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Physician-assisted Suicide. Reflections on the Possibility of Legalization on the Basis of the Polish Legal System

Abstract:

Physician-assisted suicide is one of the current moral dilemmas around which a debate in contemporary countries is conducted. This debate, with increasing intensity, also takes place in Poland. The article in the first part focuses on explaining the concepts relevant to the debate, proper understanding of which is necessary for further consideration. Then the article makes an attempt to present and evaluate arguments raised by supporters and opponents of legalization of this procedure. The text also touches upon the issue of Polish legal regulations focused on this subject as well as problems and difficulties, which are necessary in the context of Polish debate on medically assisted suicide and is a prerequisite for further consideration of possibility of legalization of this procedure in the Polish legal system.

Key words: physician-assisted suicide, euthanasia, Constitution, Criminal Code, Code of Medical Ethics

1. Introduction

Over the last few decades we can observe an increase in intensity of the debate about physician-assisted suicide and euthanasia. Since the 1970s, when some attempts were taken in the Netherlands to legalize those procedures, societies of more and more countries are wondering about legalization physician-assisted suicide or euthanasia. We can observe an increasing debate on this topic also in Poland. A thorough analysis of this issue

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in the Polish legal system has to be conducted in two aspects: what are the arguments for and against the legalization, presented by supporters and opponents of the legalization, and not less important whether the Polish legal system allows legalization of physician-assisted suicide or euthanasia.

2. Distinction between the concepts

At the very beginning of the consideration about possibility of legalization physician-assisted suicide, the most important concepts have to be explained. Polish debate, but also discussions taking place in other countries, involves confusion of terms – physcian-assisted suicide is often mistaken for euthanasia and as the euthanasia are often understood behaviours which has nothing in common with it and are murders[2].

We have to demarcate the main concepts: physician-assisted suicide, suicide, euthanasia and murder. The concept of murder and suicide seems to be the least controversial. Defining murder we can base at the statutory definition from the Polish Criminal Code. In the article 148 Polish Criminal Code states that whoever kills a human being shall be subject to the penalty of the deprivation of liberty for a minimum term of 8 years, the penalty of deprivation of liberty for 25 years or the penalty of deprivation of liberty for life[3]. Both terms of euthanasia and physician-assisted suicide are defined by various definitions and can be understood in many ways. In order to conduct those consideration, let us adopt the definitions which are the least controversial. As a physician-assisted suicide we shall therefore understood a thought through and intentional help offered by a doctor to a patient to commit suicide, which is motivated by the desire to relieve their suffering. Physician-assisted suicide consists in prescribing medicines by a doctor, which are taken by a patient in the intention of committing suicide. Prescribing the medicines is made on the fully voluntary and competent demand of a patient. This definition is not fully compatible with the statutory definition from the article 151 of the Polish Criminal Code, which states 'whoever by persuasion or by rendering assistance induces a human being to make an attempt on his own life shall be subject to the penalty of the deprivation of liberty for a term of between 3 months and 5 years'. Polish Criminal Code thus states two differences in relation to the aforementioned definitions: it is universal crime, which means that it can be committed by everyone, not only by a doctor, and moreover – responsibility of perpetrator is related with at least making an attempt of suicide.

As an euthanasia we shall understood a thought through and intentional help offered by a doctor to a patient to end their life, which is motivated by desire to relieve their suffering. The difference between euthanasia and physician-assisted suicide relies on the role of doctor in the act of ending patient's life. In committing euthanasia an active role of the doctor is needed, whose action would cause the patient's death. The term of euthanasia is definitely more capacious because we can point at various

[2] M. Aramini, *Bioetyka dla wszystkich*, Cracow 2011, p. 254.

[3] Act of 6th June 1997 – Criminal Code of the Republic of Poland. As published in Dziennik Ustaw No. 88, item 553.

types of euthanasia – voluntary, involuntary, nonvoluntary. That is why this problem requires another, separate analysis and will not be explored in this article. The issues of euthanasia have some common aspects with the issues of physician-assisted suicide but shall be understood as a different issue. That is why main considerations focus on the assisted suicide and mention euthanasia only for stressing the differences between these two cases. The main difference between physically-assisted suicide and euthanasia is based on the person whose action causes patient's death. In the act of assisted suicide doctor delivers medicines, but patient's death is caused by the action taken by themselves, whereas euthanasia consists of causing patient's death by doctor's activity, for example by a lethal injection.

