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Master thesis

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The problematics of the evolution of euthanasia and assisted suicide in the United States of America in relation to the development of global human rights

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Abstract

My thesis addresses the question of how the issue of euthanasia and physician-assisted dying in the United States of America has been evolving in relation to the development of human rights. Taking a long-term view, arguments of the current debate on the issue of evaluation of both practices, euthanasia and physician-assisted dying has revealed the persistent controversial stance on moral justifications of ethics dissonance and the economic response. The point is to illustrate the scope of the dissociation by analyzing arguments and counter-arguments in relation to the question of the bilateral interweaving and interaction with respect for fundamental human rights and a synopsis of the ethics of dying that take into account the abuse of euthanasia and physician-assisted suicide.

The interpretation of the development of the attitude of American society and the American medical diaspora has been reflected. In euthanasia and physician-assisted dying debates, analytical synopsis of the development of tolerance in American society in the context of rational choice in view of the economic, ethical, and religious assumptions and the possibility of an alternative option have been critically scrutinized. Given the ambiguous nature of ethical permissibility and legalization of euthanasia and assisted suicide, debates on morality remain a source of manifest controversy due to the ambiguity of the current issue.

Abstrakt

Moje diplomová práce se zabývá otázkou, jak se vyvíjí problematika eutanazie a umírání za pomoci lékaře ve Spojených státech amerických v souvislosti s vývojem lidských práv. Z dlouhodobého hlediska argumenty současné debaty o vývoji obou praktik, eutanazie a asistovaného umírání, odhalují přetrvávající kontroverzní postoj k morálnímu ospravedlnění etické disonance a ekonomické odezvy. Zásadním bodem bylo ilustrovat rozsah disociace analýzou argumentů a protiargumentů ve vztahu k otázce bilaterálního prolínání a interakce s respektováním základních lidských práv a

souhrnem etiky umírání, která zohledňuje zneužívání eutanazie a lékařsky asistované sebevraždy.

Interpretace vývoje postoje americké společnosti a americké lékařské diaspory byla reflektována. V debatách o eutanazii a asistovaném umírání byla kriticky zkoumána analytická synopse vývoje tolerance v Americké společnosti v kontextu racionální volby s ohledem na ekonomické, etické a náboženské předpoklady a varianty alternativního řešení. Vzhledem k nejednoznačné povaze etické přípustnosti a legalizace eutanazie a asistované sebevraždy zůstávají debaty o morálním kodexu zdrojem zjevných kontroverzí v souladu s nejednoznačnosti aktuální problematiky.

Klíčová slova

Spojené státy americké, eutanázie, asistovaná sebevražda, legalizace, lidská autonomie, racionální volba, sebeurčení, společnost, argumenty, protiargumenty

Keywords

United States of America, euthanasia, assisted suicide, legalization, human autonomy, rational choice, self-determination, society, arguments, counterarguments

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Declaration of Authorship

1. The author hereby declares that he compiled this thesis independently, using only the listed resources and literature.

2. The author hereby declares that all the sources and literature used have been properly cited.

3. The author hereby declares that the thesis has not been used to obtain a different or the same degree.

Prague 01.08.2022

Marija Kovalenko

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2. Introduction

This thesis aims to provide an analytical synopsis of the issue of euthanasia and physician-assisted dying in the United States of America and perspective taking on concern for tolerance of euthanasia and physician-assisted suicide as a legalized rational choice of contemporary American society and the public health sector and points to the need for further debate. Interpretation of the development of social, medical, and legislative aspects of the problematics of euthanasia and physician-assisted dying in the United States of America in the context of the global development of human rights has been critically scrutinized.

'Ubique mors est; optime hoc cavit deus. Eripere vitam nemo non homini potest; At nemo mortem; mille ad hanc aditus patent.'[1] ('Death is everywhere: heaven has well provided for that. Any one may deprive us of life; no one can deprive us of death. To death there are a thousand avenues.'— Seneca, Theb:, i, I, 151.)[2] It is worth noting that the process of detabooization of death has initiated the development and interest in the ethics of dying with regard to respect for human autonomy and the humanization of the terminal stage of human life with a dignified, peaceful, painless death surrounded by family. Despite the fact that a good death is preferred from the moral, ethical and individual perspectives, there exist distinct levels of the dying process in advanced societies that encompasses the issue of euthanasia and physician-assisted dying.

The issue of euthanasia and assisted suicide is a highly controversial and debatable issue connected with philosophical-historical, moral-ethical, legal, social aspects and religious beliefs, furthermore, it is "also one of the major problems in the national and international health limits."[3] The debate on physician-assisted dying and euthanasia "recognizing the freedom to freely dispose of oneself"[4] occurs specifically in the advanced societies, and this issue closely correlates with a multidisciplinary

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[1] Michel de Montaigne, William Carew Hazlitt, and Charles Cotton, *Essays* (Waiheke Island: The Floating Press, 2009), 806.
[2] Ibid.
[3] Božidar Banović, Veljko Turanjanin, and Anđela Miloradović, "An Ethical Review of Euthanasia and Physician-assisted Suicide," *Iran J Public Health* 2, no. 46 (February 2017): 173, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5402774/.

[4] Bernard Ars and Etienne Montero, *Suffering and Dignity in the Twilight of Life* (The Hague: Kugler Publications, 2004), viii.

approach in healthcare focusing on increasing modernization and technization of healthcare particularly intensive therapy and cardiopulmonary resuscitation, which paradoxically intermittently leads to prolongation of the unnecessary and inhuman suffering of patients with unfavorable prognosis.

The achievement of a balance between individual human autonomy and the protection of the general welfare and between reassurance of life values and perception of death as an irreversible natural process is of crucial importance.[5] Proponents of euthanasia and physician-assisted suicide consider altruism as a motivational tool for ending genuine pain in the absence of another undignified egocentric motive "such as revenge, hate, indifference, money, or a desire to get rid of the burden of caretaking."[6] Technology advancement and pharmacological innovations in the healthcare sector, the probability of long-term survival of the patient in a persistent vegetative state or the maintenance of vitality through the medium of life-sustaining equipment initiates the approach to death as a controlled and manipulated process. Some of the key arguments for euthanasia and assisted suicide, such as respect for the autonomy of the patient, are difficult to evaluate and are susceptible to manipulation in the case of an application to individuals that are likely to lose the potential to make deliberate rational decisions, namely mentally handicapped patients or minor children. For this reason, it's worth taking into consideration that it is particularly problematic to determine the individual approach to this issue for the opponents or the proponents of euthanasia and assisted suicide due to the diversity, specificity and uniqueness of each clinical case.

Currently, the law of the United States do not allow euthanasia to be included in the daily routine of medical practice, while assisted suicide is allowed in certain American states. Physician-assisted suicide is legally condoned and not prohibited under the law in a few states such as California, Colorado, Hawaii, Maine, New Jersey, Oregon, the District of Columbia, New Mexico, Montana, Vermont, and Washington.[7] The absence of the legal basis of the extension of the commitment to individual freedom and of the legalization of law enabling patients with infaust prognosis to end their own

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[5] Sidney Callahan, "The Moral Case Against Euthanasia," *Catholic Health Association of the United States*, last modified January-February, 1995, https://www.chausa.org/publications/health-progress/article/january-february-1995/the-moral-case-against-euthanasia.

[6] Ibid.

[7] "Medical Aid in Dying," *End of Life Choices New York*, last accessed May 24, 2022, https://endoflifechoicesny.org/advocacy/proposed-legislation/aid-in-dying/.

existence with medical assistance in dying motivates patients who deal with incurable diseases to cross state borders for the purpose of entering the state that legalizes physician-assisted suicide for patients in critical condition.[8]

3. Literature review

As part of the book, Euthanasia – The "Good Death" Controversy in Humans and Animals, issued in September 2011, Josef Kuře, the author of the chapter Everything Under Control: How and When to Die – A Critical Analysis of the Arguments for Euthanasia, provides a profound and thorough overview of arguments and counter-arguments against euthanasia with the application of the comparative method. Furthermore, the author provides a critical constructive assessment of the further specification of the definition of the concept of euthanasia and physician-assisted suicide, which is often incorrectly presented as equivalent words, regardless of "two diverse entities."[9]

In the introduction to this chapter, the author outlines the research methodology and research strategy and specifies that the analysis of arguments and counterarguments concerning euthanasia is conducted in the context of active voluntary euthanasia, which is initiated by the rational choice approach in accordance with the perfect rationality of an authentic person. As the author remarks, involuntary euthanasia means an act of the intentional termination of the life of a non-competent person who lacks the decisional capacity concerning the artificial preservation of life or termination of life, and a competent decision is taken by consensus by a designated health care agent.

Within this chapter, a thorough and accurate categorization of arguments and counterarguments is particularly difficult due to complementarity, a process of interweaving, bilaterality, interdependence, and individuality of each clinical case. Accordingly, the consequential argumentative classification is derived from the prerequisites that individual reasoning is based on the prevalence of arguments in favour

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[8] Howard Ball, *At Liberty to Die : The Battle for Death with Dignity in America* (New York: New York University Press, 2012), 1.

[9] Josef Kuře, *Everything Under Control: How and When to Die - A Critical Analysis of the Arguments for Euthanasia* (Brno, 2011), 128, https://www.intechopen.com/chapters/19615.

of euthanasia, such as human autonomy or arguments against allowing euthanasia, namely[10] “slippery slope.”[11]

The author of the article examines the concept of human autonomy and its interpretation from the perspective of supporters and opponents of euthanasia, which appears as a controversial concept on the subject of an investigated issue. It has commonly been assumed that the legalization of euthanasia supports autonomous persons in the direction of taking control of their lives and the process of dying, nevertheless, the criminalization of euthanasia is portrayed as a limitation of autonomy. Euthanasia constitutes a preferred choice on the basis of human autonomy in accordance with the conviction of humans concerning the absence of the necessity of palliative care services and unnecessary suffering.[12] According to the author of the article, the freedom of rational choice in accordance with individual preference constitutes a further aspect of human autonomy.

