euthanasia is ethically justified. The problem is seen as, among other things, the valuation and determination of suffering. ETENE believes that supporting and promoting hospice and palliative care would be necessary.

ETENEn kannanotto eutanasiaan (ETENE's position on euthanasia) in 2017 describes the Finnish legislation affecting the subject in more detail, as well as the significance of international human rights treaties. It briefly describes the prevailing practices in euthanasia and assisted suicide. The right to life is the most fundamental human right and its protection is seen as a prerequisite for the realization of other human rights.

The ethical obligation of healthcare is described as doing good and avoiding harm, alleviating pain and suffering, respecting human dignity and the right to self-determination, and treating patients equally, regardless of illness.

The statement states that *"the shortcomings of care make it difficult to provide a reliable assessment of the nature of suffering, which cannot be eliminated even by good treatment of symptoms. Only, when sufficient and comprehensive end-of-life care has been arranged for patients who need it, can we reliably assess how many patients endure from suffering that cannot be adequately treated."*

On the other hand, it is pointed out that there are views according to which, regardless of suffering, a person should be allowed to decide on their own death*, "when they no longer find their own life meaningful or valuable."*

The problems of euthanasia are brought up extensively. The following questions are raised:

• Under what conditions can a request for euthanasia be considered to be based on information?

• Is the request for euthanasia based on inadequate treatment of suffering or pain or on fear of being left without such help?

• How can definitions be made of the serious illnesses that are required as grounds for euthanasia and how can the proximity and time of death be predicted when experts do not have consistent views?

• How can the intolerability or tolerability of suffering be defined?

• What are the actual grounds for euthanasia? Is it the case that euthanasia would be resorted to even when good symptomatic or curative treatment was available as an alternative?

• Is euthanasia carried out appropriately for those suffering from psychiatric illnesses and for those whose euthanasia wish is implemented on the basis of a previously drawn up medical will?

• How can euthanasia be justified from the perspective of patient autonomy, when the time and place of the procedure are ultimately determined by others?

• Can economic interests expand the criteria for euthanasia, when professionals in private companies also perform euthanasia?

• Is it the case that elderly people are pressured into euthanasia?

• Do elderly people feel obliged to request euthanasia when their functional capacity deteriorates, and they need external help?

• Is it possible that euthanasia would affect the attitudinal climate and weaken the experience of disabled people that they have an equal right to life with healthy people and that their lives have the same value as physically healthy people?

• When serious disability increases the risk of suicide, could euthanasia become a channel for the fulfilment of the wish to die?

• Can retrospective reporting be considered sufficient as a means of monitoring?

The euthanasia debate is said to be hampered by the confusion of terminology. ETENE clarifies its own statement by first describing the definitions of the terms it uses. Some of the surveys conducted on euthanasia are found to be unreliable, but overall public opinion is found to have become more positive towards euthanasia. Healthcare personnel are found to be more critical of euthanasia than others.

The right to life is stated to be the most fundamental human right. It is linked to respect for human dignity and means securing a life of dignity, but not maintaining life for as long as possible. The right to self-determination is not seen as absolute in nature.

ETENE points out as its statement:

"The right to self-determination and the experience of suffering, the tolerability of which is assessed by the patient himself, speak in favour of making euthanasia possible. From the point of view of the legislation on euthanasia, the difficulties in defining what constitutes unbearable suffering, incurable illness and short life span and how to assess when a request for death has been made with full understanding and voluntarily have been considered problematic. Euthanasia is not a simple question of self-determination, neither in the citizens' initiative nor in the legislation of countries that allow euthanasia, because criteria are always set for euthanasia and the fulfilment of them is ultimately determined by others than the person making the request. It is also not only a question of individual rights but can be seen as a reflection of the values of society more broadly. Concern about the threat of losing the experience of human dignity and equality has been expressed in particular by those who need a lot of support and services from society.

Only by guaranteeing good end-of-life care to everyone who needs it can reliable assessments be made about how many patients there may be in Finland who cannot be helped and their suffering alleviated even by the most effective methods of end-of-life care. Only then could it be more precisely defined in which situations healthcare and medical means are not able to sufficiently alleviate the suffering of a dying patient, and whether a separate law is needed for these situations. In ETENE's view, in the current situation, the position of dying patients would be improved more by measures promoting palliative care and end-of-life care than by a euthanasia law. Euthanasia wishes, which are based on insufficient relief of treatable symptoms or fear of it, are more a sign of insufficient resources and insufficient expertise than of the necessity of assisted dying."

7.13. The Effects of Euthanasia and Physician-assisted Suicide on Physicians

The medical profession has a special status as a profession, the practitioners of which have special rights and obligations. This special status is associated with autonomy: the work of a physician is guided by medical ethics and medical knowledge about the best treatment to be implemented.[419]

Legalizing euthanasia or physician-assisted suicide would fundamentally change the image of the medical profession. The profession would have a collective obligation to implement these actions, which do not actually belong to the healthcare sector. Society would impose an obligation to value human life, and the medical profession would have to assess in practice whose life is worth living and whose is not.[420]

On the other hand, it has been suggested that legalizing euthanasia or physician-assisted suicide could increase trust in the doctor-patient relationship, as the patient could be sure that he or she would not have to suffer in vain. On the other hand, it has been suggested that legalizing these practices could cause distrust in the medical profession, which would also have the power to kill a patient at their request. At the same time, distrust would be directed at the entire healthcare system.[421] [422]

In all countries that have legalized these, physician-assisted suicide and euthanasia have been made voluntary. In the Finnish medical profession, the willingness to carry out these practices themselves is significantly more reluctant than their general permission. According to a study conducted in 2023 by the Finnish Medical Association and the University of Tampere, to the question *"If euthanasia were allowed in Finland, I would sometimes practice it myself",* 13.5% answered *"completely agree"* or 18.3% answered *"partially agree";* 42.7% *"completely disagree",* 7% *"partially disagree"* and 19% *"cannot say*". Of those with special qualifications in palliative

medicine 8% answered *"completely agree"* and 15% *"partially agree"*; 57% *"completely disagree",* 6% *"partially disagree"* and 15% *"cannot say".*[423]

The implementation of euthanasia has been found to have significant adverse effects on physicians.[424] [425] Many have experienced stress and very ambivalent feelings, on the one hand relief, on the other hand anxiety about ending a patient's life. Some have had feelings of moral guilt and experiences of isolation. Over time, after having implemented euthanasia or physician-assisted suicide several times, the feelings become less intense. Some physicians have been willing to perform these actions only very rarely. However, quite a few who have taken the action have been willing to repeat their actions.[426] [427]

Since the implementation of euthanasia and physician-assisted suicide has significant effects on the integrity, emotions and psychological burden of the doctor, it is also a matter of occupational safety and protection of interests.[428]

If euthanasia or physician-assisted suicide is allowed, it may have an impact on the recruitment of those specialists whose employees would most likely have to perform these procedures. Since the profession would have a legal obligation to carry out the acts in question, there could be pressure to train primarily specialists who would perform them. Would freedom of conscience then work?

