MEDICAL ASSISTANCE IN DYING FOR PALLIATIVE PATIENTS IN DIFFERENT COUNTRIES OF THE WORLD: LESSONS ON EUTHANASIA LEGALIZATION

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ABSTRACT

Background. The practice of countries in legalizing euthanasia is useful for other countries that have not yet allowed Medical Assistance in Dying (MAiD). Palliative patients in these countries have varying levels of access to medical care, including adequate analgesia. Medical care in many countries does not meet the needs of palliative patients, and systems of palliative and hospice care are often poorly developed. MAiD can be an alternative to the suffering of palliative patients at the end of life.

Aim. Analysis of legal, social and financial aspects of euthanasia legalization in different countries of the world.

Materials and Methods. The method of system analysis, comparative method and bibliosemantic method were used for the research.

Results and Conclusions. The path to the legalization of euthanasia begins with a wide public debate. Important is the opinion of medical professionals, who are usually divided into two camps: those who deny the necessity and humanity of euthanasia, as well as those who advocate legalization to end the suffering of their patients, seeking to satisfy their persistent and conscious desire to exercise their "right to die". Countries take different paths and at different speeds to legalize euthanasia. The difference between the models of legalized euthanasia lies, first of all, in its permitted type (passive or active), distribution to different age categories of hopeless patients (in particular, to children), to incapacitated patients with cognitive disorders. Active euthanasia is allowed in such European countries as the Netherlands (since 2001), Belgium (since 2002), Luxembourg (since 2009), Spain (since 2010), Switzerland (since 2011). Since these years, there has been a change in the attitude towards medically assisted death of the European Court of Human Rights, which previously categorically regarded euthanasia as intentional murder. In all countries that have legalized euthanasia, an active discussion continues regarding the rules for its implementation. A common feature of countries that have already legalized euthanasia is the approval of the procedure by at least a third of medical professionals.

Keywords: *medically assisted suicide, suicide tourism, Quality of Death Index, suicide of critically ill palliative patients, right to life, right to die.*

INTRODUCTION

In many countries, the proportion of elderly people in the population is increasing, and with it the incidence of cancer and other diseases that lead to a painful death. To compare countries according to the organization of the best dying, the Quality of Death Index (QDI) was developed in 2010 [1], which assessed the availability and quality of end-of-life care in 40 countries according to 24 indicators. In 2015, the QDI already evaluated 80 countries using 20 quantitative and qualitative indicators in five categories: palliative environment and health care, human resources, accessibility of health care, quality of health care, and level of community involvement [2]. The 2010 country assessment identified Great Britain as the best country for dying, thanks to a comprehensive national policy, broad integration of palliative care into the national health care system and the development of the hospice system [3].

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Great Britain also took the 1st place in 2015. The 2nd place in the list was taken by Australia, and the 3rd by New Zealand. The USA was on the 9th place, Canada on the 11th. The leading countries of the rating noted an effective national policy of palliative care, a high level of public spending on health care services, developed educational programs of palliative medicine, large charitable contributions to Palliative and Hospice Care (PHC) institutions, wide availability of opiates for pain relief, public awareness of PHC problems.

The state of PHC with all aspects of care for palliative patients, ensuring their rights and meeting their needs, depends to a large extent on the funding of national PHC programs. Approaches to funding the best national PHC systems vary: in the UK, the main source of funding is philanthropy. Australia, Denmark, Belgium and Ireland fund 80–100% of palliative patient costs with public funds. The Ukrainian model of package financing of PHC also gives hope for improving the rating of the country [4]. The models of PHC organization are also different. For example, Panama has integrated palliative care into its primary care services, and Mongolia is rapidly increasing the number of hospices. The availability of narcotic painkillers (and medical cannabis in particular) correlates with the country's place in the rating [5; 6]. Pain relief is one of the basic needs of palliative patients [7], but only 33 of the 80 countries in the 2015 ranking had opiates freely available.

The calculation of the QDI is related to the determination of the burden of diseases and the prevalence of severe disabling diseases [8]. In 2015, the qualitative weight of the burden of diseases in the defined QDI was 60%. Another important factor in the development of national PHC systems is orientation to patient needs [9]. Social and military crises, on the contrary, inhibit the development of these systems [10]. Important for development is a wide list of palliative diseases recognized by states [11; 12]. In the 2015 QDI ranking of countries, Ukraine ranked last in Europe with a score of 25.5 points, and the 69th out of 80 places in the overall ranking. The indicators of such countries as India (26.8 points), Colombia (26.7 points), Ethiopia (25.1 points), and China (23.3 points) were close to the indicator of Ukraine. In order to understand which factors are decisive for the development of the PHC system of countries to ensure the dignified and painless dying of palliative patients, an analysis of the practices of legalizing euthanasia in other countries of the world is necessary.