3. Arguments for legalization of physician-assisted suicide

The main argument for legalization of assisted suicide is based on the self-determination right. The Article 31 section 2 of the Constitution of the Republic of Poland[4] states that everyone shall respect freedoms and rights of others. No one shall be compelled to do what is not required by the law. On the basis of this guaranteed freedom, everyone has the right to present different philosophical or religious beliefs, also on the attitude to the moment of the end of life. That is why some people can be interested in extending their lives as long as possible, whereas others can ask for a measure which let them end lives at the moment that will, in their opinion, be the best. Moreover, we have to stress that an unquestionable patient's right is to decide whether to undergo the treatment, including the life-rescuing treatment or not[5]. If patient is empowered to decide about taking up and conducting the treatment, thus it is justified to let them decide about suicide and to get medical help to commit it[6]. Incontestable is also the fact that human – as a rational individual – can make decisions and decide what is the best for them in a particular situation. Thus there is no need to refuse helping patient in committing suicide if they consider that such action is the best for them. On the other hand, we can point out that there are situations when patient declares will to end their life, whereas – due to for example mental disorders – they cannot rationally discern their best interest. Those concerns should be taken into consideration by legislator, whose role is to introduce proper safety mechanisms to counteract abuses.

Moreover, supporters of the right to assisted suicide point out that if the patient without any reasonable doubt clearly declares to the doctor their will to end life due to obnoxious pain and the doctor does not carry out their wish, the doctor in fact leaves the patient without help. The behavior of the doctor is in fact forcing the patient to anxious and painful death. We can point at two kinds of pain which patient has to contend – the physical and the mental one. The physical pain is undoubtedly

[4] The Constitution of the Republic of Poland of 2nd April 1997. As published in Dziennik Ustaw No. 78, item 483.

[5] S.M. Wolf, *Physician-Assisted Suicide,* Clinics in Geriatric Medicine 2005, 21, p. 183.

[6] D.W. Brock, *Samobójstwo z pomocą lekarza bywa moralnie uzasadnione* [in:] *Wokół śmierci i umierania*, red. W. Galewicz, Cracow 2009, p. 261.

unpleasant, but nowadays doctors know how to deal with it successfully. After decades of understanding pain as an inherent part of therapy doctors are able to minimalize pain and in hospitals special pain-clinics are formed, which role is to minimalize pain during therapy. Other question is whether all doctors know how to deal with patient's pain and offer them effective solutions to minimalize it. But besides the physical pain, we also have to mention the mental one. Realising how important reason for making a decision of ending life can mental pain be, provides us to conclusion that this pain can justify legalization of physically-assisted suicide basing on the mercy. Some authors, for example Don Marquis, stand that indelible mental pain is a sufficient argument to legalize assisted suicide and none of the other arguments can undermine it[7].

4. Arguments against legalization

The main argument against legalization of physically-assisted suicide is based at the theory of sanctity of life. In the doctrine of the Catholic Church human lives are sacred because there were given to us by God and only God can decide about giving and taking human lives. All acts which are taken against life given to us by God – abortion, euthanasia, suicide – are seen as a sacrilege due to an unlawful embezzlement of God's property. This argument definitely cannot be disproved for those people who declares themselves as a Catholics. But this argument finds no reason if we adopt other religious or philosophical position. Negation the role of God in human lives result in rejecting this argument and provides us to expose commonly accepted conception of freedom which let people decide about their lives, including the moment of ending it. Moreover, some opponents of the physician-assisted suicide point at that sanctity of life results from our traditions and intuitive moral sense. That is why the sanctity of life should be an important argument not only on the basis of the religion. But on the other hand, supporters of physician-assisted suicide point at that life has to be seen as a supremely valuable, not in the abstract, but for something or to someone. If the life in question is an unwanted burden to the person who is living that life, does the value or sanctity of life in the abstract justify requiring its continuation?[8]

Another argument, which is raised by the opponents of legalization, is based on the patient's will. As we can see, the argument based on the patient's will is raised both by supporters and opponents of legalization, but the same argument lead them to different conclusions. The opponents point at that legalization will marginalize the patient's will due to the pressure exerted on the patient, for example by their family. A terminally ill patient will feel that the death is their duty, not to be a burden for their family, may be motivated by the guiltiness and can be more prone to family's expectation to end their life[9]. However, the problem stressed in this argument by the opponents of legalization is not a problem connected with legalization from its

[7] D. Marquis, *Słabość argumentu za legalizacją samobójstwa z pomocą lekarza* [in:] *Wokół śmierci i umierania*, red. W. Galewicz, Cracow 2009, p. 310.

[8] G. DuVal, *Assisted suicide and the notion of autonomy*, Ottawa Law Review 1995, Vol. 27, p. 13.

[9] K. Szewczyk, *Bioetyka. Medycyna na granicach życia,* Warsaw 2009, p. 374.

essence but in fact is a problem connected with proper configuration of the procedure. If the procedure is configurated correctly, so as to oblige the doctor to get to know the patient's motivation and to consult with the patient's family, so as to get know their attitude to the patient's will, we will find out that this argument becomes invalid. This argument should not be found relevant whether to legalize physician-assisted suicide or not, but rather how it should be formed and executed, and which safety mechanism should be introduced so as to counteract the malpractice. Moreover, we can observe that in the countries which enacted in their laws physician-assisted suicide special effective safety mechanisms had been implemented, so as the risk of malpractice has been minimalized what will be analised further in the text.