In many countries, monitoring mechanisms only follow afterwards. In this case, there is some uncertainty as to whether the euthanasia or physician-assisted suicide met the criteria required by law. The doctor has to wait for the decision of the monitoring body whether he will be released from liability or not. This causes psychological stress for the doctor.

Correspondingly, post-mortem monitoring is problematic in terms of the patient's legal protection, and relatives can no longer get their deceased person back.

When euthanasia or physician-assisted suicide are permitted, they are also included in the range of services. There is a constant need in healthcare to allocate resources in a cost-effective manner. In such cases, the euthanasia or physician-assisted suicide may inevitably seem more affordable, because they appear to be measures that save healthcare resources in relation to good palliative care or hospice care. It is possible that this may result in financial pressure to act in favour of euthanasia and physician-assisted suicide.

8. Euthanasia citizens' initiatives

8.1. The Euthanasia Citizens' Initiative Submitted to Parliament in 2017 and its Processing

Several citizens' initiatives have been submitted to legalize euthanasia.[429] The fourth of them exceeded the threshold of votes and was submitted to Parliament in 2017: Eutanasia-aloite hyvän kuoleman puolesta (Euthanasia initiative for a good death).[430]

The citizens' initiative (KAA 2/2017 vp) presented euthanasia as a possibility in a situation where a person has an incurable illness that will lead to death in the near future and unbearable suffering, for which he or she cannot receive sufficient relief even from good palliative care.

It presented the criteria for allowing euthanasia, including adulthood, legal capacity, and a request that has been made voluntarily, thoughtfully, and repeatedly. In addition, it was proposed that the condition for allowing euthanasia is that the doctor and the dying person both agree that there are no other meaningful alternatives to the situation.

Parliament held an extensive referral debate on the citizens' initiative.[431] The Parliament's Social Affairs and Health Committee widely requested expert opinions on the matter[432] and prepared a report in which it recommended rejecting the initiative and approving a draft statement that would oblige the Government to establish an expert working group for further investigation of the matter.[433]

Parliament rejected the euthanasia citizens' initiative by 128–60 votes on 4 May 2018 in accordance with the proposal of the Social Affairs and Health Committee. At the same time, this statement was adopted:[434]

"Parliament requires that the Government establish a broad-based expert working group to investigate the regulatory needs regarding good care at the end of life, the right to self-determination, and end-of-life care and euthanasia and, if necessary, submit proposals to Parliament for legislative amendments based on the investigation."

8.2. Expert Opinions on the Euthanasia Citizens' Initiative

During the hearing of the euthanasia initiative, the Parliamentary Committee on Social Affairs and Health heard the initiators of the initiative and the experts they requested, who numbered 27 in total, and requested written statements from seven instances. Written statements were also submitted during the hearings.

8.2.1. The Expert Opinion from the Finnish Medical Association

The Finnish Medical Association was heard and provided an expert opinion.[435] The opinion in its entirety reads:

"KAA 2/2017 – Euthanasia initiative for a good death

The Finnish Medical Association is grateful for the opportunity to present its views on the citizens' initiative proposing the legalization of euthanasia. The Medical Association welcomes the citizen debate on end-of-life care in Finland that the initiative has sparked.

The Finnish Medical Association opposes the legalization of euthanasia. *The Finnish Medical Association also opposes that physicians, as a profession, would be obliged to take measures whose primary purpose is to hasten the death of a patient. Although the wishes for euthanasia are understandable, in the opinion of the association there is no sufficient ethical basis or practical need for the legalization of euthanasia in Finland. Legislation permitting euthanasia would in principle represent a significant change in values. The task of physicians is to use the possibilities of modern medicine to treat suffering, and deficiencies in the care system should not be corrected by euthanasia.*

The Finnish Medical Association bases its opposition to euthanasia legislation on, among other things, the following arguments:

• Euthanasia is never simply a private matter for an individual, but a value choice for society.

• Allowing euthanasia is justified by the right of people to self-determination. However, euthanasia legislation does not give the individual the right to self-determination, but the realization of the patient's euthanasia wish depends on the assessment and actions of another person, the physician.

• There are ways to alleviate the suffering of a patient at the end of his or her life that work well when used correctly and sufficiently. The importance of psychological support plays an important role here.

• Allowing euthanasia would mean a fundamental change in the nature of the physician's work — that is, the profession — and the medical community would abandon the principles of respect for and protection of life on which the entire profession is built.

• Euthanasia is desired to be the responsibility of the medical profession because of the professional competence of physicians. Euthanasia is not a therapeutic act, part of healthcare. The ethical obligation of a physician to alleviate suffering also when death is approaching does not mean that the physician should actively end the patient's life.

• In countries that allow euthanasia/physician-assisted death, many physicians find it difficult to assist, even though it is voluntary. For example, in Canada, it has been found that many Canadian physicians who assist a patient to die, suffer from stress/depression, insomnia and need therapy. The experience is so mentally difficult that many only assist a patient to die once in their careers.

• According to the World Medical Association (WMA), euthanasia is unethical. On the other hand, giving up unnecessary, ineffective treatments and artificial prolongation of life and allowing death is not.