The aim of the study was to analyze the legal, social and financial aspects of the legalization of euthanasia in other countries of the world.

Materials and Methods

The research used methods of systematic analysis, comparative and bibliosemantic, with a search for sources on PubMed, Google and Google Scholar using the keywords "palliative and hospice care", "legalization of euthanasia", "foreign experience", "medically assisted death", "suicides of palliative patients", "quality of death index" in Ukrainian and English. In connection with the theoretical approach to the research, bioethical examinations of the research materials were not conducted. Statistical methods were also not used.

Results and Discussion

Palliative care is intended neither to delay nor hasten death. But a significant number of patients experiencing intense chronic pain at the end of life is pushing for an alternative to self-initiated gradual dying – Medical Assistance in Dying (MAiD). Euthanasia is legalized in Sweden, Netherlands, Belgium, Switzerland, Finland, Germany, Chile, USA, Canada, Israel, Mexico. Public discussions about death had a significant influence on countries' decisions to legalize euthanasia [13]. The willingness of countries to legalize euthanasia also depends significantly on the religiosity of the population [14]. If a country has a neighboring country that allows euthanasia, or the country's population has sufficient income for medical suicide tourism, palliative patients travel to other countries to end their lives with dignity.

Legislators of countries that were moving towards the legalization of euthanasia, to a certain extent, added to the opposition of the international law system. The position of the European Court of Human Rights regarding euthanasia was categorically condemning before its legalization in many countries of the world. The court saw euthanasia as a violation of Article 2 (right to life) of the European Convention on Human Rights [15]. However, the evolution of legal interpretations changed the attitude: the "right to die" became an important component of the right to life. In the field of palliative medicine, it is more often called "the right to a dignified death". Titko E.V. & Deineko O.V. (2020) note that citizens will not resort to euthanasia tourism if the right to euthanasia is enshrined in the legislation of their countries. Switzerland has become the most attractive country for foreigners with liberal conditions for performing euthanasia [16]. The Swiss canton of Zurich is the most famous area where euthanasia is widely used

for foreigners. The Swiss clinic "Dignitas", opened in 1998, is called the "Mecca of suicide tourism". But the US citizens sometimes go to Mexico for MAiD. And this is despite the fact that euthanasia has already been legalized in some states of the country. Such a choice may be related to the fact that upon returning home, persons who accompanied their relative to the MAiD site may face criminal prosecution. It will be easier to prove guilt if the suicide took place on the territory of one's own country.

From a legal point of view, euthanasia is "the action or inaction of a doctor at the request of his patient in order to end his suffering, the result of which is the realization of the right to a dignified death, provided that the patient understands and is aware of his actions in compliance with the law" [17]. A dignified death in Ukraine cannot be provided by active euthanasia. Thus, Clause 4 of Article 281 of the Civil Code of Ukraine limits this right as follows: "It is prohibited to satisfy the request of an individual to end his life". Article 52 of the Law of Ukraine "Fundamentals of the Legislation of Ukraine on Health Care" defines: "Medical workers are prohibited from performing euthanasia – intentionally hastening the death or mortification of a terminally ill patient in order to end his suffering". Similarly, Ukrainians are often deprived of the right to a dignified death without pain [6; 8; 18]. In addition, Ukrainian society is not ready to start a dialogue about the possibility of legalizing euthanasia [14]. Therefore, for Ukraine and other countries with low QDI, the experience of countries that have already legalized QDI is useful.