In addition, the opponents argued that a patient who is asking for help to commit suicide in fact wants to show that they feel lonely in the situation when none of the procedures implemented to relieve pain are successful and that such patient just asks for help[10]. This argument has to be found relevant due to the study of statistics, which shows that still not enough terminally ill patients get an effective palliative care to help them to minimalize pain. There is no doubt that in the last 15 years situation in palliative care in Poland has been a little bit improved, but still is not at the satisfying level. That gives Poland the far, 16th place of all European countries in the Quality of Death Index[11].

5. Examples of countries, in which jurisdiction legalized physician-assisted suicide

Jurisdictions of some countries legalized physician-assisted suicide. A brief review shall help us to analyse conditions under which this procedure is legal in those countries. The first country is the Netherlands, which legalised euthanasia and physician-assisted suicide under the Termination of Life on Request and Assisted Suicide Act passed in 2001, which entered into force on 1st April 2002[12]. First of all it has to be said that under this law a physician-assisted suicide is not punishable if it is committed by a doctor who acts in accordance with criteria of due care. Those criteria are:

1. Patient's request should be voluntary and well considered.
2. Patient's suffering should be unbearable and without prospect of improvement.
3. Patient should be informed about their situation and prospects.
4. There are no reasonable alternatives.
5. Another, independent physician should be consulted.
6. Termination of life should be performed with due medical care and attention.

[10] M. Aramini, *op.cit.*, p. 288–289.

[11] Economist Intelligence Unit. The 2015 Quality of Death Index. Ranking palliative care across the world. London, New York, Hongkong, Genewa: The Economist Newspaper 2015, https://eiuperspectives.economist.com/sites/default/files/2015%20EIU%20Quality%20of%20Death%20Index%20Oct%2029%20FINAL.pdf, 14.05.2018.

[12] The Dutch Termination of Life on Request and Assisted Suicide Act, https://www.worldrtd.net/dutch-law-termination-life-request-and-assisted-suicide-complete-text, 20.05.2018.

Under this law, according to the article 293 section 2 of the Dutch Criminal Code, the only person who cannot take responsibility for patient's death is a doctor, thus any other person who helps patient to commit suicide will take the responsibility for their death[13]. Even if a non-doctor acts in accordance with the criteria of due care, they will have to take the responsibility for patient's death. Under section 293 clause 1 of Criminal Code of the Netherlands any person who terminates life of another person at that other person's express and earnest request, shall be liable to a term of imprisonment not exceeding twelve years or a fine of the fifth category. Moreover, we have to say that under the Dutch bill, physician-assisted suicide is allowed when patient is at least twelve years old, but for ending life of patients who are between 12 and 16 years old consent of both parents is required.

A slightly different procedure of physician assisted suicide is regulated by the law adopted in Oregon, USA. In 1997 it has been legalised under the Death with Dignity Act[14] but only for terminally ill, mentally competent adult patients. Also in Oregon specific criteria of due care have been adopted. First of all, a terminally ill person, who wants to end their life, has to be over 18 years old, be mentally competent and suffer terminal illness that will lead to death within 6 months. Moreover, we have to stress, that patient who wants to end their life has to express their will twice and between each request have to pass at least 15 days, what is called 'cooling off' period. This period is provided for eliminating cases when patients make their decision about finishing their lives on the spur of the moment. In addition, the request to doctor has to be expressed in written to dispel doubts and patients have to take the life-ending medication by themselves.

Comparing it to the Dutch regulation we can see that regulation passed in Oregon is definitely more restrictive. First of all, this procedure is provided only for people whose terminal illness will lead to death within 6 months, whereas in the Netherlands procedure is possible for terminally ill people whose suffering is without prospect of improvement. Moreover, in the Netherlands the procedure is available for people who are under 18 years old, what is forbidden in Oregon. The state Oregon also passed more strict criteria of due care – patient has to express their will twice and between each request have to pass minimum 15 days, thus patient has to reconsider their will, and moreover the request has to be expressed in written form. Such criteria of due care make the procedure of physician-assisted suicide long-lasting, but definitely helps to avoid doubts.

6. Conclusions

Taking all things into consideration we can say that numerous risen arguments support legalization of medically assisted suicide, or are against it. The discussion on this subject can take on a different character when it is considered on the Polish ground

[13] Criminal Code of the Kingdom of Netherlands. Act of 3 March 1881, http://www.ejtn.eu/PageFiles/6533/2014%20seminars/Omsenie/WetboekvanStrafrecht_ENG_PV.pdf, 20.05.2018.