• In countries that allow euthanasia, it is seen that euthanasia is becoming more common in more and more situations. Causing death is becoming acceptable. This culture makes it possible, among other things, that, according to a study published in the scientific journal Lancet, 23% of euthanasia cases in the Netherlands are not reported, despite being required to be.

• Post-hoc supervision of euthanasia (notification to the supervisory body as proposed) is not sufficient in terms of the physician's legal protection. At worst, the physician can "hang in limbo" for a long time before he learns whether euthanasia is acceptable in the situation in question or whether he will be charged with causing death, manslaughter, etc. Euthanasia that has been carried out cannot be undone based on a post-hoc assessment.

• It is ethically questionable to enact a law permitting euthanasia when good palliative care and end-of-life care are not equally available to everyone.

The Finnish Medical Association believes that a patient should always receive appropriate end-of-life care, including sufficient pain relief and emotional support. The Association ***considers it of primary importance to develop end-of-life care to be functional and sufficient*** *so that it is equally available to everyone in need in an environment that allows the presence of relatives. A step forward has already been taken in the development of hospice care in the form of a new recommendation on the organisation of palliative care and end-of-life care (Reports and memoranda of the Ministry of Social Affairs and Health 2017:44). Now the recommendation needs to be implemented effectively.*

The Finnish Medical Association has conducted several surveys to find out physicians' views on euthanasia. The profession's attitude has changed in a more liberal direction since twenty years ago, but only just under a quarter would consider implementing euthanasia. Physicians' attitudes are influenced by their specialty and job description. Physicians who treat dying patients have a more negative attitude towards euthanasia. The most recent survey was conducted in early 2017 and according to it, only 17% of doctors providing end-of-life care support the Euthanasia Bill. Euthanasia is not a solution to the problem of the finiteness of life and human suffering."

8.2.2. Other Expert Opinions

The expert opinions and hearings requested by the Parliamentary Committee on Social Welfare and Health constitute the key material, which highlights aspects in favour of and against euthanasia.[436] In addition to the initiators of the initiative, several organisations, researchers, lawyers, and experts in palliative medicine and end-of-life care were consulted as experts.

The expert opinions address two main themes. The first is the issue of patient autonomy and its expansion. This is related to the issue of human rights. The second is the issue of "unbearable suffering" and other proposed grounds for implementing euthanasia, their definition and assessment, and whether they can be implemented in a reliable manner. The opinions present views on the consequences of implementing euthanasia. The importance of hospice and palliative care instead of euthanasia is highlighted.[437]

The authors and supporters of the Euthanasia initiative highlight the extension of the individual's right to self-determination to include the right to receive assistance in dying when the individual considers it appropriate due to their own suffering. The justification for this is presented as the relief of unbearable suffering and the increased positive attitude of citizens towards euthanasia and physician-assisted suicide (e.g. Lax et al.[438], Seppänen[439], Exitus ry[440], Hänninen[441]). Patient cases are presented as examples of unbearable suffering (Hänninen, Seppälä[442]) and reference is made to the positive experiences of some physicians in the Netherlands with euthanasia (Hänninen). Euthanasia is seen as possible in medical ethics, although it is recognized that the Finnish Medical Association and the World Medical Association are opposed to euthanasia (Hänninen, Seppälä, Exitus ry). The basis is also that a similar practice already exists in several countries and that there is a view of human rights from the decisions of the European Court of Human Rights that provides an opportunity for the drafting of such legislation (Lehtonen[443], Lahti[444], Nuotio[445], Nieminen[446]).

The initiators and key supporters of the initiative consider the criteria proposed therein to be sufficiently strict to prevent abuse (including Lax et al., Seppänen, Exitus ry, Hänninen). Some of

the initiators of the Euthanasia initiative are, however, unclear about what is meant by euthanasia, as some of them consider it to include palliative sedation (Lax et al.).

Those who have a negative attitude towards the Euthanasia initiative raise several aspects. From the perspective of social ethics and human rights, the right to life, which is the highest of the fundamental rights, is by its nature such that it cannot be waived. The right to self-determination is not seen as a priority, so that it could displace the right to life as a legal good protected by society (Hallamaa[447], Finnish Christian Medical Association (SKLS)[448]). The initiative has been seen as contradictory in its grounds, as it emphasises the right to self-determination, when in fact the decision-making power would be given to the physician (Hallamaa, Louhiala[449], Finnish Palliative Medicine Association (SPLY)[450] , SKLS). The physician's legal protection would be questioned, as euthanasia is in principle a punishable act, for which the impunity or punishment would only be determined afterwards (Hallamaa).

In expert opinions, representatives of medicine in particular have highlighted that making the assessments presented as criteria for euthanasia is very problematic. It is difficult to unambiguously define “incurable terminal illness”, life expectancy, “unbearable suffering” and when its alleviation is sufficient, in which case the condition for euthanasia is not met (Saarto[451], Pöyhiä[452], Louhiala, Lehtinen[453], SKLS). The assessment that the decision for euthanasia has arisen from the patient’s own will is also challenging, as is the assessment of the request of those suffering from mental illnesses (Saarto, SPLY). Euthanasia is not included in international definitions of palliative care, and it is not a medical procedure (Pöyhiä). Euthanasia is inconsistent with medical ethics (Pöyhiä, SPLY, SKLS) and there is no significant support for it among end-of-life care physicians (SPLY). Good end-of-life care has been considered to be able to alleviate the symptoms of the dying person (Saarto, Pöyhiä, SPLY, SKLS). Euthanasia has been considered to be capable of undermining trust in healthcare and physicians and causing stress for physicians, which is an occupational safety issue (Pöyhiä, SKLS).

Referring to international examples, it has been seen as a risk that the practice of euthanasia would expand to a wider use than its original purpose, i.e. the so-called slippery slope phenomenon would materialize (Hallamaa, Saarto, Pöyhiä, Lipponen[454], Louhiala, SKLS).

The retrospective monitoring mechanism proposed in the initiative has been seen as problematic, as a significant proportion of euthanasias are not reported in the Netherlands and Belgium, and other abuses have been identified, which means that patient safety is not achieved (SKLS). The acceptance of euthanasia has created a “culture of death”, in which other medical methods are also used to intentionally cause death often without the patient's consent (SKLS). Problems have been seen in the implementation of euthanasia, as death is not always quick and good due to complications (Pöyhiä). Euthanasia has been seen as threatening the status of disabled people and their appreciation of life (Kynnys ry).[455]

The possibilities of palliative care and end-of-life care have been emphasised, and their development has been seen as important instead of euthanasia (Saarto, Pöyhiä, Lehtinen, Lipponen, Super[456], SPLY, SKLS).