Within this analytical study, opponents of euthanasia doubt the humane basis of compassionate argument; compassion is thorough, sensitive, and comprehensive care for a dying person, not euthanasia, in accordance with their ideological assumption. In the analysis of this chapter, the author illustrates the right to die as a lucid and free decision of competent person in terminal stages of serious incurable diseases accompanied by unbearable suffering. In a religious way, the author presents arguments and opposing points concerning the inviolability or sanctity of human life and moral objections in a logical sequence as the primary concern in accordance with obligations of the patient to the family and society as a whole as a counter-argument against the right to die.

Within this chapter, a liberal approach to euthanasia moves in the direction of an individual choice of autonomous persons as a means to assert their autonomy within the framework of advanced modern society or toward social preferences in which the decriminalization of euthanasia act as a regulatory mechanism to prevent criminal deviation and abuse. Furthermore, the author primarily draws attention to the radicalism of the libertarian view of euthanasia that promotes the uncontrolled expansion of this phenomenon with an authoritarian mindset and the limitations of normative ethics.

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[10] Ibid, 130.
[11] Ibid.
[12] Ibid, 135.

Taking everything into consideration, Josef Kuře, in the chapter on *Everything Under Control: How and When to Die – A Critical Analysis of the Arguments for Euthanasia*, thoroughly examines arguments and counter-arguments concerning euthanasia that are interconnected; furthermore, the author of the article conducts an in-depth analysis of objections to the argument such as the competence of a dying individual. In the analysis of this chapter, the exact interpretation of pro-euthanasia arguments or the counter-arguments is intricate and ambiguous owing to complex correlation, the interaction and mutual dependence between individual subjects of analysis; in addition, this article highlights the need to be explicit about exactly what is signified by the semantic representation of the term euthanasia. Within this analytical study, a summary of the analysis forms the basis of an enhanced comprehension of the essence of the issue and correspondingly "a matrix of arguments"[13] as shown in Figure 1, which presents an exploratory analysis of the interactions between pro-euthanasia arguments and the counter-arguments; nevertheless, this interrelation can be examined in relation to a broad spectrum of various areas and contexts and its aim is to pursue a further multidisciplinary expert discussion.

The following article*, Legalizing euthanasia or assisted suicide: the illusion of safeguards and controls*, describes the development and evaluation of perspectives of the legalization of both practices of euthanasia and physician-assisted suicide and provides evidence of the imperfection of existing legal measures, an inefficient subjective legal justice system, furthermore, the article discusses the spread of practices targeted at disadvantaged groups within society. This paper examines the effectiveness of legal measures for the purpose of preventing the abuse of euthanasia and physician-assisted suicide in countries that have legalized these practices of euthanasia and physician-assisted dying.

Within this analytical study, the author of the article, José Pereira, presents the growing tendency of the abuse of euthanasia and physician-assisted suicide in the healthcare sector, particularly in Holland, Belgium, and the U.S. state of Oregon as jurisdictions allowing either or both of these acts. At this juncture, there is an absence of a clearly defined legal framework and legal ethical obligations addressing the issue of euthanasia and physician-assisted dying that would be capable of reducing the risk of abuse of these assessment tools.

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[13] Ibid, 157.

The analysis demonstrates that ineffective legislative measures, unjustified social tolerance of these practices, and the spread of non-medical indications such as 'tired of living'[14] with the intention of hastening death and performing a juridical act in certain societies such as the Dutch and Belgian illustrates the risk of the likelihood of 'slippery slope.'[15] In sharp contrast to the other territorial jurisdiction that permit only qualified physicians to administer euthanasia or assisted suicide, Switzerland permits euthanasia or physician-assisted to be performed by a non-physician who has been granted access to seriously ill people.[16] A total of 2,410 lethal outcomes were the result of euthanasia or physician-assisted dying, accounting for 1.7 % of all deaths in the Netherlands in 2005.[17] Out of the total number of cases, more than 560 patients received a lethal injection without their informed consent, which is 0.4% overall.[18]

It has been demonstrated that the mortality of "involuntary euthanasia and non-voluntary euthanasia"[19] in the absence of informed consent in Belgium is three times as much as in the Netherlands.[20] The author presents statistical data on the subject of an approach to euthanasia in Belgium over an unspecified time period. Recent research has shown that "66 of 208 cases"[21] of 'euthanasia'[22] occurred in the Flemish Region of Belgium without the request for informed consent, which means mortality resulting from assisted dying practice surged by 32% in the analyzed area.[23] Non-compliance with the requirements to obtain informed consent and the wishes of patients concerning the termination of their lives assessing a comatose patient, accounting for 70% of the analyzed group of patients diagnosed with dementia, accounting for 21% of the analyzed group.[24] The physicians performed euthanasia without valid informed consent in 17% of reported cases in the belief that the act was[25] 'clearly in the patient's best

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[14] José Pereira, "Legalizing euthanasia or assisted suicide: the illusion of safeguards and controls," *Current Oncology* 18, no. 2 (April 2011): 38, doi:10.3747/co.v18i2.883.

[15] Ibid.
[16] Ibid.
[17] Ibid, 39.
[18] Ibid.
[19] Ibid.
[20] Ibid.
[21] Ibid.
[22] Ibid.
[23] Ibid.
[24] Ibid.
[25] Ibid.

interest'[26] and in 8% of reported cases that a debate about the overall prognosis of patients could result in harm.[27]

Further analysis has shown that the number of cases of physician-assisted dying detected in Oregon remains at a relatively low level with respect to the population of Oregon, nevertheless, the rate has steadily increased from 1998, 24 individuals received prescriptions and out of the total number of cases, 16 patients died by means of a prescribed lethal substance, 67 prescription medications were issued in 2003 and out of the total number of cases, 43 patients died by means of a prescribed lethal substance and in 2007, 89 prescriptions were already dispensed.[28] The author draws attention to the need to ensure a safe environment for a patient in the course of the treatment in the absence of conscious manipulation of cognitive performance and a one-sided attitude of a physician towards the desire of a patient, which can result in a sensory deprivation of a patient and influence his decisions. "In Oregon, a physician member of a pro-assisted-suicide lobby group provided the consultation in 58 of 61 consecutive cases of patients receiving pas in Oregon."[29]

Globally, the article has revealed that the absence of public interest concerning criminal prosecution in the case of an indeterminate act of euthanasia or assisted suicide in jurisdictions allowing either or both of these acts indicate the imperfection of the judiciary system and societal indifference, which also relies on hyper-tolerance towards social issues. At the end of the article, the author presents a manifest example of the Netherlands as a jurisdiction that legalized assisted dying practice, which, despite the continuous long-term historical development of the society, traditions and culture are moving towards medicalization that gives rise to multiple controversial motives to perform a medical act with the underestimation of the actual predominance of the social concern in the context of assisted dying practice.

The Annals of Palliative Medicine published an article by Sarah Mroz et al., titled *Assisted dying around the world: a status quaestionis*, which describes key determinants of issues of legislation in various jurisdictions and globalization trends with a particular focus on demographic, ethical, and social aspects. The author of the article presents the key concepts and principal insight on the development of euthanasia

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[26] Ibid.

[27] Ibid.

[28] Ibid, 42.

[29] Ibid, 40.

and physician-assisted suicide on a global scale, in particular, as a consequence of the demographic transition of mass society, an increase in life expectancy, and an aging population principally in developed countries; correspondingly, advances in medical technology that enable the optimization of therapeutic course of action.

So within the following analysis of problematics, the author of the article conducts a semantic analysis of the terminology of euthanasia and physician-assisted dying "within the socio-cultural context in various jurisdictions"[30] with a particular focus on the consistency and transparency of basic terms. From a global perspective, this article describes the social environment of a network of complex, interconnected, and intertwined phenomena and presents data on increased public interest concerning the legalization of euthanasia and physician-assisted suicide as a result of recent trends in globalization.

The author describes the key determinants of the historical developments of euthanasia and physician-assisted suicide in various jurisdictions in the context of a relationship between law and morality; consequently, the article further presents a notion of the process of legalization of physician-assisted dying in the United States of America in accordance with the Supreme Court rulings that "ruled that right-to-die decisions would be left to the states."[31] The author specifies certain legal regulations concerning consumption of lethal substances in the course of performance of euthanasia and physician-assisted suicide in various jurisdictions; as far as United States is concerned, a physician "is often not present"[32] during the performance of the act of physician-assisted suicide within the framework of respect for individual autonomy and patients are entitled to receive certain intimacy and freedom in rational decision-making at the end of their lives and implement end-of-life planning in accordance with their own preferences.

Within this analytical study, the author highlights the importance of the necessity of observing the procedural safeguards of the spread of euthanasia and physician-assisted suicide on a global scale concerning the impact of the trends in globalization on society. Furthermore, the article also highlights the importance of a risk assessment for

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[30] Sarah Mroz, Sigrid Dierickx, Luc Deliens, Joachim Cohen, Kenneth Chambaere, "Assisted dying around the world: a status quaestionis," *the Annals of Palliative Medicine* 10, no. 3 (2021): 3542, doi: 10.21037/apm-20-637.

[31] Ibid.