In the Netherlands, MAiD is legal for patients from the age of 16. From 12 to 16 years of age, the consent of parents or guardians is required for this procedure. Since 2005, in exceptional cases (most often in the terminal stages of cancer), the Groningen Protocol has allowed neonatal euthanasia (for babies under 1 year old). Children aged 1–12 years are not eligible for MAiD [19]. Decisions about MAiD are made by consensus of several doctors. After the legalization of euthanasia in 2001, society continues to actively discuss the rules of the procedure. In the Netherlands, legislators take the position that the state "is obliged to protect citizens from making decisions that do not correspond to their best interests, for example, the decision to die, when "unbearable suffering" can be reduced so much that the person gives up the desire to end suffering by death" [20]. Therefore, doctors should offer the patient alternatives to MAiD and allow time to test them. Legislators in Canada, where patients are allowed to decide for themselves whether to try other methods of palliative medicine before deciding on MAiD, think differently. Canadian doctors only give a patient with a clear intention to resort to MAiD the choice: to perform a lethal injection, or to allow the patient to perform such an injection himself. Also, the Canadian doctor must make sure that the patient answers confidently and uniformly when asked about the choice of MAiD. Therefore, the question about MAiD should be asked several times. A guardian cannot ask a doctor for MAiD for an adult incompetent patient, but the parents or guardians of a minor terminally ill child can request it [21]. For adults, the right to MAiD is limited if the palliative condition is due to one mental illness with a cognitive disorder that does not allow you to confidently express your wish for MAiD [22].

In Canada, parents of children with palliative diagnoses are willing to discuss the feasibility and practical aspects of MAiD with doctors and research scientists. In a 2017 survey of almost 2,000 parents, 46% called children's MAiD acceptable. The percentage of similar answers varied in subgroups of interviewees depending on the diagnoses offered for discussion and the age of the children. A high percentage of acceptance of euthanasia was also demonstrated by pediatricians and nurses of children with palliative diagnoses. Doctors' refusal to consent to the appointment and conduct of MAiD was associated with their religiosity, disagreements with colleagues on specific cases and the very attitude to MAiD, the burden of observing patients dying [23].

In the legalization on euthanasia in Canada, the discussion of the problem in the mass media played a significant role. From 1972 to 2016, Canadian newspapers in English and French discussed the role of doctors in the care of critically ill patients and their possible involvement in MAiD, legal and political aspects of legalization (appeals to the Supreme Court of Canada in euthanasia cases, legal cases against Canadian doctors and Dr. Kevorkian, parliamentary legalization), the attitude of Canadians to MAiD. Crumley E.T. et al. (2019) conducted an analysis of 813 newspaper articles during this time, and divided the 44 years of media discussion before the legalization of euthanasia into three periods: 1) awareness of the problem, 2) anxiety and euphoric enthusiasm, and 3) awareness of the price of significant progress [24]. The researchers concluded that, based

on the results of the random sample, there were more positive articles about MAiD. They explained the victory of euthanasia supporters, including the decline of religion in Canada.

One of the problems that Canada was dealing with after the legalization of MAiD was the insufficient level of professional training of medical workers to work in the PHC system. A survey of 452 physicians, nurses, administrators, and volunteers working in Canada's PHC system one year after euthanasia was legalized revealed a need for more professional issues specific to palliative care in training programs and a lack of funding for such training programs [25].

While active euthanasia is allowed in the Netherlands, Belgium and Canada, passive euthanasia is allowed in Sweden, France and Finland [17]. In Ukraine, passive euthanasia is not allowed *de jure*, but *de facto* it is often performed when a physician decides to end life support. In low- and middle-income countries, health care facilities are often under-resourced, so doctors prefer to save available drugs for patients who can be saved. Arguments about the high risk of professional error at the moment of brain death, after which disconnection from resuscitation equipment can no longer be qualified as intentional murder, are unconvincing. When it comes to diagnosing brain death, the majority of doctors in the world are in approximately the same conditions [26]. But it was this argument that was the main one when the Ukrainian parliament (Verkhovna Rada) refused to legalize euthanasia in 2003 and 2010.

Belgium became the second country in the world to decriminalize euthanasia, after the Netherlands. But even after legalization in 2002, society continued to discuss the problems associated with it: obtaining donor organs, euthanasia of infants, the illegal practice of euthanasia alongside the legal one [27]. The latter accounted for 4.5% of all deaths in the country after legalization. A similar practice was widespread in the country even before legalization. But the activity of legislators regarding legalization was also high: in the period 1984–1996, 9 draft laws on legalization were submitted to the Belgian Parliament. The population of Europe at that time gradually changed its attitude towards euthanasia for the better. During 1981–1999, the number of positively disposed citizens increased by 22%. In 1996, the Federal Advisory Committee on Bioethics was established in Belgium, which studied public opinion but did not make any recommendations. The first criminal investigation into illegal euthanasia in the country began in 2000 against two doctors. But they were not punished because the sentence was announced in 2003, after legalization, and the legalization law applied retrospectively to cases of euthanasia. Legalization was accelerated by the absence of Christian Democrats in the country's government.