Those with reservations describe the studies they have conducted (Terkamo-Moisio[457]) or the key aspects of their field, placing emphasis on the development of end-of-life care (Tehy[458]).

Some of the experts do not have a clear position for or against. They describe the attitudes of their field (Sairaanhoitalliitto[459]), aspects of their field (Vanhustyön keskusliitto[460], Geronomiliitto[461]) or studies (Kankkunen[462]) with background on the topic.

The statements requested from religious communities are negative about euthanasia. The main justifications are the inviolability of human dignity and respect for life, as well as the religious community's own theological justifications (Helsinki Jewish Community[463], Finnish Orthodox Church[464], Finnish Evangelical Lutheran Church[465]). Based on its expertise in hospital spiritual care, the Finnish Evangelical Lutheran Church also raises a wide range of justifications that are consistent with the justifications raised by physicians, such as the problem of definitions, the danger of a slippery slope and the erosion of trust in the medical profession, while emphasizing the importance of developing end-of-life care instead of euthanasia.

An expert opinion was also requested from two persons in the Netherlands, one of whom supported euthanasia and the other who opposed it. The euthanasia supporter (Jonquiére[466]) described the criteria of the Dutch legislation and its implementation process, trying to demonstrate their functionality and that there would be no slippery slope phenomenon. The euthanasia opponent (Boer[467]) drew attention to the continuing significant increase in the number of euthanasias and the increase in controversial cases. He also pointed out that euthanasia is no longer a procedure to be carried out in special cases, but that there is pressure on doctors and patients to make euthanasia the normal course of action and perhaps the only way to die that is considered dignified, which means that the slippery slope phenomenon is going on.

The safeguarding of the freedom of conscience of healthcare personnel has been seen as important in several statements both supporting and opposing the initiative. However, the citizens' initiative does not seem to propose real freedom of conscience, as the proposal includes an obligation to refer to another physician. According to the WMA, freedom of conscience is only considered to be realized if the physician does not have an obligation to refer the patient to another physician in such cases. The obligation may extend to the requirement to inform the patient about the possibility of seeking another physician.[468]

After expert hearings, the Parliamentary Committee on Social Affairs and Health prepared a memorandum for parliamentary consideration. It reviews the basic issues of euthanasia and palliative care, as well as end-of-life care and its development. After the memorandum, the committee proposed that Parliament reject the citizens' initiative and oblige the Government to establish a working group to investigate the issues in the subject.[469]

The parliamentary consideration and expert opinions had a significant impact on the formation of the opinion of the MPs. Before the consideration, it was anticipated that the initiative might gain sufficient supporters, but the opposite happened. Parliament rejected the initiative by a clear margin of 128–60, but on the other hand considered that further consideration of the matter was appropriate.[470]

8.3. New Euthanasia Citizens’ Initiative Released 2023

A new citizens' initiative was launched on 2 November 2023 to legalise euthanasia.[471] The citizens' initiative website includes a link to the website of the Oikeus arvokkaaseen kuolemaan OAK (Association for the Right to a Dignified Death, formerly known as Exitus ry), which states that the organisation is behind the citizens' initiative.[472]

On its homepage, OAK justifies the legalisation of euthanasia with population surveys on support for euthanasia and examples of euthanasia legalisation in other countries. The sub-pages contain a question-and-answer type description of the conditions for implementing euthanasia in different

countries. There are also links to lectures and articles in the media, videos and programmes on the subject, as well as patient cases.

The central argument of the citizens' initiative is that: *"The Euthanasia Act is needed to increase the end-of-life options for those of our fellow human beings who do not receive sufficient relief from their unbearable suffering, despite good palliative care."*

Another central argument is that: *"However, at the end of our lives we do not have the right to self-determination - that is, the freedom to decide how or when we can die. In a civilized society, a person's individual freedom should also mean that they are allowed to decide about their own life and its end when circumstances become impossible, and life is no longer worth living in the person's own opinion. In a situation where a terminally ill person absolutely wants to end their own suffering, greater weight should be placed on self-determination, and the person's own will should be respected."*

The initiative also presents criteria for the cases in which euthanasia could be implemented. The criteria are mainly the same as in the previous citizens' initiative on euthanasia that was rejected by Parliament. It is now specifically stated that an incipient memory disorder is not an obstacle to euthanasia if the person is capable of making a decision. It is no longer required that clinical depression be treated before euthanasia is carried out. If the mental state requires it, it is now specified that a second assessment must be requested from a psychiatrist and, in the case of a person with memory disorder, from a geriatrician.

The new initiative states that euthanasia can be carried out if the person refuses treatment that would substantially alleviate their suffering. It is mentioned as a general obligation that the physician has familiarized himself with the patient's medical records of the illness in question. Suffering resulting from an accident is mentioned as a possible justification for euthanasia.

The initiative proposes that supervision be implemented retrospectively, as was the case in the previous initiative.

The citizens' initiative reached the threshold of 50,000 supporters required to advance to Parliament in 3/2024.

9. Report of the Working Group on End-of-Life Issues Appointed by the Ministry of Social Affairs and Health

When Parliament rejected the citizens' initiative on euthanasia on 4 May 2018, it also approved a statement requiring the Government to set up a broad-based expert working group to investigate the regulatory needs regarding good care at the end of life, the right to self-determination, and end-of-life care and euthanasia.[473] The Ministry of Social Affairs and Health (STM) set up such a working group.[474] The final report of this End-of-Life Issues Working Group was published on 30 August 2021.[475]

The report's main contribution is the recommendations for improving hospice care. The report does not recommend legalizing euthanasia or physician-assisted suicide. The working group was broad-based and also included representation from the Finnish Medical Association and palliative medicine. The results of the working group on end-of-life care have been described above (see Chapter 3).