[32] Ibid, 3550.

the prevention of abuse of assisted dying practices geared towards disadvantaged groups within society in the context of respect for personal autonomy, which can lead to "a critical public health issue."[33]

4. Historical background

The historical development of euthanasia and physician-assisted dying in the United States is characterized by immense interconnectedness. "Trends such as eugenics, positivism, social Darwinism, and scientific naturalism"[34] initiated the evolution of discussion in American society concerning traditional deeply ingrained ideas about social acceptance of life and the dying process "in the early twentieth century."[35] The interpretation of the fundamental philosophical and moral foundations of human existence provided an explicit vision of the modification of the concept of the sanctity of human life and the issue of unnecessary and unbearable suffering.

The development of "the Progressive movement between the 1890s and the 1930s"[36] intertwined with the transmutation of this particular direction of thought process gave impetus to the conception of 'natural right to a natural death'[37] for the first time in the history of the United States.[38] According to the representatives of the Progressive movement, euthanasia was thought of as a regulatory tool of public health aimed at reducing expenditure in reference to deprived social groups, rebuilding the foundations of fundamental social hierarchy and enhancing the welfare and prosperity of upcoming generations.[39]

The debate on the issue of euthanasia has emphasized the importance of pointing to this phenomenon after a wave of suicides that gained broad publicity during the 1930s and the subsequent establishment of the Euthanasia Society of America founded in 1938 gave impetus to the perpetuation of a nascent movement facing pressure from opponents until the second half of the 20th century, specifically up until

[33] Ibid, 3551.
[34] Ian Dowbiggin, *A Merciful End : The Euthanasia Movement in Modern America* (New York, 2003), 2.
[35] Ibid.
[36] Ibid.
[37] Ibid.
[38] Ibid.

the 1960s.[40] Nearly 40% of Americans surveyed in 1939 supported the government-controlled legalization of euthanasia indicated for patients with an infaust prognosis at an advanced stage.[41] Humanistic and philosophical principles, the absence of religious faith and the authority of the Word of God, the accentuation of human beings as the final judge of their own life and death have initiated a positive reflection on the significance of the issue of euthanasia and physician-assisted suicide in view of their propaganda in American society.

The First Humanist Society was established by Charles Francis Potter in 1929, who held the position of an Unitarian minister.[42] As Charles Francis Potter observed, voluntary euthanasia represents outstanding instances of Humanism in practice.[43] He was an outspoken opponent of conventional religious beliefs that underlined the importance of ingrained ethical principles, which are highly valued in American society and cultural milieu; furthermore, he represented the view of the supporters of "eugenics, social Darwinism, and the mercy killing"[44] of inmates with severe disabilities.[45] It permitted terminally ill patients to retain control over their death to a great extent, leading to the enrichment of life experiences in the last stage of human existence.[46]

The Great Depression, the major economic crisis throughout the 20th century in the United States, triggered the major economic downturn, and furthermore, the long-term consequences of social sphere that initiated the general frustration in the society, the insufficiency of interpersonal relationships associated with the global prevalence of anxiety, mood disorders, and depressive disorders, human feelings of inadequacy, the lack of fundamental human needs for the meaning of human existence, an increased risk of suicidal ideation and suicidal behavior. The case fatality rate of suicidal acts had increased from[47] "13.9 per 100,000 in 1929 to 17.4 in 1932."[48]

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[39] Ibid, 7.
[40] Ibid, 31.
[41] Ibid, 32.
[42] Ian Dowbiggin, '"A Rational Coalition': Euthanasia, Eugenics, and Birth Control in America," 1940–1970," Journal of Policy History, 14, no. 3 (2002): 234, doi:10.1353/jph.2002.0017.
[43] Ibid.
[44] Ian Dowbiggin, *A Merciful End : The Euthanasia Movement in Modern America* (New York, 2003), 33.
[45] Ibid.
[46] Ian Dowbiggin, '"A Rational Coalition': Euthanasia, Eugenics, and Birth Control in America," 1940–1970," Journal of Policy History, 14, no. 3 (2002): 234, doi:10.1353/jph.2002.0017.

[47] Ian Dowbiggin, *A Merciful End : The Euthanasia Movement in Modern America* (New York, 2003), 34.

With regard to some of the psychological concepts of approach to the analyzed issue, the American physician Harry J. Haiselden became involved in the issue of pediatric euthanasia, which appears to be risky and delicate, nevertheless, Haiselden preferred and even performed euthanasia of infants based on his own individual diagnostic criteria. The right to choose a peaceful end has been promoted by "human and civil rights movements"[49] that have accentuated the right to rational self-governance, personal empowerment, the sanctity of human life, and the right to manage the dying process from the beginning of 1960.[50] As a proponent of euthanasia argued in 1975, it was a particularly appropriate time to 'break the stranglehold of tradition and religious dogma'[51] that ran through the mainstream of American society.[52]

Public opinion research conducted in 1937 indicated that almost half of Americans surveyed, specifically 45 percent, whose view was consistent with the belief of Harry Haiselden, took a stance against the protection of life of[53] "infants born permanently deformed or mentally handicapped."[54] Haiselden took a stance against the survival of predestined children and adhered to the view that these newborn children are socially disadvantaged and are dissonant with social integration.[55]

"Charles Francis Potter (1885– 1962)"[56] rose to make his speech at the regular meeting of the Euthanasia Society of America held in 1940.[57] "Euthanasia, or merciful release from suffering,"[58] Potter proclaimed,[59] "is rapidly emerging from the stage when it was considered merely the obsession of a few left-wing social re- formers to the

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[48] Ibid.

[49] Josef Kuře, *Everything Under Control: How and When to Die - A Critical Analysis of the Arguments for Euthanasia* (Brno, 2011), 140, https://www.intechopen.com/chapters/19615.

[50] Ian Dowbiggin, *A Merciful End : The Euthanasia Movement in Modern America* (New York, 2003), 34.

[51] Ibid, 124.

[52] Ibid.

[53] Ibid, 33.

[54] Ibid.

[55] Matthew Archbold, "The Curious and Tragic Case of Dr. Haiselden and the Baby Bollinger," *National Catholic Register*, November 19, 2014, https://www.ncregister.com/blog/the-curious-and-tragic-case-of-dr-haiselden-and-the-baby-bollinger.

[56] Ian Dowbiggin, "'A Rational Coalition': Euthanasia, Eugenics, and Birth Control in America," 1940–1970," Journal of Policy History, 14, no. 3 (2002): 223, doi:10.1353/jph.2002.0017.

[57] Ibid.

[58] Ibid.

period when it is being recognized as an important social measure in the same class with birth control and eugenics."[60] The Euthanasia Society of America (ESA) made a formal request to the Human Rights Commission of the United Nations in 1952 for the recognition of the right to a dignified death a fundamental human right for people diagnosed with an incurable terminal illness.[61] "The Patient Self-Determination Act"[62] was passed in 1990 and has acknowledged that all persons have a right to a dignified death and a refusal to accept medical treatment in a lawful manner in accordance with access to their own confidential medical records in health care facilities; the right to die has been authenticated by the Supreme Court of the United States in 1990 on the basis of civil liberties.[63]

With regard to modern history, respondents in the U.S. state of Oregon in 1994 held a national referendum on legalizing physician-assisted suicide with a narrow margin of 51% to 49%.[64] Potentially the most convincing argument introduced by this coalition has been a continuously obvious danger that physician-assisted suicide could become a means of control over healthcare expenditures; in particular, the healthcare system in the United States that tends to be profit-oriented and controlled by Health Maintenance Organizations and associated with budget deficits continually occurring within government-controlled public insurance programs, namely Medicare and Medicaid.[65]

5. What is euthanasia and physician-assisted dying?

Euthanasia in the context of health care implies active or passive acts as part of medical performance aimed at the prevention of excessive suffering and preservation of human dignity at the end-of-life period when death is inevitable. The basic concept of active or passive euthanasia is justified and motivated by mercy and compassion for an

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[59] Ibid.

[60] Ibid.

[61] Ian Dowbiggin, *A Merciful End : The Euthanasia Movement in Modern America* (New York, 2003), 94.

[62] Josef Kuře, *Everything Under Control: How and When to Die - A Critical Analysis of the Arguments for Euthanasia* (Brno, 2011), 140, https://www.intechopen.com/chapters/19615.

[63] Ibid.

[64] Bernard Ars and Etienne Montero, *Suffering and Dignity in the Twilight of Life* (The Hague: Kugler Publications, 2004), 71.

[65] Ibid, 73-74.

ill person, a presumption of a dignified end to mental and physical suffering, and pain manifestations incompatible with the life of a human being.

According to the American physician, Jack Kevorkian with the nickname of Dr. Death, “If you don't have liberty and self-determination, you've got nothing, that's what this is what this country is built on. And this is the ultimate self-determination, when you determine how and when you're going to die when you're suffering.”[66] With regard to death and dying, Dr. Kevorkian took a stance on the issue in view of the pathological interpretation of human autonomy by performing irrelevant medical experiments on individuals by means of shaping their own fate. In this view, the procedures conducted by Dr. Kevorkian as the controversial promoter of euthanasia did not receive positive publicity among American public. Furthermore, the debates about the morality and legality of this practice triggered negative responses in the American medical diaspora.