Before the procedure, the patient must be informed about his/her condition. The wish for euthanasia must be certain. There should be several conversations with the doctor. The physician must be satisfied that there are no reasonable alternatives to euthanasia. Each patient's euthanasia should be discussed with another physician, nurse, and the patient's relatives/caregivers. The patient should be allowed to discuss euthanasia with whomever he chooses. The activities of doctors who agreed to euthanasia are audited. In case of non-fulfillment of the procedure, the commission forwards the audit results to the prosecutor's office.

There is no age limit for euthanasia in Belgium. Under special conditions, it can be prescribed even to newborns. For euthanasia of infants, an examination by a psychologist or psychiatrist is mandatory. For adults, such consultation is only desirable. The first case of euthanasia of a minor was registered only in 2016. Therefore, the permission for euthanasia of infants is more of a political step, but does not have significant consequences.

In Belgium, euthanasia of patients with dementia is not allowed. A survey of neurologists in the country in 2019 showed that 77% of respondents approve of the law on euthanasia, but 65% are against extending the law to patients with dementia [28]. Another survey of Belgian family doctors in the same year [29] showed that 59% were against extending the practice of euthanasia to patients with terminal stages of dementia, if these patients cannot clearly express their will. At the same time, non-religious doctors supported such an expansion twice as often as their religious colleagues. 72% of GPs reported that they fear pressure from relatives if care-givers are allowed to claim MAiD for their incapacitated relatives.

Only active euthanasia is allowed in Belgium. Stopping treatment to end life is prohibited. The wording of the law "in the absence of a reasonable alternative" for euthanasia is too vague and has been criticized for many years. Even after legalization, half of all euthanasia cases are not registered by doctors as euthanasia. In the early 2010s, 80% of euthanasias occurred in the Belgian region

of Flanders. There is concern in Belgian society about the high risk of involuntary euthanasia. It is partly related to the removal of donor organs, which is permitted in the country, without the prior consent of the deceased. But within the period of 2007–2015, only 2% of donor lungs were obtained from patients after euthanasia. Many patients who turn to doctors to end their lives have cancer that is a contraindication for organ transplantation. Concerns may become more grounded in the growing number of young people seeking euthanasia. The shortcomings of the practical implementation of the Belgian law on euthanasia should be taken into account by other countries.

In the US, there is considerable variation in state-to-state law on key aspects of life and death. Euthanasia is legalized in Oregon, Montana, Washington, California, and Vermont. The laws of the states of Oregon and Washington allow medically assisted suicide only for patients whose life expectancy does not exceed 6 months [30]. Many right-to-die advocates have preferred to expand the list of conditions in which MAiD is possible, particularly in cases where terminally ill patients show a persistent and rational desire to die but are physically unable to end their own lives. Refusal to help such patients was considered by many to be "torture of inaction." In Europe, the USA and Canada, some married couples expressed a desire to die together, sometimes committing suicide at the same time. This practice raised the issue of allowing MAiD of healthy people before the society. Of course, it is impossible to give permission for the procedure to mentally ill people during psychosis. But if the patient shows a persistent desire to die, no one can prevent him from committing suicide on his own. Unfortunately, in this case, the way to end life can be painful.

In the US, euthanasia was first legalized in California in 1977, with the adoption of the world's first right-to-die law. The life expectancy of a patient with an incurable disease who is given drugs for self-enduring should not exceed 6 months. The patient must be of legal age, able to act, understand his diagnosis, prognosis and consequences of the decision made. The decision to provide medication is made by several physicians.

A number of social and medical ethical problems are associated with euthanasia. For example, how to evaluate a patient who is on long-term opiates due to excruciating chronic pain caused by an incurable disease. Soh T.L. et al. (2016) [31] convincingly refute the popular thesis that "iatrogenic loss of consciousness equals loss of personality and death". Their work is based on the analysis of empirical data. The study demonstrates the refutation of a false but popular philosophy by the methods of evidence-based medicine. Terminal sedation can lead to the death of the patient unintentionally as a side effect [19]. Opponents of euthanasia claim that the availability of euthanasia reduces the demand for palliative care, that doctors can treat palliative patients inappropriately: why treat a palliative patient for a long and difficult time, if you can just kill him. Proponents of euthanasia respond to this: the doctor's wishes are secondary, the wishes of the patient, who considers his suffering unbearable and asks for it to be stopped, must be respected. Opponents of euthanasia argue that children under the age of 12 are not capable of giving informed consent to their own death (euthanasia is legal from the age of 12 in the Netherlands), just as they are not allowed to vote in elections, join the army, marry, or have sex. Likewise, children 12 years old are not given the right to allow their own sterilization. Proponents of euthanasia respond to this: one cannot compare civic and social immaturity, and even a potential life without offspring to a life with constant excruciating pain.