The Parliamentary Committee on Social Affairs and Health stated in its report that served as the background to the parliamentary decision:[476] *"The Committee believes that the matter requires a broad public debate similar to that sparked by the citizens' initiative and a careful ethical assessment. The assessment of the matter also requires a comprehensive report on, among other things, constitutional rights, criminal law and the position of health care personnel to determine whether new regulations or other measures are needed to ensure good care and for terminally ill patients and the realization of their right to self-determination at the end of life. In the Committee's view, the need for legislation on the care of dying people and euthanasia should be assessed after these investigations."*

The decision to establish the Ministry of Social Affairs and Health (STM) working group did not require an ethical assessment to be carried out as a basis for its work. The starting point for such work would have been the expert opinions requested by the Parliamentary Committee on Social Affairs and Health, but no analysis has been made of them. The legal basis for euthanasia and physician-assisted suicide has been examined, among other things, in the document provided as background material in the light of the decisions of the European Court of Human Rights.[477] The document takes the view that it is within the discretion of the state whether to enact a law on euthanasia or physician-assisted suicide.

In Finland, the Constitution plays a central role in what can be enacted on euthanasia. There is no statement from the Constitutional Law Committee on the matter. In connection with the constitutional reform, strict conditions were described for when an individual's fundamental rights – in this case, the right to life – can be infringed. The final report does not provide a thorough explanation of this. The shortcomings of the ethical and legal assessment basis of the final report are highlighted in the statement by palliative medicine specialists at the end of the report.[478]

The report provides an appropriate overview of the legislation of a few countries that have approved euthanasia or physician-assisted suicide. However, the report does not include an analysis of research data from countries that allow euthanasia and physician-assisted suicide on their practical implementation and the factors behind requesting euthanasia. Medical ethics are given only little weight.

The report takes the individual's right to self-determination as its starting point. This is a different starting point than ETENE's position on euthanasia. The report describes two alternative models

for implementing euthanasia and physician-assisted suicide. These are described to provide concrete starting points for the discussion on the matter. The report lacks a risk analysis of implementing euthanasia and physician-assisted suicide and a description of the criminal sanctions for violating the obligations of the operating models presented in these draft regulations. Patient safety is not a key consideration. The legal status of physician-assisted suicide is stated to be unclear, and it is hoped that this will be clarified.

One of the models of euthanasia and physician-assisted suicide described by the working group is stricter in terms of regulations than any of the existing laws on the subject described in the report, focusing on physician-assisted suicide and allowing euthanasia in exceptional cases, making advance supervision a condition for the actions. The other model allows physician-assisted suicide and euthanasia equally and is based more broadly on the patient's right to self-determination and is more liberal, following the Dutch model. Advance supervision can also be bypassed in certain cases and the patient is not obliged to receive appropriate treatment for their symptoms. The report states that this second option did not have time to be discussed in depth in the legislative working group or the end-of-life expert working group.

This report by the Ministry of Social Affairs and Health end-of-life working group has significantly contributed to the development of palliative care and end-of-life care in Finland. The report provides background to the discussion on euthanasia and physician-assisted suicide and makes them concrete with exemplary draft legislation. This enables a more detailed discussion of legislative issues. The working group members had the opportunity to attach their views, and a few did so.

10. Opinion Surveys Among the Public

Several surveys have been conducted among citizens with the aim of mapping opinions on euthanasia. A common issue with these surveys is the lack of clear definitions for the terms used in the questions.

Until the fall of 2023, the term “kuolinapu” (assisted death) was defined in the Dictionary of the Finnish Language Office (Kielitoimiston sanakirja) as "hastening death by ceasing certain medical treatments—passive euthanasia." Therefore, in surveys conducted before this date, this official definition must be considered. Surveys using this term before the fall of 2023 cannot be used to draw conclusions about support for euthanasia.

For example, a survey on euthanasia commissioned by MTV3 and conducted by Think If Laboratories Oy in 2012 revealed that 72% of Finns were in favor of allowing euthanasia, 15% were against it, and 13% were undecided. This survey was conducted online between May 24-29, 2012, with 1,819 respondents representing a cross-section of adult Finns in terms of age, gender, and residence.[479]

In 2016, YLE, in collaboration with Taloustutkimus, conducted a phone survey on euthanasia.[480] The question posed was: *"Do you accept euthanasia—i.e., should a person have the right to receive assisted death (kuolinapu)?"* However, subsequent assessments have noted that *"in one-question opinion polls, the background of euthanasia is not explained separately. Thus, respondents base their answers on their perceptions. Some participants in YLE's street poll mentioned after answering that they understood euthanasia to involve, for example, turning off the ventilator of a patient in a coma..."*

The question in the YLE survey was problematic because it equated two terms with officially different meanings. Some respondents understood the question based on the official definition of “kuolinapu" (assisted death) and responded accordingly, making the survey unreliable.

Newspaper Helsingin Sanomat commissioned Kantar TNS in 2017 to conduct a survey on assisted dying, asking whether terminally ill patients should have the right to assisted death (kuolinapu).[481]

The newspaper reported the findings as indicative of support for euthanasia. However, according to the official definition, the survey did not ask about euthanasia because the question was about “kuolinapu” = *”hastening death by ceasing certain medical treatments”.* Thus, the results cannot be interpreted as support for euthanasia. Although the newspaper published a letter to the editor explaining this issue, it did not correct its reporting or issue another clarification. Instead, the newspaper repeated the survey that same autumn.[482]

In 2017, a survey on euthanasia was emailed to nurses, reaching 41,093 members, of whom 2,683 responded, resulting in a response rate of 6.5%. The low response rate means that the survey cannot be considered publishable, and no conclusions about nurses' attitudes can be drawn from it.[483]

In 2016, parliamentary candidates were asked during the election process in a survey whether "a terminally ill person should have the right to assisted dying (avustettu kuolema)". The term “avustettu kuolema" (assisted dying) was not defined in the survey, and there is no official definition for it. The term could be interpreted to mean either discontinuing treatment or euthanasia. However, the responses have been interpreted as support for euthanasia.[484]

Thus, there is a significant number of opinion polls that do not meet the criteria for proper research. Despite the obvious flaws in these polls, the results have been used uncritically by proponents of euthanasia to claim support for its legalization and to justify the acceptability of legalizing euthanasia based on these support figures.[485]

In February 2024, a new public survey on euthanasia and physician-assisted suicide was launched. A similar survey will also be conducted specifically among nurses.[486]

11. Euthanasia and Physician-Assisted Suicide – For and Against

11.1. Organizations and Websites For and Against and Comparisons of Arguments

Internationally, there are several organizations and websites that support euthanasia and physician-assisted suicide, and there are also several that oppose them. In addition, there are websites that present both points of view and compare arguments on the subject. Below is a sample of a few such websites.