It is worth noting that there exist opposing views on the issue of euthanasia in the broader context of the argumentation and on the practical implementation of the act of euthanasia; in addition, in accordance with the preferences of opponents who condemn euthanasia, the act of euthanasia is considered morally unacceptable and this practice is identified as uncompromising murder in an inconsiderate manner. “The physician who performs euthanasia assumes unique responsibility for the act of ending the patient’s life.”[67]

The act of euthanasia is fundamentally irreconcilable with the mission of the doctor as a healer, furthermore, this process gets effortlessly out of control and could create social risk factors.[68] In the context of standard healthcare performance and on the basis of a confidential discrete doctor-patient interaction, proponents of euthanasia justify the moral permissibility of the act of euthanasia based on the assumption that it is the only correct choice in the absence of an effective alternative to terminate suffering and the patient choose the act of intentional termination of life in a free valid rational way.

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[66] Neal Nicol, Harry L. Wylie, *Between the Dying the Dead: Dr. Jack Kevorkian, the Assisted Suicide Machine, and the Battle to Legalise Euthanasia* (London: Vision Paperbacks, 2006), 18.
[67] Sidney Callahan, “The Moral Case Against Euthanasia,” *Catholic Health Association of the United States*, last modified January-February, 1995, https://www.chausa.org/publications/health-progress/article/january-february-1995/the-moral-case-against-euthanasia.

[68] “Chapter 5: Opinions On Caring For Patients At The End Of Life,” *AMA Principles of Medical Ethics: I,IV*, last accessed April 11, 2022, https://www.ama-assn.org/system/files/2019-06/code-of-medical-ethics-chapter-5.pdf.

Physician-assisted suicide without considerations of moral motivation, ethical behavior and rational choice represents the suicidal self-destructive act in which the person concerned is the initiator and immediate perpetrator of this act and, above all, is endowed with the right to freely choose between life or death right up until the moment of the lethal outcome. Approximately 20% of Americans live in areas that have legalized medical assistance in dying, and the total number of persons who are qualified to receive medical aid in dying is projected to increase due to increased transparency in support for legalization of medical assistance in dying.

6. Theoretical framework / methodology

Within the methodological framework, quantitative data analysis and qualitative data analysis of the nature of examined phenomenon will be presented for the purpose of study concerning arguments in favor and against physician-assisted suicide and specific characteristics of various types of pro and contra arguments with general differentiation used for support or refusal of euthanasia and physician-assisted suicide. Data analysis are conducted in the context of approach to the elucidation of assisted dying practices in the context of the globalization tendencies and interrelationship between the analysis of the development of the phenomenon in the United States of America and the analogous phenomenon in European countries.

In line with analytical synopsis, a dichotomy between arguments and counterarguments in examined phenomenon, particular arguments and counterarguments in its initial verified argumentation are evaluated. In this way, in view of the interrelationship between arguments and counterarguments, arguments can be applied in the context of a counterargument “taken from different fields and contexts” [69] to identify the essence of the phenomenon under investigation. In line with analytical synopsis, a dichotomy between arguments and counterarguments in examined phenomenon, particular arguments and counterarguments in its initial verified argumentation are evaluated. The creation of the theoretical and conceptual framework in view of the consistent action chosen by deliberative reasoning takes into account the

[69] Josef Kuře, *Everything Under Control: How and When to Die - A Critical Analysis of the Arguments for Euthanasia* (Brno, 2011), 157, https://www.intechopen.com/chapters/19615.

consistency and practical coherence of a rational agent to elicit a desirable scenario and reduce the likelihood of making an unwise decision.

6.1 Rational choice theory

The rational choice theory provides a coherent account of human decision-making and provides the foundations for elucidation of human thinking "that, ultimately at least, would permit the consequentialist weighing of goods in order to determine the morality of an action."[70] Purposeful behavior of an individual in the context of rational choice theory aims at the implementation of actions that maximize utility with current consistent preferences for the purpose of minimizing losses, producing consistent choices, and optimizing outcomes and that certain conduct performed by individual actors is applied to social phenomena in respect of conscious behavior of society. Rationality as a means of understanding the nature of the examined issue and as a matter of coherence establishes the preconditions that have widely been viewed as practical reasoning concerning the rational interests of individual actors and the dual relationship inclusive of outcomes that are consistent with their own self-interest.

"In rational-choice theory, which can be considered as the most sophisticated formal articulation of instrumental rationality,"[71] the role of objectives or aspirations is represented by[72] "the preference relation or utility function"[73] based on the assumption that the possibility of choice of anticipated outcomes of the courses of action will be provided in the area of interest.[74] Complete and transitive preferences represent a precondition for the applicability of rational action, consequently, this theory gives a logically unavoidable condition that preferences defined in this way will be classified as complete and transitive.[75] A personal belief of an individual shall be in accordance with the comprehensiveness of all acceptable consistent convictions and should be articulated

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[70] Craig Paterson, *Assisted Suicide and Euthanasia: A Natural Law Ethics Approach* (Abingdon: Routledge, 2008), 27.
[71] Peter Kroes, Maarten Franssen, and Louis Bucciarelli. *Philosophy of Technology and Engineering Sciences: Rationality in Design* (Amsterdam: Elsevier, 2009), 577, https://doi.org/10.1016/B978-0-444-51667-1.50005-7.
[72] Ibid.
[73] Ibid.
[74] Ibid.
[75] Ibid.

in such a way that the individual could believe in the particular possible consequences of already pre-existing beliefs.[76]

James Margolis and Margaret Battin represent the view of the proponents of instrumental rationality associated with the problematics of the performance of suicide and physician-assisted suicide.[77] According to Margaret Battin, an American scholar and a supporter of physician-assisted suicide, this phenomenon “would be rational if the suicide candidate is able to articulate a consistent worldview”[78] and is capable of evaluating rational arguments and counter-arguments considering his preferences for termination of life.[79] The ability of an individual to express a clear perspective on the circumstances of dying depicts a valid outcome indicator to[80] “a rationally informed basis to justify suicide and to seek support from others.”[81]

Margolis proclaimed that suicide is regarded as a rational and judgmatical means[82] “if it is understood to be the only realistic way”[83] of empowering patients to determine their own objectives with a clear intention regarding suicide.[84] The patients are presumed to be competent to adequately assess the act of physician-assisted suicide as an effective means of achieving well-defined objectives that have been set; however, this form of rationality does not require the preservation of optimal functioning of the cognitive capabilities of patients.[85]

Given the nature of rational choice theory, the theory is a primary driver for gathering information on the basis of rational calculations based on rational argumentation and rational motive that initiates the goal-directed behavior of striving toward the desired objective.

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[76] Ibid.
[77] Craig Paterson, *Assisted Suicide and Euthanasia: A Natural Law Ethics Approach* (Abingdon: Routledge, 2008), 26.
[78] Ibid.
[79] Ibid.
[80] Ibid.
[81] Ibid.
[82] Ibid.
[83] Ibid.
[84] Ibid.
[85] Ibid.

6.2.1 Qualitative research

As previously indicated, in view of a dual relationship, “different types of argumentations can be identified”[86] within the context of rational argumentation, “which use different or the same arguments so one and the same argument is used within diverse argumentations,”[87] in view of the application of both practices of euthanasia or physician-assisted dying in the concept of quality of life in terms of preservation of individual autonomy and human dignity can be administrated. As previously indicated, the latest technological advances in medical technology and bioethical procedures, in conformity with medical and ethical competence, enable a substantial increase in life expectancy that put a high emphasis on the quality of life and postponement of death. “Insofar as death is a part of life, quality of life can be referred to the quality of dying,”[88] especially taking into account that in particular cases life-prolonging treatment represents non-rational choice, and infaust prognosis quoad vitam et sanationem; in essence, demonstrates avoiding death and artificial prolongation of the agonizing dying process.

Individuals with an infaust prognosis, a long-term state of stabilized cognitive function, maintained self-determination, and who are approaching death shall have the right to make autonomous decisions as a rational act with a preference for euthanasia or assisted suicide that aims to end the uncontrolled pain expansion and unmanageable physical or mental suffering. It is crucial to highlight the importance of perspective of representatives of the medical community on the question of euthanasia and physician-assisted suicide in the contemporary world, particularly in the context of continuous physician-patient interaction, expert knowledge of etiology, pathogenesis, and the nature of advanced incurable diseases and advances in medical research.

Dr. Miloš Stoilov, CSc., a highly qualified physician, who acted as an expert witness, working as an accredited doctor of internal medicine in a multidisciplinary field with continued international experience, a proponent of physician-assisted suicide

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[86] Josef Kuře, *Everything Under Control: How and When to Die - A Critical Analysis of the Arguments for Euthanasia* (Brno, 2011), 157, https://www.intechopen.com/chapters/19615.
[87] Ibid.
[88] Ibid, 155.

and euthanasia states that this is a non-standard medical act intended for different types of patients with advanced and incurable diseases and infaust prognosis, which is accompanied by debilitating fatigue, unbearable suffering, and a lack of options for curative treatment in the provision of consistent dignified termination of life. From a clinical point of view, determining validity can be viewed as an non-altered state of consciousness, and a patient is capable of an independent and voluntary decision that could be viewed as respect for the inherent dignity of the human person. He holds the same views concerning patients with incurable diseases in case of failure of curative treatment, which due to the nature of disease, may also be accompanied by a general deterioration and existential suffering, and a patient is not capable of determining the conditions and circumstances of the intentional termination of life.

Therefore, according to Dr. Stoilov, a physician must be maximally competent and determine means to reduce intolerable suffering in the best interest of patient, in accordance with the relevant ethical norms as tools for promoting the moral goals of mercifulness. The priority of the medical profession is the provision of attainable maximum physical and mental comfort in a humane and dignified manner whilst trying to reduce suffering by means of transparency, legalization, and beneficence.