The problem of euthanasia also intersects with the issues of suicide. The experience of Northern Ireland, which had the highest suicide rates in the United Kingdom in 2014–2015 (1.7% of all deaths, or 16.5 suicides per 100,000 population in 2015), shows that suicides are more male (3/4 in 2015) that most suicides are committed at the age of 25–35 [32]. The use of methods of evidence-based medicine was transferred to the field of euthanasia precisely from the pool of research on suicides [33; 34]: errors in statistical evidence are not associated with falsifications, but with the mischaracterization of events in the criminal process. Similar qualifications in the criminal legislation of different countries are different, as well as criminal responsibility. Thus, for example, in the Criminal Code of Switzerland, euthanasia is in the section "Murder" (Homicide, article 114). For murder at the request of the victim, at his own genuine and persuasive request, his own and persistent request, the penalty is imprisonment for not more than three years or a monetary fine. At the same time, the term of imprisonment for inciting suicide or aiding suicide may be up to five years of imprisonment [35]. In some countries, high criminal liability is also provided for actions associated with suicide. For example, in Norway, a per-

son who produced drugs that were used for suicide can be punished with up to 5 years of imprisonment [36].

The WHO states that the largest number of suicides in the world is naturally associated with clinical depression [37]. The number of palliative patients among people who have committed suicide is small (0.2–4.6% of total deaths, 1998–2015), but it is still hundreds of times greater than the number of palliative patients who find their way to legal euthanasia. On the other hand, the European Association for Palliative Care states [38] that the majority of representatives of professional organizations of PHC systems of different countries during a survey in 2016 believed that euthanasia and MAiD should not be included in the list of palliative medicine procedures. Euthanasia is not included in the "White Book of Palliative Medicine" [39]. A similar opinion has been held by the World Medical Assembly for many decades [40]. A similar denial of the "right to die" by medical professionals can be explained by the traditional long-term funding of medical universities and medical associations by religious organizations (e.g., the Roman Catholic Church). A significant part of medical students who study medicine in medical universities for a long time accept the position of the universities, which is dictated by religion.

Historically, euthanasia was frequently practiced in the ancient world. For example, weak children unfit for military service were killed in Sparta, which is known from the works of Plutarch and Thucydides [41–43]. The negative background of euthanasia was also created by the mass murders of the Nazis in the Second World War [44]. That is why only passive euthanasia is allowed in Germany since 2015, and active euthanasia is a criminal offense. From a legal point of view, in addition to active and passive euthanasia, most countries that have legalized it distinguish between "Mercy killing" (when a doctor injects a hopelessly ill patient with an excessive dose of an anesthetic drug, resulting in the desired death) and "Physician-assisted suicide" (when a doctor only helps a terminally ill person to end his life).

It was the last tactic that six times helped the world-famous American pathologist, doctor and supporter of the "right to die" Jack Kevorkian (1928–2011) avoid criminal responsibility for MAiD. In his practice, Jack Kevorkian used a special device "Mercitron" (from English *mercy*) of his own invention, which allowed patients to self-inject medical drugs that stopped the heart. But in 1999, Kevorkian was still sentenced to 25 years for murder after performing a fatal injection recorded on video to a patient who wanted to die but could no longer administer the lethal drug himself [45; 46].

Conclusions

The countries that have already legalized euthanasia have come to this decision in different ways and at different speeds. But there are common features of this process in different countries: the path to legalization begins with a wide public debate, the process of legalization is accelerated due to the activities of dissidents or with an appeal to the courts to protect one's right to euthanasia. At the time of legalization, euthanasia is usually approved by at least a third of doctors who treat critically ill patients. In the countries with sufficient financing of national health care systems, the arguments of supporters and opponents of medically assisted suicide are usually used to argue about the integrity of doctors, the acceptance of the procedure by society, religious prohibitions, the rights of patients to life and death, but the lack of resources of the health care system and the inability to provide seriously ill patients with the necessary medical care, including analgesia for chronic unbearable pain are not taken into account.