Critical views of euthanasia and physician-assisted suicide

Care not Killing https://www.carenotkilling.org.uk/
Euthanasia Prevention Coalition https://www.epcc.ca/
- EPCC blog http://epcblog.org/

Euthanasia Prevention Coalition – USA https://epc-usa.org/
Euthanasia.com http://euthanasia.com/
- Medical profession opinions: http://euthanasia.com/page17.html

End of Life Care http://www.epce.eu/en/
Right to Life UK https://righttolife.org.uk/knowledgebase/assisted-suicide-and-euthanasia
Right to Life Australia https://righttolife.com.au/life-issues/euthanasia
Patients Right Council http://www.patientsrightscouncil.org/site/
CARE https://care.org.uk/cause/assisted-suicide
LifeSite https://www.lifesitenews.com/topics/euthanasia
The Protection of Conscience Project https://www.consciencelaws.org/index.aspx
Dying Well https://www.dyingwell.co.uk/
National Rights to Live https://www.nationalrighttolifenews.org/category/euthanasia/
Physicians For Compassionate Care Education Foundation https://www.pccef.org/
Australian Care Alliance http://australiancarealliance.org.au/
Suomen Kristillinen Lääkäriseura https://www.skls.fi/nakokulmia/eutanasiasta/

Euthanasia advocates

Oikeus arvokkaaseen kuolemaan ry https://oakry.fi/
Exit international https://www.exitinternational.net/
World Federation of Right to Die Societies (WFRtDS) https://wfrtds.org/
- WFRtDS member organizations https://www.worldrtd.net/member-organizations/

My Death, My Decision https://www.mydeath-mydecision.org.uk/
De Nederlandse Vereniging voor een Vrijwillig Levenseinde NVVE https://www.nvve.nl/about-nvve

Assisted suicide advocates

Death With Dignity https://deathwithdignity.org/
End of Life Washington https://endoflifewa.org/
Friends at the End https://fate.scot/
Die Deutsche Gesellschaft für Humanes Sterben (DGHS) https://www.dghs.de/

Those presenting and discussing perspectives & arguments on the issue

BMA. Key arguments used in the debate on physician-assisted dying
https://www.bma.org.uk/media/4394/bma-arguments-for-and-against-pad-aug-2021.pdf?_gl=1*m4uc1z*_up*MQ..*_ga*MTE3Mjc2MDY5NC4xNzA1MTY0NjU4*_ga_F8G3Q36DDR*MTcwNTE2NDY1Ny4xLjAuMTcwNTE2NDY1Ny4wLjAuMA.
Britannica ProCon.org http://euthanasia.procon.org/
Encyclopedia of Death and Dying http://www.deathreference.com/En-Gh/Euthanasia.html

• Pälve H. Claims related to euthanasia. - in the book Palliatiivinen hoito (Palliative care).[487]

A large number of studies and articles have been published on euthanasia and physician-assisted suicide in medical journals,[488] and several books have been written on the subject. The Duodecim journal's Eutanasia article (euthanasia) from 2018 contains an extensive description of euthanasia and physician-assisted suicide.[489] A domestic doctoral dissertation has been written on attitudes towards death and euthanasia.[490] The Library of Parliament has compiled a literature reference material about euthanasia.[491]

11.2. Euthanasia and Physician-Assisted Suicide in the Media and Influencing Opinions

The population gets its understanding of end-of-life care, euthanasia and physician-assisted suicide mainly through the media. Some also have personal experience of end-of-life care for loved ones. The media plays a key role in the image that is formed of these, especially euthanasia and physician-assisted suicide.

Daily newspapers and magazines, as well as electronic media, have an editorial board that sets the tone for the newspaper's writing and approach to issues. The editor-in-chief and editorials in particular play a key role in choosing policies. Such policies are most often based on value choices.

The type of topics the newspaper's journalists want to write about also matters. The newspaper can also be offered topics for articles or people to be interviewed. The status of the media is proportional to how large a readership, viewership or audience it has and how the views it presents are spread.

The media relations of parties supporting or opposing euthanasia also play a key role in how they get the media to accept the story topics, interviewees or finished stories they offer.

In social media, the visibility of large media houses is significant, but there is significantly more room for freer opinion formation. In social media, follower numbers are important. Some sites or individuals can gain the status of opinion leaders.

The responses to opinion polls have an obvious correlation with how the media has presented the issue under study and in what light.

12. The Finnish Medical Association Surveys and Statements

12.1. The Finnish Medical Association Surveys

In 2013, Tampere University, in collaboration with the Finnish Medical Association (FMA), conducted a survey, according to which 45.7% of physicians were partly or completely in favor of legalizing euthanasia and 45.5% were partly or completely against it. Ten years earlier, in a similar survey in 2003, just under a third of respondents to a similar survey were in favor of euthanasia. The study has been published in the Journal of Medical Ethics.[492] [493]

On 6 October 2016, the Finnish Medical Association published the results of the Physician and Assisted Dying survey (Lääkäri ja kuolinapu -kysely) at the Good Death Seminar (Hyvä kuolema -seminaari) 9/2016.[494] The purpose of the survey was to survey physicians' opinions and experiences of the care provided by a physician just before death. The survey attempted to redefine the term “kuolinapu” (assisted dying), but this led to problems. The definition did not follow the definition of the Language Agency (Kielitoimisto) or the use of the term in professional language. The definitions in the survey have not been used by the FMA since then. Euthanasia was excluded from the survey.[495]