Dr. Galina Konkina, the pediatrician and radiologist at the Newark Beth Israel Medical Center in Newark, New Jersey, The United States, supports euthanasia and physician-assisted suicide as a human right to self-determination. On this view, Dr. Konkina highlights that euthanasia and physician-assisted suicide shall be used in accordance with the legal and ethical recognized standards and a commitment to human rights law, which governs the moral principles of human behavior in any given jurisdiction. Therefore, according to Dr. Konkina, she inclines to the view that persons who are approaching the end of their life have the right to determine autonomously the circumstances surrounding the death.

Unlike Holland and Belgium, European countries with a rich historical background in view of the development of euthanasia and assisted suicide present a pragmatic view on regulation in the course of performance of both practices, inclusive of the abuses of social indicators, by contrast, the spectrum of indications for performance of physician-assisted dying with a serious health condition prevails among American public. According to the publicly accessible data obtained from the Colorado Department of Public Health and Environment, 193 patients who received prescriptions for lethal substances in the period 2017-2018, were diagnosed with internal diseases,

severe neurological diseases, and malignant tumors; by way of illustration, diseases of the nervous system of neurodegenerative etiology[89] "such as amyotrophic lateral sclerosis and progressive supranuclear palsy,"[90] respiratory diseases with a prolonged course[91] "such as chronic obstructive pulmonary disease"[92] and cardiovascular disease[93] "such as heart failure."[94]

According to the findings of the Colorado Department of Public Health and Environment, 75% of patients who received the lethal drug for Medical Assistance in Dying enrolled in a hospice.[95] Therefore, the inclusion criteria included the aforementioned diagnosis and receipt of palliative care.[96]

In this particular study, qualitative data analysis reported[97] "111 Dutch case summaries"[98] of euthanasia cases in patients with dementia in the period of 2012-2020, reported out of the total number of[99] "1117 cases"[100] released by the[101] "Regional Euthanasia Review Committees (RTE)".[102] Several questions of an ethical and personal nature regarding the euthanasia procedure were elaborated, especially the argument of voluntariness and the argument of unbearable pain, which revealed the prevalence of social indications to perform the procedure such as fear of loneliness, an uncertain future, which was a source of greater suffering than suffering of a person with incurable disease. A thorough evaluation of the current psychological state of a patient and assessment of his cognitive deficit requires professional medical examinations, which physicians no longer perform owing to the nature of dementia, which makes it impossible to express a valid will. Religious denominations hold different views on the

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[89] Vinay Kini et al., A novel methodology to identify and survey physicians participating in medical aid-in-dying," *Scientific Reports* 12, no. 6056, (2022): 2, https://doi.org/10.1038/s41598-022-09971-7.
[90] Ibid.
[91] Ibid.
[92] Ibid.
[93] Ibid.
[94] Ibid.
[95] Ibid.
[96] Ibid.
[97] Antonie Stef Groenewoud, PhD., Ellen Leijten, and Theodoor Adriaan Boer, PhD., "The ethics of euthanasia in dementia: A qualitative content analysis of case summaries (2012–2020)," *Journal of the American Geriatrics Society* 70, no. 6 (2022): 1704, doi: 10.1111/jgs.17707.

[98] Ibid.
[99] Ibid.
[100] Ibid.
[101] Ibid.
[102] Ibid.

moral permissibility of suicide.[103] In 2013, about 50% of white representatives of the Evangelical church and black representatives of the Protestant Church in the United States of America rejected the notion that the right of a person to commit suicide is morally permissible and morally justified based on any of the four conditions defined in the survey.[104] By contrast, white representatives of the Protestant Church in the United States of America in the absence of religion and white representatives of the American Roman Catholic Church will most likely declare that there exist moral justification for suicidal ideation and dysphoric mania in all the four situations.[105] Among religious denotations, there is a similar behavioral model concerning the act of allowing physician-assisted dying for patients in the terminal phase of their lives.[106]

6.2.2 Quantitative research

The cult of youth, social well-being, the pursuit of physical perfection, career success and financial independence in advanced industrial societies have greatly contributed to societal transformation in the context of medical and psychological neglect of socially disadvantaged individuals if they suffer from health problems related to a medically determinable physical or mental impairment. Numerous studies from various countries that have legalized euthanasia or physician-assisted suicide indicate the persistence of intermittent risk of abuse of this act that was initiated by modifiable social factors rather than irreversible medical factors, namely loss of dignity, a decline in self-sufficiency, and self-worth.

"Indeed, according to a review of the Fourth Annual Report published by the OHD,"[107] the agonal state accompanied by excruciating pain did not represent a primary reason for physician-assisted dying in the vast majority of cases and the main indications for the performance of physician-assisted suicide are "losing autonomy: 85%; decreasing ability to participate in activities that make life enjoyable: 77%; losing control of bodily functions: 63%; and, being a burden on family, friends/caregivers:

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[103] "Views on End-of-Life Medical Treatments," *Pew Research Center*, last modified November 21, 2013, https://www.pewresearch.org/religion/2013/11/21/views-on-end-of-life-medical-treatments/#an-aging-america-with-limited-attention-to-preparation-for-dying.
[104] Ibid.
[105] Ibid.
[106] Ibid.
[107] Bernard Ars and Etienne Montero, *Suffering and Dignity in the Twilight of Life* (The Hague: Kugler Publications, 2004), 79.

34%."[108] Intractable pain as a justification for the indication for assisted suicide was the cause of only a small amount of reviewed requests for physician-assisted suicide in the five-year period after Measure 16 came into force in 1994.[109]

From the perspective of legal moralism, there is a clear violation of the basic axiom of medical ethics, which is the protection of life of a patient; a patient, in the case of expressed interest in justified suicide, according to the law, has a certain time to think about consequences of his potential act, therefore, a patient has the opportunity to freely decide between his own life and death and exercise free will over his choices. Abuse of the principle of non-maleficence, neglecting a patient and the principle of self-determination initiates deformations and distortions of the definitive patient choice. Thus, the physician who conduct euthanasia, as a representative of interest of a patient, on the basis of beneficiation, chooses for a patient the procedure that he considers optimal for the patient without respect for his personal autonomy.

On the latter issue, in the U.S. state of Oregon, a physician treating a patient who seeks physician-assisted suicide is required by law to provide psychiatric and psychological interventions to the patient in cases of suspicion of psychiatric disorder affecting the decision-making process of patients such as major depressive disorder.[110] With regard to certain psychological aspects of well-being and physical health, it is presumed that the depressed state of a patient can be the key determinant of support for the idea of assisted suicide and timely intervention of the physician is capable of limiting the amount of interest, however, the U.S. state of Oregon, did not provide the psychological or psychiatric support for any of patient in 2007.[111] In the analysis of this situation, a group of oncology patients with an inauspicious prognosis was examined and the proportion of patients with verified suicidal ideation and dysphoric mania constituted 59%,[112] "but only 8% among patients without such a desire."[113]

In the period between 1998 and June 2017, 1,857 people who requested an assisted death received prescriptions for lethal medications and these substances were orally dispensed; consequently, the mortality rate were estimated to be 64%, respectively and a total of 1179 patients have died from the lethal dose of a given

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[108] Ibid.

[109] Ibid.

[110] José Pereira, "Legalizing euthanasia or assisted suicide: the illusion of safeguards and controls," *Current Oncology* 18, no. 2 (April 2011): 40, doi:10.3747/co.v18i2.883.

[111] Ibid.

[112] Ibid.

substance in the U.S. state of Oregon with the longest period of legalization of the practice.[114] The summary of the data concerning the mortality as a result of physician-assisted dying in Oregon, which occurred for the period 1998-2015 with the statistical data on the mortality as a result of physician-assisted dying in Oregon in Washington, which occurred for the period 2009-2015 indicate that physician-assisted dying represents only 0.4% of the total number of all deaths; nevertheless, the statistics have shown a continuous upward trend of a statistical indicator.[115]

Empirical own research of 25 physicians from different medical specialties is conducted with the purpose of analyzing the approach to the legalization of euthanasia and assisted suicide on a worldwide scale. Physicians who participated in this survey were surveyed without revealing identities due to anonymity barriers and confidentiality of personal data. Outcomes derived from the findings of the case study concerning the approach to the legalization of euthanasia and assisted suicide point to decision-making patterns that have been thoroughly affected by fundamental religious and ethical arguments, namely the sanctity of human life and autonomous determination of “the power to specify the conditions and circumstances of one’s own death and dying.”[116]

As previously indicated, research has shown that 25 physicians were surveyed on the legalization of euthanasia and physician-assisted dying from a global perspective. The research argues that 11 out of 25 physicians voted in favor of euthanasia for terminal patients in the terminal phase of their lives, accounting for 44% of all physicians surveyed. 11 out of 25 physicians said that the act of euthanasia is morally justified and should be allowed in exceptional cases to reduce the terminal delirium as a result of multi-organ failure. By contrast, research indicates that 14 of 25 physicians took a strict stance against euthanasia, accounting for 56% of all physicians surveyed. However, 15 out of 25 physicians voted in favor of physician-assisted dying for terminal patients in the final phase of their lives, accounting for 60 % of all physicians surveyed. 15 out of 25 physicians said physician-assisted dying should be allowed concerning patients with an incurable diseases and genuine pain. By contrast, research

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[113] Ibid.

[114] Sarah Mroz, Sigrid Dierickx, Luc Deliens, Joachim Cohen, Kenneth Chambaere, “Assisted dying around the world: a status quaestionis,” *the Annals of Palliative Medicine* 10, no. 3 (2021): 3550, doi: 10.21037/apm-20-637.

[115] Ibid.