The difference in the models of legalized euthanasia concerns primarily its type (passive or active), coverage of different age groups (in particular, children), patients with dementia who cannot consciously and clearly express their desire to end their suffering with medically assisted suicide. The number of suicides of palliative patients is insignificant, and decreases almost to zero after the legalization of euthanasia. But the risks of involuntary euthanasia and violations of the existing rules for conducting medically assisted suicide are high. Suicide tourism is acceptable for wealthy families. A comparison of the legalization situation in the Netherlands, Belgium, Canada and the USA with Ukraine shows that Ukraine is at the beginning of the path to the future parliamentary approval of the procedure.

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References

1. The quality of death Ranking end-of-life care across the world. A report from the Economist Intelligence Unit. Commissioned by Lien Foundation. London-New York-Hong Kong: Economist Intelligence Unit; 2010. 39 p. Available at: https://www.lienfoundation.org/sites/default/files/qod_index_2.pdf

2. The 2015 Quality of Death Index Ranking palliative care across the world. A report. Commissioned by Lien Foundation.London-New York-Hong Kong-Geneva: Economist Intelligence Unit; 2015. 72 p. Available at: https://impact.economist.com/perspectives/health/2015-quality-death-index

3. Lekhan VM. Retrospective analysis of the construction of the national system of hospice and palliative care in Great Britain. Inter Collegas. 2024;11(1):52-6. DOI: 10.35339/ic.11.1.lvm.

4. Holovanova IA, Shevchenko AS. Evaluation of packaged funding programs for palliative and hospice care by the National Health Service of Ukraine. Experimental and Clinical Medicine. 2021;90(4):45-52. DOI: 10.35339/ekm.2021.90.4.hos.

5. Lekhan VM. Impact of different types of pain on organizational decisions in palliative medicine. Medicine Today and Tomorrow. 2024;93(1):47-55. DOI: 10.35339/msz.2024.93.1.lvm.

6. Nesterenko VG. The controllability of pain in palliative medicine as a factor in the medical and social impact on the patients' quality of life at the end-of-life. Experimental and Clinical Medicine. 2024;93(1):69-86. https://doi.org/10.35339/ekm.2024.93.1.nes [in Ukrainian].

7. Holovanova IA, Shevchenko AS. Determination of the main needs of palliative patients and ways of their provision in the health care system of Ukraine. Experimental and Clinical Medicine. 2021;90(3):88-94. DOI: 10.35339/ekm.2021.90.3.hos.

8. Nesterenko VG, Shevchenko AS, Zelenska KO, Hryhorov MM. Clinical and epidemiological characteristics of disabling neurological diseases (literature review). International Neurological Journal. 2024;20(4): 176-84. DOI: 10.22141/2224-0713.20.4.2024.1079. [In Ukrainian].

9. Holovanova IA, Shevchenko AS. The issue of patient-oriented organization of palliative and hospice care in Ukraine. Experimental and Clinical Medicine. 2021;90(2):21-7. DOI: 10.35339/ekm.2021.90.2.hos.

10. Nesterenko VH, Peresypkina TV, Shevchenko OS, Sarkhadova II. Palliative and hospice care in the Kharkiv region in the first year of the war. Ukraine. Nation's Health. 2023;73(3):106-12. DOI: 10.32782/2077-6594/2023.3/18.

11. Nesterenko VG, Shevchenko VV. Calculation of the national need for palliative care by the refined method of trends in the conditions of a military crisis. Eastern Ukrainian Medical Journal. 2024;12(3):711-20. DOI: 10.21272/eumj.2024;12(3):711-720.

12. Nesterenko VG, Redka IV, Sukhonosov RO, Grygorov SM, Shevchenko AS, Aliieva TD. Forecasting the need for palliative and hospice care using the creeping trend method with segment smoothing. Wiad Lek. 2024;77(5):980-4. DOI: 10.36740/WLek202405116. PMID: 39008586.

13. Nesterenko VG, Krasnikova SO, Shevchenko AS. Media discussions about hospice and palliative care in Ukraine since the beginning of the war. Proceedings of the VI-th scientific and practical conference with international participation "Public health in Ukraine: problems and ways to solve them", dedicated to the 100-th anniversary of the department of public health and health care management of the Kharkiv National Medical University (Tomilin's readings), 2 Nov 2023. 4 p. DOI: 10.5281/zenodo.10053065.