In January 2017, the Finnish Medical Association conducted a survey on end-of-life care and euthanasia for physicians treating terminal patients. The survey was addressed to 705 physicians, who were specialists in cancer, geriatrics and lung diseases, as well as physicians with a special qualification in palliative care. 290 physicians responded to the survey (response rate 41.1%). The majority (71%) of those who responded to the survey wanted a hospice law. 17% supported the euthanasia law and 64% opposed it. 15% supported the law on physician-assisted suicide and 59% opposed it. The survey was conducted for physicians, who are presumably best acquainted with the problems of dying patients and the possibilities of end-of-life care.[496]

The availability of end-of-life care was studied as part of the 2018 Health Care Canters’ Physician Situation Survey. Basic-level end-of-life care was reasonably well available throughout Finland, but specialized and complex specialized services were only available in just over half of the health care centers. Development areas raised by respondents included home end-of-life care services and staff training.[497]

In 2020, the Finnish Medical Association conducted an online survey of its members on their opinions on euthanasia and physician-assisted suicide. 6,489 physicians and 400 medical students responded to the survey. In the survey, 33.8% of the total respondents (33.9% of working-age people) were opposed to euthanasia, which was the largest group; 12.1% were partially opposed (12.7% of working-age people). 25.6% (24.5% of working-age people) supported euthanasia and 23.6% (23.6% of working-age people) gave partial support to euthanasia. 4.9% (5.5% of working-age people) were undecided.[498]

In the survey, 57% of working-age physicians either partially or completely agreed that with adequate end-of-life care and pain management, there is no need for euthanasia. Even among euthanasia supporters, one in five partially or completely agreed that if palliative care and end-of-life care were sufficient, euthanasia would not be necessary.

The longer the physicians had worked in treating patients at the end of their lives, the greater the proportion opposed the legalization of euthanasia. Support for euthanasia had not changed significantly since the previous survey in 2013. Opinions regarding physician-assisted suicide had changed in a more permissive direction.

In 2023, Tampere University, in collaboration with the Finnish Medical Association, repeated a survey of physicians conducted every 10 years, which surveyed physicians' opinions on euthanasia and physician-assisted suicide. The response rate was 31%, and the target group was 28,534 members of the Finnish Medical Association. 8,857 responses were received, of which 5,861 were employed, 444 were students, 2,340 were retired and 172 were otherwise out of work. The survey was sent to all members of the Finnish Medical Association who had not refused to receive surveys and whose email addresses were known to the Finnish Medical Association. The Finnish Medical Association comprises approximately 91% of doctors.[499]

The definitions of euthanasia and physician-assisted suicide in the book Lääkärin etiikka (Physician's Ethics) were used.

Of all respondents, 29.3% completely agreed with the statement *"Euthanasia should be legalized in Finland"* and exactly the same number, 29.3%, completely disagreed. 25.2% partially agreed and 11.0% partially disagreed. 5.3% were undecided.

Of all respondents, 18.2% completely agreed with the statement *"A doctor should be able to assist his patient in suicide"* and 30.2% completely disagreed. 31.4% partially agreed and 14.1% partially disagreed. 6.1% were undecided.

Of those with special qualifications in palliative medicine, 12% completely agreed with the statement *"Euthanasia should be legalized in Finland"* and 50% completely disagreed, 20% partially agreed and 15% partially disagreed. 3% were undecided.

Of those with special qualifications in palliative medicine, 8% completely agreed with the statement *"A doctor should be able to assist their patient in suicide"* and 44% completely disagreed, 25% partially agreed and 17% partially disagreed. 6% were undecided.

The study shows that support for both euthanasia and physician-assisted suicide has increased slightly compared to the 2020 study. For the first time, the responses of those with special qualifications in palliative medicine were available separately. Their position is clearly negative. Since they are best acquainted with the possibilities of treating a dying patient and the issues of end-of-life care, their position carries special weight. The response rate for them was remarkably high, meaning that the study provides reliable results about their position.

13.5% of all physicians completely agreed with the statement *"If euthanasia were allowed in Finland, I could practice it myself someday"*, 42.7% completely disagreed, 18.3% partially agreed and 7.0% partially disagreed. 18.5% were undecided.

15.7% of all physicians completely agreed with the statement *"I could assist a patient in suicide myself if it were allowed in Finland"*, 38.6% completely disagreed, 22.1% partially agreed and 8.4% partially disagreed. 15.1% were undecided.

Clearly fewer physicians are willing to carry out euthanasia or physician-assisted suicide themselves than they are to allow them.

Opinions were also asked on the statement *"With adequate palliative care and end-of-life care, there is no need for euthanasia"*. 28% completely agreed and 26% partially agreed. 15% completely disagreed and 28% partially disagreed. 3% could not express their opinion. In other words, quite many believed that with good care it might be possible to achieve such a treatment outcome that euthanasia is not needed.

The study also provides information on the distribution of responses by, for example, gender, age, involvement in working life and specialty groups.

The question was also asked *"Should the Finnish Medical Association change its position on euthanasia?"* 44.8% wanted the position to change, 37.4% would maintain the current position, and 17.8% were undecided. 32.0% would change the position of the Finnish Medical Association on physician-assisted suicide, and 47.8% would keep it unchanged, and 20.2% were undecided.

12.2. The Finnish Medical Association Statements

12.2.1. The FMA Expert Opinion to the Parliament's Committee on Social Affairs and Health

The Finnish Medical Association has taken a negative position on euthanasia with ethical and practical arguments when providing an expert opinion on 15 February 2017 to the Parliamentary Committee on Social Affairs and Health when it was considering a citizens' initiative on euthanasia (see Chapter 8 above).[500]

12.2.2. The FMA Council Statement 9th December 2016

The Council of the Finnish Medical Association set forth in its statement of 9 December 2016, among other things: *"The Finnish Medical Association opposes the legalization of euthanasia. The euthanasia debate concerns many fundamental questions and values of being human and of being a physician. Although the wishes for euthanasia are understandable, there are no sufficient ethical grounds or practical need for the legalization of euthanasia in Finland. Legislation permitting euthanasia would in principle be a significant change in values. The task of physicians is to use the possibilities of modern medicine to treat suffering, and the shortcomings of the care system should not be corrected with the help of euthanasia. In countries that permit euthanasia, it can be seen that euthanasia is becoming more common in more and more situations. The Finnish Medical Association considers it a priority to develop functional and sufficient end-of-life care so that it is equally available to all in need in an environment that allows the presence of relatives."* [501]

12.2.3. The FMA Council Statement 10th December 2020

The Council of the Finnish Medical Association has taken a position on euthanasia and physician-assisted suicide on 10 December 2020, stating that the Finnish Medical Association opposes their legalization.[502] At that time, the Council of the Finnish Medical Association discussed a survey conducted in the fall of 2020 on the position of the membership. The topic was previously discussed extensively in the FMA committees and the Ethical Committee, so the Council had a broad basis for forming its position.