[116] Josef Kuře, *Everything Under Control: How and When to Die - A Critical Analysis of the Arguments for Euthanasia* (Brno, 2011), 139, https://www.intechopen.com/chapters/19615.

indicates that 10 of 25 physicians took a strict stance against physician-assisted dying, accounting for 40% of all physicians surveyed (details in Figure 5).

In this particular study concerning physician-assisted suicide and euthanasia focused on the United States was reported that a total of 3102 patients qualified physicians, accounting for 11% of all physicians surveyed[117] "95 percent confidence interval, 9 to 12 percent,"[118] announced that in accordance with legal restrictions, the circumstances under which the lethal drug would be prescribed to a valid patient in the absence of impaired consciousness who would use a given substance consciously; 36 percent of all physicians surveyed[119] "95 percent confidence interval, 34 to 38 percent"[120] reported that they would prescribe lethal substance in the case of the legalization of this act.[121] By contrast, 7% of all physicians surveyed[122] "95 percent confidence interval, 4 to 10 percent"[123] reported that in accordance with legal restrictions, the circumstances under which they would inject a patient with lethal substances; 24% of all physicians surveyed[124] "95 percent confidence interval, 23 to 26 percent"[125] stated they would perform this action in the case of the legalization of this practice.[126]

Furthemore, the wild interest in California to legalize assisted suicide was influenced by the attitude change of the American society toward euthanasia.[127] In the study conducted in May 2015, out of the total number of cases, almost two-thirds of adult persons, accounting for 68% showed interest in the tolerance of the approval of the legalization of assisted suicide in exceptional cases of manifest alarming pain.[128] In this particular study, an increase of 10 percentage points within the last 12 months can

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[117] Diane E. Meier, M.D et al., "A National Survey of Physician-Assisted Suicide and Euthanasia in the United States," *New England Journal of Medicine* 338, no.17 (1998): 1193, doi: 10.1056/NEJM199804233381706.

[118] Ibid.
[119] Ibid.
[120] Ibid.
[121] Ibid.
[122] Ibid.
[123] Ibid.
[124] Ibid.
[125] Ibid.
[126] Ibid.
[127] Michael Lipka, "California legalizes assisted suicide amid growing support for such laws," *Pew Research Center*, last modified October 5, 2015, https://www.pewresearch.org/fact-tank/2015/10/05/california-legalizes-assisted-suicide-amid-growing-support-for-such-laws/.
[128] Ibid.

be demonstrated.[129] Furthermore, an increase of 17 percentage over 24 months can be seen.[130]

According to the "Regional Euthanasia Review Committees (RTE),"[131] in survey period 2012-2020,[132] qualitative data analysis reported 115 cases of euthanasia in patients with dementia out of the total number of 1117 cases[133] (details in Figure 6). The study selects clinical cases that have been included in the group of reviewed and published cases of euthanasia in patients with dementia in the period of 2012-2020 as a consequence of controversial circumstances. Furthermore, clinical cases of euthanasia performed on demented patients are shown that reflect its basic nature.

7. The context of human rights and the respect for individual autonomy in American society

The attitude of society to the issue of the analyzed phenomenon reflects the objective development of fundamental human rights and the subjective understanding of individual human autonomy and the possibilities of free decision-making in the final phase of life. As far as privacy is concerned, the decision of affected patients is autonomous, considering that a person has decisional capacity and is accountable for his actions, nevertheless, there is an irrational component in the decision-making process as a result of insufficient personal space and insufficiency of authenticity, which is a fundamental feature of human identity.

In relation to developmental psychology, autonomy can also be understood gradualistically: autonomy is something what we progressively acquire, develop and lose. Then the question of to what extent a dying person has real autonomy is reciprocal to the question of to what extent has this person lost his/her autonomy (understood as full autonomy, as dispositional autonomy or as substantial autonomy).[134]

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[129] Ibid.

[130] Ibid.

[131] Antonie Stef Groenewoud, PhD., Ellen Leijten, and Theodoor Adriaan Boer, PhD., "The ethics of euthanasia in dementia: A qualitative content analysis of case summaries (2012–2020)," *Journal of the American Geriatrics Society* 70, no. 6 (2022): 1704, doi: 10.1111/jgs.17707.

[132] Ibid, 1705.

[133] Ibid.

[134] Josef Kuře, *Everything Under Control: How and When to Die - A Critical Analysis of the Arguments for Euthanasia* (Brno, 2011), 136-137, https://www.intechopen.com/chapters/19615.

A patient who is competent and capable of making decisions with respect to his medical condition exercises free will over his relevant choices and acts, his decisions, choices, and acts are up to his conscious control and the treatment process of a patient cannot start in the absence of rational consensus by means of informed consent. Voluntary and competent consent or refusal of a proposed diagnostic or therapeutic procedure is a matter of respect and the ethical recognition of human autonomy and freedom of the will that is the necessary part of comprehensive care for patients. A physician has an ethical and legal duty to provide a course of direction for a subsequent therapeutic process with respect to objective facts and in the best interest of a patient if a patient lacks the decisional capacity to make well-justified rational decisions with respect to a planned course of treatment. As an illustration, nosological units include diseases with impaired consciousness, advanced dementia, and intellectual disability.

The principle of respect for human autonomy is considered to be one of the core principles of contemporary advanced societies and implies that each individual must be given the opportunity to make decisions that correspond to his own self-interest and determine the way of life; furthermore, the maximum degree of freedom of person shall not interfere with the liberty and the autonomy of others. Nevertheless, the simplification of this particular concept does involve a diverse range of unresolved practical or theoretical issues concerning the individualized approach to persons with cognitive impairment.

The interpretation of human autonomy as a state of self-determination and freedom of decision-making and action, including the right to have control over its own death and control over the timing, method, spiritual accompaniment and conditions of the overall dying process has been closely associated with the "well-intentioned efforts of the medical profession to restore or support life."[135] Proponents of these practices interpret the human right to die as a fundamental human right with a solid moral foundation and "as a specific right or can be derived from other rights such as from the right to life"[136] in debates about euthanasia and physician-assisted dying.

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[135] Margaret Somerville, *Death Talk: The Case Against Euthanasia and Physician-Assisted Suicide*, 2nd ed., (Kingston: McGill-Queen's University Press, 2014), 237.

[136] Josef Kuře, *Everything Under Control: How and When to Die - A Critical Analysis of the Arguments for Euthanasia* (Brno, 2011), 141, https://www.intechopen.com/chapters/19615.

The liberal approach of the United States to physician-assisted suicide has resulted in the legalization and decriminalization of this phenomenon only in selected countries where the impunity of physician-assisted suicide has been established in compliance with certain legal actions and medical indications. Concerning the lawful exercise of the right, two conditions have to be fulfilled as a basic premise: an external condition and an internal condition.[137] The first requirement is based on the assumption of the absence of external influence on the subject entitled to exercise a right.[138] The second requirement is the lucidity of the affected persons.[139] The mental status indicates that the patient is psychologically stabilized and mentally mature with a clear and unambiguous purpose concerning euthanasia.[140]

In this context, the American Medical Association is also antagonistic towards both voluntary active euthanasia and physician-assisted suicide.[141] The American Medical Association propagates a symptomatic medical approach to patients who are approaching the end of their lives and need supportive care via mental health assistance with adherence to the principle of respect for autonomy, effective doctor-patient communication, non-invasive care and adequate pain management instead of referring to voluntary active euthanasia and physician-assisted suicide.[142]

In the course of the debate on the nature of legal moralism and moral inadmissibility of euthanasia, the issue of legalisation of euthanasia represents the current dilemma from the perspective of the process of obtaining organs through euthanasia, which is a major health and social problem especially for disadvantaged population groups. As noted above, there is a continuous and explicit escalating interest in organ donation to meet patient needs who, as a result of organ failure, are registered on the transplant waiting list for a transplant procedure.

According to the current laws that govern the process of an organ transplant, a patient-donor who is capable of valid decision-making and free and reliable choice must give verbal and written consent to the donation of his organs after his death to a patient-recipient. In a number of countries where euthanasia is a legalized act, organ donation

[137] Ibid, 139.

[138] Ibid.
[139] Ibid.
[140] Ibid.
[141] John Keown, *Euthanasia, Ethics and Public Policy : An Argument Against Legalisation*, 2nd ed., (University of Cambridge:Cambridge University Press, 2003), 231.
[142] Ibid.

after euthanasia is an alternative option to maximize the number of available organs for transplant procedures; nevertheless, there is a great risk of abuse and criminalization of the donation process and a lack of social control inclusive of a violation of medical ethics and professional behavior by a physician. Despite the improvement in transplant performance of transplant surgery, the latest innovations, and highly qualified pre-operative and post-operative care, there is a continuous risk of the lethality of a patient-recipient on the transplant waiting list. The demand for donor organs is much greater than the supply of organs for donor-recipient. "There are more than 100,000 patients on the waiting list for a deceased donor organ in the US: in 2007, 18 patients per day died on waiting lists for transplants."[143] "It is estimated that such a change would increase the donation rate by 25–30% in the US,"[144] and from the perspective of medical management, economic benefits, humanistic desires, and satisfaction of patient-recipient represent the beneficial act.