14. Nesterenko VG, Lytvynenko OYu. Readiness for dialogue regarding euthanasia of palliative patients in Ukraine. Experimental and Clinical Medicine. 2024;93(2):79-88. DOI: 10.35339/ekm.2024.93.2.nel. [In Ukrainian].

15. Shevchenko AS, Kuts YuV, Gavrylova SA, Gavrylov EV. Legislative, historical and practical aspects of phenomena that potentially violate the right to life. Bull KhRIPHS. 2020;93(1):20-7. DOI: 10.5281/zenodo.3960410. [In Ukrainian].

16. Titko EV, Deineko OV. Euthanasia / suicide tourism as the human rights protection phenomenon in the present time. Academic notes of the V.I. Vernadsky Tavrida National University. Series: Legal Sciences. 2020;31(70(2(3))):227-32. DOI: 10.32838/2707-0581/2020.2-3/36. [In Ukrainian].

17. Holopapa DI, Mialovytska NA. Euthanasia: the right to life. Uzhhorod National University Herald. Series: Law. 2013;23(1(1)):122-4. Available at: http://surl.li/sizlqa [in Ukrainian].

18. Lekhan VM. The importance of medical cannabis for solving the problem of providing analgesia to palliative patients in Ukraine. Experimental and Clinical Medicine. 2024;93(1):87-93. DOI: 10.35339/ekm.2024.93.1.lvm.

19. Brouwer M, Kaczor C, Battin MP, Maeckelberghe E, Lantos JD, Verhagen E. Should Pediatric Euthanasia be Legalized? Pediatrics. 2018;141(2):e20171343. DOI: 10.1542/peds.2017-1343. PMID: 29317518.

20. Mishara BL, Kerkhof AJFM. Canadian and Dutch doctors' roles in assistance in dying. Can J Public Health. 2018;109(5-6):726-8. DOI: 10.17269/s41997-018-0079-9. PMID: 29981089.

21. Davies D. Medical assistance in dying: A paediatric perspective. Paediatr Child Health. 2018;23(2):125-30. DOI: 10.1093/pch/pxx181. PMID: 30653625.

22. Simpson AIF. Medical Assistance in Dying and Mental Health: A Legal, Ethical, and Clinical Analysis. Can J Psychiatry. 2018;63(2):80-4. DOI: 10.1177/0706743717746662. PMID: 29216738.

23. Shaw J, Wiebe E, Nuhn A, Holmes S, Kelly M, Just A. Providing medical assistance in dying: Practice perspectives. Can Fam Physician. 2018;64(9):e394-9. PMID: 30209113.

24. Crumley ET, Sheppard C, Bowden C, Nelson G. Canadian French and English newspapers' portrayals of physicians' role and medical assistance in dying (MAiD) from 1972 to 2016: a qualitative textual analysis. BMJ Open 2019;9:e020369. DOI: 10.1136/bmjopen-2018-020369.

25. Antonacci R, Baxter S, Henderson JD, Mirza RM, Klinger CA. Hospice Palliative Care (HPC) and Medical Assistance in Dying (MAiD): Results From a Canada-Wide Survey. J Palliat Care. 2021;36(3):151-6. DOI: 10.1177/0825859719865548. PMID: 31411105.

26. Wijdicks EF, Varelas PN, Gronseth GS, Greer DM; American Academy of Neurology. Evidence-based guideline update: determining brain death in adults: report of the Quality Standards Subcommittee of the American Academy of Neurology. Neurology. 2010;74(23):1911-8. DOI: 10.1212/WNL.0b013e3181e242a8. PMID: 20530327.

27. Saad TC. Euthanasia in Belgium: Legal, historical and political review. Issues in Law & Medicine. 2017;32(2):183-204. Available at: https://www.researchgate.net/publication/322854307

28. Picard G, Bier JC, Capron I, De Deyn PP, Deryck O, Engelborghs S, et al. Dementia, End of Life, and Euthanasia: A Survey Among Dementia Specialists Organized by the Belgian Dementia Council. J Alzheimers Dis. 2019;69(4):989-1001. DOI: 10.3233/JAD-181277. PMID: 31127774.