In forming its position, the Council of the Finnish Medical Association, in addition to the survey, also carefully considered ethical issues related to euthanasia and physician-assisted suicide. The article on euthanasia and physician-assisted suicide to be included in the book Lääkärin etiikka (Physician Ethics) was under consideration by the Council and the Council approved it as such, which gave the article special weight.[503]

When discussing the topic, the Council of the Finnish Medical Association also used the survey conducted in early 2017 among physicians in certain specialties who treat dying patients and physicians with special palliative qualifications.[504]

12.2.4. The FMA Council Maintained the Medical Association's Negative Position on Euthanasia in 2022

In May 2022, the Council of the Finnish Medical Association discussed a proposal that the Medical Association change its position on euthanasia from negative to neutral. The proposal was rejected by a clear majority in the vote.[505]

12.2.5. The Stance on Euthanasia in the Book Lääkärin etiikka (Physician's Ethics)

The book Lääkärin etiikka (Physician's Ethics) has been edited by the Ethical Committee of the Finnish Medical Association and has been revised periodically. The latest revised edition is from 2021. The book contains a separate chapter "Elämän loppu" (End of Life) and an article called "**Eutanasia ja lääkäriavusteinen itsemurha**" (Euthanasia and Assisted Suicide)[506] (see Chapter 7 above). The article briefly reviews the ethical and practical aspects related to euthanasia and physician-assisted suicide. The article was discussed by the Council of the Finnish Medical Association on 10 December 2020 and the policy in it was approved by the Council.

The article states:

"The Finnish Medical Association opposes the legalization of euthanasia. The Medical Association also opposes that physicians as a profession would be obliged to perform procedures whose primary purpose is to hasten the patient's death (physician-assisted suicide).

Many of the questions and problems of the euthanasia debate discussed above are the same when talking about physician-assisted suicide. The physician acts to achieve the same purpose in both euthanasia and physician-assisted suicide: the goal is to cause the patient's death. The legal difference arises from whether the patient takes the medication themselves or whether the physician gives an injection or intravenous medication. In both cases, the physician plays a central role in the proper implementation of the act, so he is ethically responsible in both.

The euthanasia debate concerns many fundamental questions and values of being human and working as a physician. Legislation permitting euthanasia would in principle be a significant change in values and would open up unforeseen developments. The task of physicians is to use the possibilities of modern medicine to treat suffering, and the shortcomings of the treatment system should not be corrected by euthanasia or physician-assisted suicide."

In line with the above, the position of the Finnish Medical Association has been that end-of-life care should be developed instead of legalizing euthanasia.[507]

13. Abbreviations

AMA	The American Medical Association
ARM	The BMA Annual Representative Meeting
BMA	The British Medical Association
BÄK	Bundesärztekammer
CAMAP	The Canadian Association of MAiD Providers and Assessors
CASP	The Canadian Association for Suicide Prevention
CMA	The Canadian Medical Association
COPD	Chronic obstructive pulmonary disease
CPME	The Standing Committee of European Doctors (Comité Permanent des Médecins de la C.E.E.)
CRPD	The United Nations Convention on the Rights of Persons with Disabilities
DCD	Donation after circulatory death
DNLF	Den Norske Legeforening
EAPC	The European Association for Palliative Care
EHCR	The European Court of Human Rights
ELCPAD	The End-of-life care and physician-assisted dying project
ETENE	Valtakunnallinen sosiaali- ja terveysalan eettinen neuvottelukunta (Finland's National Advisory Board on Social Welfare and Health Care Ethics)
FMA	The Finnish Medical Association
IAHPC	The International Association for Hospice & Palliative Care
ICESCR	The International Covenant on Economic, Social, and Cultural Rights
ICoME	The International Code of Medical Ethics
KNMG	De Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst
MAID	Medical Assistance in Dying
NVVE	Nederlandse Vereniging voor een Vrijwillig Levenseinde
OAK	Oikeus Arvokkaaseen Kuolemaan ry (The Right to Dignified Death)
SCEN	Steun en Consultatie bij Euthanasie in Nederland (Support and Consultation for Euthanasia in the Netherlands)
SKLS	Suomen Kristillinen Lääkäriseura (The Finnish Christian Medical Society)
SLL	Suomen Lääkäriliitto (The Finnish Medical Association)
SMER	Statens medicinsk-etiska råd (The Swedish National Council for Medical Ethics)
SPLY	Suomen Palliatiivisen Lääketieteen Yhdistys (The Finnish Palliative Medicine Association)

STM	Sosiaali- ja terveysministeriö (The Ministry of Social Affairs and Health)
THL	Terveyden ja hyvinvoinnin laitos (The Finnish Institute for Health and Welfare)
UN	The United Nations
WHO	The World Health Organization
WMA	The World Medical Association

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Google Scholar gives the following results with the corresponding search terms: Euthanasia 648,000; Physician assisted suicide 248,000; Assisted death 3,390,000; Physician assisted death 1,380,000.
Domestic medical journals give the following results with the corresponding searches: Suomen Lääkärilehti (years 1992–2024): Eutanasia (euthanasia) 131; Lääkäriavusteinen itsemurha (physician-assisted suicide) 25; Avustettu itsemurha (assisted suicide) 43; Kuolinapu (assisted death) 74. Duodecim (search does not indicate years): Eutanasia (euthanasia) 47; Lääkäriavusteinen itsemurha (physician-assisted suicide) 4; Avustettu itsemurha (assisted suicide) 5; Kuolinapu (assisted death) 8.
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