Dominic Wilkinson, and Julian Savulescu, authors of the article *Should we allow organ donation euthanasia? Alternatives for maximizing the number and quality of organs for transplantation* describe the issue of the development of "Organ Donation Euthanasia"[145] from the perspective of maximizing the benefit of the patient-recipient who has received sufficient donated organs; thus, the standing point is to maximize the number of sources for the process of obtaining vital, high-quality donor organs for the purposes of American modern transplant surgery. Various possibilities were discussed concerning the process of obtaining organs from individuals without the request for informed consent from "individuals in persistent vegetative state or anencephalic infants"[146] by way of illustration. "Technically, this would be a form of killing – active euthanasia."[147]

Over the long term, these empirical opinions without valid legislation are a foundation for expert debates, in the present instance, however, the illegal manipulation of potential sources of donor organs is subject to the rule of law in the United States of America. "The Combat Human Trafficking Act of 2015 (CHTA) (34 U.S.C. §

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[143] Dominic Wilkinson, Julian Savulescu, "Should we allow organ donation euthanasia? Alternatives for maximizing the number and quality of organs for transplantation," *Bioethics* 26, no.1 (2012): 33, doi: 10.1111/j.1467-8519.2010.01811.x.

[144] Ibid, 34.
[145] Ibid, 33.
[146] Ibid, 41
[147] Ibid.

20709(e))"[148] defines strict legal consequences to decriminalize criminal activity such as "arrests for human-trafficking offenses by state law enforcement officers, prosecutions of individuals in state courts for humantrafficking offenses."[149] By way of illustration, a number of countries have moved to or are considering proposals for opt-out consent systems for organ donation.[150]

In the case of patients with an infaust prognosis, the development of an overall condition, which moves towards the terminal phase of life is definite and in the case of the act of "Organ Donation Euthanasia"[151] strategy, a greater number of vital organs will be removed with the aim of donating organs to other persons, and it can be assumed by physicians that the patient-donor would potentially prefer the procedure after death; therefore, the wishes of patients are respected.[152] "One of the most basic principles of rationality and economics is that if one state of affairs is "a Pareto improvement,"[153] we have strong reason to prefer it."[154] "Organ Donation Euthanasia"[155] for "Life Support Withdrawal Donors"[156] can be defined "as a Pareto improvement to the current practice of withdrawal of life-sustaining treatment and donation after cardiac death."[157]

Therefore, the current transplant strategy correlates with "Organ Donation Euthanasia"[158] and, despite certain moral and ethical discrete aspects and the absence of legal justification, it is an acceptable alternative from a medical perspective with the aim of maximizing sufficient quality donor organs "though it would come at the cost of patient and family autonomy."[159] In the context of a rational choice, the maximum

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[148] Amy D. Lauger, Matthew R. Durose, "Human Trafficking Data Collection Activities, 2021," *Bureau of Justice Statistics,* last modified October 2021, https://bjs.ojp.gov/library/publications/human-trafficking-data-collection-activities-2021#additional-details-0.

[149] Dominic Wilkinson, Julian Savulescu, "Should we allow organ donation euthanasia? Alternatives for maximizing the number and quality of organs for transplantation," *Bioethics* 26, no.1 (2012): 33, doi: 10.1111/j.1467-8519.2010.01811.x.

[150] Ibid.
[151] Ibid, 46.
[152] Ibid, 41.
[153] Ibid.
[154] Ibid.
[155] Ibid, 46.
[156] Ibid.
[157] Ibid.
[158] Ibid, 46
[159] Ibid.

benefit of “Organ Donation Euthanasia”[160] is the donation of organs and significant improvement in the quality of life for other persons, which has a profound impact on society in the current period of global-social interrelations and progressive aging of the population in developed countries. In this context, it is noteworthy to point out that there exists a persuasive argument, based on a notion of autonomy, that each individual shall be given the option of applying for “Organ Donation Euthanasia”[161] to become a deceased organ donor, especially taking into account that they have an incurable disease with an infaust prognosis and decide to withdraw life-sustaining treatment.[162] Finally, the arguments advanced above in support of novel concerning organ donation alternatives would support a much broader policy of allowing patients to choose[163] “Organ Donation Euthanasia,”[164] for example, if they were terminally ill or rationally suicidal.[165]

8. The globalization of human rights in the context of transnationalism

“Human rights embody core values.”[166] Certainly, the value of dignity of every human person with respect for individual autonomy and freedom of choice corresponds to a certain degree of self-control and an empathic relationship with other members of society.[167] The current dynamic period enables the emergence of international flexible socio-economic relations, social stratification, cultural convergence and has initiated the process of transnationalism with mutual cultural enrichment. The intensification of interaction between societies is closely linked to the unification of social phenomena by means of the elimination of heterogeneity through the evolution of traditional prevailing values and moral principles in tackling global challenges. Current global trends in the

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[160] Ibid.
[161] Ibid, 47.
[162] Ibid.
[163] Ibid, 46
[164] Ibid.
[165] Ibid.
[166] Douglass Cassel, “The Globalization of Human Rights: Consciousness, Law and Reality,” *Northwestern Journal of International Human Rights* 2, no. 1 (2004): 3, https://scholarlycommons.law.northwestern.edu/cgi/viewcontent.cgi?article=1009&context=njihr.

[167] Ibid.

context of human rights limit the concept of state sovereign immunity and initiate greater multiculturality of individual human rights with support of freedom of choice and self-governance with emphasis on intersocial relations.

Globally, an increase in the proportion of older persons make up a growing share of the overall population; as a result, the tendency concerning the increase in multiple chronic conditions with a prolonged course has also been linked to the deepening of the moral and ethical issues related to the ethics of aging and the termination of life in mass geriatric society.[168] With regard to this approach, Jose Pereira published an article in April 2011 titled *Legalizing euthanasia or assisted suicide: the illusion of safeguards and controls*, claiming that the debates concerning both conceptual and evaluative morality and legality concerns of assisted dying practice have been a continuous source of controversy in a relevant sphere of a multidisciplinary approach.

As an illustration, the act of administering a lethal substance without an explicit request of the patient has been linked to approximately 900 cases annually, “and in one jurisdiction,”[169] half of all cases of euthanasia remain unreported.[170] Ambivalence toward these practices remains subject to controversial debate on the ethical, moral dilemmata, and legal basis of these acts,[171] nevertheless, “over 200 million people around the world are now living in jurisdictions allowing some form of assisted dying”[172] as shown in Figure 1 and more regions are likely to legalize euthanasia and physician-assisted dying.[173]

9. Religious aspects

[168] Sarah Mroz, Sigrid Dierickx, Luc Deliens, Joachim Cohen, Kenneth Chambaere, “Assisted dying around the world: a status quaestionis,” *the Annals of Palliative Medicine* 10, no. 3 (2021): 3540, doi: 10.21037/apm-20-637.
[169] José Pereira, “Legalizing euthanasia or assisted suicide: the illusion of safeguards and controls,” *Current Oncology* 18, no. 2 (April 2011): 38, doi:10.3747/co.v18i2.883.

[170] Ibid.
[171] Sarah Mroz, Sigrid Dierickx, Luc Deliens, Joachim Cohen, Kenneth Chambaere, “Assisted dying around the world: a status quaestionis,” *the Annals of Palliative Medicine* 10, no. 3 (2021): 3548, doi: 10.21037/apm-20-637.

[172] Ibid.
[173] Ibid.

As noted by Alexis de Tocqueville in the first half of the 19th century, in the 1830s, the United States was viewed as the largest and the most prevalent Christian nation and religion has firmly entered the mainstream of American life at the beginning of the 20th century.[174] "Since death is a limit or boundary-of-life event, attitudes toward dying are shaped by foundational beliefs about the meaning and purpose of life."[175] The dynamic development of modern American society is marked by the spread of secularism, however, the current issues such as the issue of access to euthanasia and physician-assisted suicide provoke a detailed thematic discussion of diverse religious and spiritual beliefs. Human beings like "free moral agents"[176] must organize their own lives and activities for their own benefit, the benefit of the immediate environment and society as a whole according to Christian belief.[177] Therefore, the analysis has demonstrated the attitude of the Protestant Church in the United States of America and the American Roman Catholic Church towards the investigated phenomenon.

9.1 Protestantism

The Protestant Church in America, compared to the American Roman Catholic Church, is a larger whole, nevertheless, within Protestantism, major diverse groups are defined as a consequence of multiple spiritual determinants of a set of immutable principles and historical backgrounds.[178] In the context of Protestantism, particular religious groups are visually observable, namely[179] "Mainline denominations, Evangelicals, Fundamentalists and Pentecostals."[180] From this perspective, "the Evangelicals, Fundamentalists and Pentecostals"[181] adopted tough stance on societal challenges and took a strict stance against suicidal ideation and dysphoric mania, physician-assisted dying, and[182] "voluntary active euthanasia."[183] However, the right to

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[174] Ian Dowbiggin, *A Merciful End : The Euthanasia Movement in Modern America* (New York, 2003), 2.
[175] Sidney Callahan, "The Moral Case Against Euthanasia," *Catholic Health Association of the United States*, last modified January-February, 1995, https://www.chausa.org/publications/health-progress/article/january-february-1995/the-moral-case-against-euthanasia.
[176] Ibid.
[177] Ibid.
[178] Richard E. Coleson, "Contemporary Religious Viewpoints on Suicide, Physician- Assisted Suicide, and Voluntary Active Euthanasia," *Duquesne Law Review* 35, no. 1 (1996): 48, https://dsc.duq.edu/cgi/viewcontent.cgi?article=3086&context=dlr.
[179] Ibid.
[180] Ibid.
[181] Ibid.
[182] Ibid.

die remains a highly contested debate in defiance of the Protestant traditions and doctrinal position against assisted dying practices. In the absence of moral resistance, certain religious groups within Protestantism remain opposed to these practices as a primary moral concern and "generally have no position on these activities rather than support them."[184]