[14] Oregon Death with Dignity Act (ORS 127.800–995), https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/statute.pdf, 20.05.2018.

than as it is in the Netherlands or in State Oregon, USA. While considering legalization of medically assisted suicide in Poland we cannot omit characteristic of Polish conditions. First of all we have to say that at present situation, introduction of physician-assisted suicide would be in conflict with the Penal Code or the Polish Code of Medical Ethics[15]. But in fact it is not a real problem, thus the legislative power can adopt amendments to those acts. In addition, we can stress that the Polish Criminal Code stands a little big erratic. Article 150, which penalizes the act of euthanasia, states in paragraph two that in some extraordinary circumstances court may apply an extraordinary mitigation of penalty or even renounce its imposition in the case when the perpetrator kills a human being on their demand. The extraordinary mitigation is provided in the case of euthanasia, whereas it is not provided in article 151 which penalizes physician-assisted suicide. It is hard to find a substantiation why the court can even impose the penalty in case of killing person on their demand, whereas it is not provided for perpetrators who only help other people to commit suicide. Moreover, worth considering is the idea of differentiation of responsibility of a doctor, who commits euthanasia or helps patient to commit suicide, from responsibility of other people acting in those ways. Such amendments to the Polish Criminal Code will make Polish regulations more similar to the concepts of euthanasia and physician-assisted suicide in science, what was already mentioned.

Moreover, Kazimierz Szewczyk draws attention to the specific conditions of Polish society. He points the insufficient level of financing of health care. In comparison to the Netherlands, which generates about 10,58% of Gross Domestic Product for health care, in Poland for this purpose around 6,34% is used[16]. The increase of financing health care should include especially the areas of geriatrics and pain treatment so as to give the elderly suffering people chance to get an effective qualified medical care so as not to suffer pain. Opponents of assisted suicide indicate the argument of discrimination against older and terminally ill people, however, the comparison of the share of people over 80 in society shows that in the Netherlands it amounts to about 4,3%, while in Poland about 4%[17]. In addition, in Poland a substantive discussion on legalization prevents the low level of education of the society. The concepts are often confused, and the still-strong experiences of the Second World War make the „dr Mengele" patron come in favor of the ending of life[18]. Changes in the area of the aspects of finishing life should be started from increasing the financing of health care, especially in the areas of geriatrics and pain treatment. Moreover, in Poland a thorough debate about euthanasia and physician-assisted suicide should be conducted, which could help to understand

[15] Compare it to the article 31 of the Polish Code of Medical Ethics, https://www.nil.org.pl/__data/assets/pdf_file/0003/4764/Kodeks-Etyki-Lekarskiej.pdf, 14.05.2018.

[16] Data presented by the Eurostat. Current health care expenditures by all financing agents (total), as percentage of GDP, https://ec.europa.eu/eurostat/statistics-explained/index.php/Healthcare_expenditure_statistics#Health_care_expenditure, 14.05.2018.

[17] Data presented by the OECD, Health at a glance 2017, http://dx.doi.org/10.1787/888933605654, 14.05.2018.

[18] K. Szewczyk, *op.cit.*, p. 380–389.

those concepts and may eliminate untrue statements. Without those changes legalization of physician-assisted suicide – which in my opinion is needed – should not be implemented. At the very ending, I want to quote the case of Doctor Timothy Quill, cited by Peter Singer in his book. A doctor from Rochester prescribed barbiturate sleeping pills to a patient with leukemia. Before issuing the funds, however, he offered the patient a comfortable care in his hospice, consisting in reducing pain. The patient thanked him, but decided to deprive him of life[19].

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Medycznie wspomagane samobójstwo. Rozważania na temat możliwości legalizacji na gruncie polskiego porządku prawnego

Medycznie wspomagane samobójstwo jest jednym z aktualnych dylematów moralnych, wokół których toczy się debata we współczesnych krajach. Debata ta z rosnącą intensywnością odbywa się także w Polsce. Artykuł w pierwszej części skupia się na wyjaśnieniu pojęć istotnych z punktu widzenia prowadzenia debaty, których prawidłowe zrozumienie jest niezbędne dla dalszych rozważań. Następnie stanowi próbę prezentacji i oceny argumentów podnoszonych przez zwolenników, jak i przeciwników legalizacji tej procedury. Tekst porusza także kwestię polskich uregulowań prawnych skupionych wokół tej tematyki, a także problemów i trudności, których rozstrzygnięcie jest niezbędne na gruncie polskiej debaty w temacie medycznie wspomaganego samobójstwa i stanowi warunek konieczny do dalszych rozważań na temat możliwości legalizacji wspomnianej procedury na gruncie polskim.

Słowa kluczowe: medycznie wspomagane samobójstwo, eutanazja, Konstytucja, kodeks karny, kodeks etyki lekarskiej

[19] P. Singer, *Etyka praktyczna,* Warsaw 2007, p. 190.