29. Cleemput J, Schoenmakers B. Euthanasia in the case of dementia: a survey among Flemish GPs. BJGP Open. 2019;3(4):bjgpopen19X101677. DOI: 10.3399/bjgpopen19X101677. PMID: 31772039.

30. Appel JM. Assisted Suicide for Healthy People. HuffPost Latest News, 16 Aug 2009, updated 25 May 2011. [Internet]. Available at: https://www.huffpost.com/entry/assisted-suicide-for-heal_b_236664 [accessed 20 Jun 2024].

31. Soh TL, Krishna LK, Sim SW, Yee AC. Distancing sedation in end-of-life care from physician-assisted suicide and euthanasia. Singapore Med J. 2016;57(5):220-7. DOI: 10.11622/smedj.2016086. PMID: 27211055.

32. A Project Examining Learning Arising from Serious Adverse Incidents Involving Suicide, Homicide and Serious Self Harm. Belfast: The Regulation and Quality Improvement Authority; 2017. 53 p. Available at: https://www.rqia.org.uk/getattachment/b31ca055-271d-4284-be39-2ce325ff1486/SAI-Suicide-Homicide-Serious-Self-Harm_Report_Final.pdf.aspx

33. Shevchenko AS, Brown GW. What evidence-based medicine can oppose to falsifications in science. Bull KhRIPHS. 2020;96(4):24-35 DOI: 10.5281/zenodo.5076629. [In Ukrainian].

34. Tollefsen IM, Hem E, Ekeberg O. The reliability of suicide statistics: a systematic review. BMC Psychiatry. 2012;12:9. DOI: 10.1186/1471-244X-12-9. PMID: 22333684.

35. Swiss Criminal Code of 21 December 1937, SR 311.0. Federal Act (Status as of 1 Mar 2019). Available at: https://www.admin.ch/opc/en/classified-compilation/19370083/index.html

36. Rossow I. Suicide among drug addicts in Norway. Addiction. 1994;89(12):1667-73. DOI: 10.1111/j.1360-0443.1994.tb03767.x. PMID: 7866250.

37. Harmer B, Lee S, Rizvi A. Suicidal Ideation. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2024. Available at: https://www.ncbi.nlm.nih.gov/books/NBK565877/

38. Radbruch L, Leget C, Bahr P, Muller-Busch C, Ellershaw J, de Conno F, Vanden Berghe P; Board Members of EAPC. Euthanasia and physician-assisted suicide: A white paper from the European Association for Palliative Care. Palliat Med. 2016;30(2):104-16. DOI: 10.1177/0269216315616524. PMID: 26586603.

39. Chambaere K, Cohen J, Bernheim JL, Vander Stichele R, Deliens L. The European Association for Palliative Care White Paper on euthanasia and physician-assisted suicide: Dodging responsibility. Palliat Med. 2016;30(9):893-4. DOI: 10.1177/0269216316664470. PMID: 27609605.

40. WMA Declaration of Venice on End of Life Medical Care. Adopted by the 35th World Medical Assembly (Venice, Italy, October 1983). Revised by the 57th WMA General Assembly (Pilanesberg, South Africa, October 2006) and by the 73rd WMA General Assembly (Berlin, Germany, October 2022) [Internet]. Available at: https://www.wma.net/policies-post/wma-declaration-of-venice [accessed 20 Jun 2024].

41. Lycurgus and Numa Pompilius. In: Plutarch. Comparative biographies. Harvard: Loeb Classical Library edition; 1917.

42. Agesilaus and Pompey. In: Plutarch. Comparative biographies. Harvard: Loeb Classical Library edition; 1917.

43. Thucydides. The history of the Peloponnesian war. 431 BC. Translated by Crawley R. Gutenberg eBook [Internet]. Available at: https://www.gutenberg.org/files/7142/7142-h/7142-h.htm [accessed 20 Jun 2024].

44. Mackintosh S. Mass Atrocities. How to achieve justice? A guide for groups of victims of mass crimes. Washington: United States Holocaust Memorial Museum; 2021. 108 p. Available at: https://www.ushmm.org/m/pdfs/Ukrainian_Language_Pursuing_Justice_Handbook.pdf [in Ukrainian].

45. Kevorkian J, Kurtz P. Medicide: the goodness of planned death. Free Inq. 1991;11(4):14-8. PMID: 11649305.

46. Kevorkian J. Medicine, ethics, and execution by lethal injection. Med Law. 1985;4(4):307-13. PMID: 4046758.

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