Paul Ramsey, an ethics specialist and representative of the Protestant Church in the analysis relevant to the choice between profit and loss in the context of health care procedures has promoted supportive therapy with a preference for essential medical indications without the necessity of expanding therapy.[185] Medical manipulation, as stated in the preceding approach, beyond the scope of basic care was thought of as exceptional patient care and redundant without qualms of conscience.[186] Within this approach, a dying person with an inauspicious prognosis does not necessitate any medical intervention.[187] Based on the above, the Protestant representatives speak favourably of hospice care and cessation "of extraordinary treatment,"[188] taking a benevolent stance on analgesic treatment causing conscious sedation, however, they remain opposed to euthanasia.[189]

9.2 Catholicism

The rationality of human rights of persons with irreversible disabilities in reference to the ending of its own existence according to a will of its own is "presented as the ultimate freedom,"[190] nevertheless the issue of the controversial topic remains a traditional point of sharp criticism from the American Catholic Church that considers the manipulation of the dynamic of life and death to be a deeply inadmissible act and a

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[183] Ibid, 48-49.
[184] Ibid, 49.
[185] Patricia L. Rizzo, "Religion-Based Arguments in the Public Arena: A Catholic Perspective on Euthanasia, Compassion in Dying v. State of Washington and Quill v. Vacco," *DePaul Journal of Health Care Law* 1, no.2 (1996): 251, https://via.library.depaul.edu/cgi/viewcontent.cgi?article=1284&context=jhcl.
[186] Ibid.
[187] Ibid.
[188] Cristina L. H. Traina, "Religious Perspectives on Assisted Suicide," *The Journal of Criminal Law and Criminology* 88, no. 3 (1998): 1149-1150, https://doi.org/10.2307/3491364.
[189] Ibid.
[190] "Euthanasia Statement," *The United States Conference of Catholic Bishops*, last modified September 12, 1991,https://www.usccb.org/issues-and-action/human-life-and-dignity/end-of-life/euthanasia/statement-on-euthanasia-1991.

violation of the moral-ethical principles of Catholicism in contemporary American society. Destruction of the boundary between curing and killing would initiate a threat of unexpected dimension that is incapable of being foreseen by the fragile members of American society and, furthermore, would define a radical shift from deep-rooted American legal and therapeutic standards.[191] Catholic health care facilities are adamant that they would not provide approval or assistance for euthanasia or physician-assisted suicide that are unacceptable in any way.[192]

Nevertheless, in rare cases, the Catholic Church blesses a dying person and provides the patient with an opportunity to choose a peaceful death in a safe and humane manner without burdensome invasive interventions if an incurable disease has been established inclusive of a complete health assessment of the person concerned, the presence of persistent physical pain and mental anguish without providing sufficient adequate support.

The main concern of liberalism that arose from the period between the Great Depression and the second half of 1950 is marked by the strong emphasis on the Catholic Church in the United States of America, which was viewed as[193] 'the dominant cultural institution in the country.'[194] The strengthening of unity reinforced preexisting beliefs resulting from allying against a common threat, namely[195] 'Christian fundamentalists, orthodox Protestants, and— in particular—Roman Catholicism.'[196] Pius XII proclaimed in 1957 that Catholics diagnosed with a terminal illness were permitted to refrain from treatment.[197] "The task of medicine is to care even when it cannot cure."[198] The beneficial presence of the Catholic Church in the American healthcare system is conditioned by the dynamic activities of religious groups and dioceses that support the activities of Catholic healthcare institutions, inclusive of

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[191] Ibid.

[192] *Ethical and Religious Directives for Catholic Health Care Services*, 6th ed. (Washington, DC: America Press, 2018), 20.

[193] Ian Dowbiggin, '"A Rational Coalition': Euthanasia, Eugenics, and Birth Control in America," 1940–1970," Journal of Policy History, 14, no. 3 (2002): 228, doi:10.1353/jph.2002.0017.

[194] Ibid.

[195] Ibid, 247.

[196] Ibid.

[197] Ibid, 248.

[198] *Ethical and Religious Directives for Catholic Health Care Services*, 6th ed. (Washington, DC: America Press, 2018), 21.

financial support.[199] The American Church supports the withdrawal of life-sustaining measures on the condition that treatment has been non-curative and permits analgesic treatment to be delivered to patients whose pain is intolerable, notwithstanding the fact that the analgesic treatment can result in termination of life.[200]

10. The contemporary debate regarding the controversial issue of euthanasia and physician-assisted suicide : a vision of public health in America / the American society

The public interest and approach to euthanasia and physician-assisted suicide are discontinuous and have been linked to ethical-moral principles, the religious beliefs in society, the degree of development of fundamental human rights, the legislative system, furthermore, the perception of the concept of human dignity and personal autonomy "with the potential to put vulnerable patients under social pressure."[201] Although the permissibility and legalization of euthanasia for terminally ill people are completely hopeless from a prognostic point of view, this has been discussed in American society over a long period of time and there does not exist such implementation yet.

The discussion about the potential legalization and the expansion of euthanasia has provoked a stormy reaction from the opponents of euthanasia, supported by the controversial experiences of countries where euthanasia has been legalized and deeply rooted; in particular, Holland and Belgium, where mental anguish, fatigue, body dysmorphic disorder are acceptable indications for approval and consequent performance of this act. The preference of the majority of Americans in favour of the legalization of euthanasia as a means of preventing potential unbearable suffering was largely related to deepening the concept of freedom, basic civil rights, especially the

[199] Brian Bransfield, *Ethical and Religious Directives for Catholic Health Care Services*, 6th ed., (Washington, DC: The United States Conference of Catholic Bishops, 2018), 6.
[200] Ian Dowbiggin, '"A Rational Coalition': Euthanasia, Eugenics, and Birth Control in America," 1940–1970," Journal of Policy History, 14, no. 3 (2002): 248, doi:10.1353/jph.2002.0017.

[201] Josef Kuře, *Everything Under Control: How and When to Die - A Critical Analysis of the Arguments for Euthanasia* (Brno, 2011), 131, https://www.intechopen.com/chapters/19615.

right to choose between life and death in accordance with individual priorities and beliefs.

In most cases, the contemporary model of death and dying in American society that is an isolated impersonal process in the healthcare sector and social care services is being weighed down by the potential risk of dysthanasia, whereas death dating from an earlier time was interpreted as a private or family affair shaped by religious beliefs and faith traditions. The highly controversial issue of euthanasia and physician-assisted suicide in the United States has been examined in view of respect for human autonomy. Within the following analysis of arguments, the highly arguable issue of euthanasia and physician-assisted dying in the United States has been examined on account of the globalization of fundamental human rights in the matter of the global development of human rights.

On this view, the successful antibiotic treatment at the beginning of the 20th century, the overall social and economic stability of society and improvement in the healthcare industry in the United States at the national level have radically changed a general view of morbidity and mortality among patients predisposed to certain diseases. The eradication and elimination of infectious diseases and effective and adequate control of previously severe infectious diseases have initiated a substantial increase in life expectancy that is paradoxically associated with a risk factor for developing debilitating chronic illnesses. By way of illustration, chronic illnesses include oncological diseases, cardiovascular diseases, progressive degenerative neurological diseases and, in addition, Morbus Alzheimer.

The issue of euthanasia and assisted suicide is affected by the broader economic context associated with the current development of medicine and the exponential growth of expensive medical care that allows to prolong life and delay natural death. The physician must rationally assess the overall condition of the patient and expertly differentiate between actual suffering, acute pain, and chronic difficulties, which are caused by the decline of biological functions and entire resilience of the human body with the accumulation of physical and mental disability on the basis of differential diagnosis. From an economic standpoint, the expansion of the practice of physician-assisted suicide and the distortion of criteria for the provision of medical care to the hopeless dying patient initiate continuing concerns about abuse of health care resources in an immoral way inclusive of disadvantaged population groups. “Given that insurers

routinely value their bottom lines over patient treatment, and the health care system devalues the lives of disabled people, these laws reduce rather than expand choice."[202]

American society, as the progressive economically developed society with advanced medical technologies and therapeutic approaches, is exposed to a great degree of risk of the reflection upon the controversial issues surrounding death and dying in the context of the technology of narrowly focused medicine. "Questions of life and death are nowhere regarded as belonging entirely to the private sphere, and this is all the more so when the power of the medical profession is involved as well."[203] The latest technological advancement in healthcare aims at enabling the maintenance of basal vital functions of persons over a long period of time, in addition, the excessive prolongation of the process of moving toward death and the maintenance of basal activity of physiological functions of terminally ill patients with multimorbidity is overshadowed by the financial strain and intermittent high financial hardship of the cost of medical services for their families who are facing persistent financial pressure.

Health insurance companies intermittently decide to refuse approval of the increasing healthcare expenditures for persons with chronic conditions and unfavorable prognoses, whereas they support a therapeutic approach that provides financially undemanding basal supportive care for persons affected by chronic irreversible diseases.[204] It is worth noting that "approximately 77% of Medicare costs for decedents occurring during the final year of life and 40% being spent in the final month."[205]

From an economic perspective, the problematics of euthanasia and physician-assisted suicide is closely related to the development of highly qualified palliative care as a dignified alternative solution to a peaceful and dignified death. In 2018, World Health Organization portrays hospice care[206] as an 'approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification

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[202] Roger Collier, "Assisted death gaining acceptance in US," *Canadian Medical Association journal* 189, no. 3 (2017): 123, doi: 10.1503/cmaj.109-5366.

[203] John Griffiths, Alex Bood and Heleen Weyers, *Euthanasia and Law in the Netherlands* (Amsterdam: Amsterdam University Press, 1998), 259.

[204] Richard M. Doerflinger, "Pope's Speech is About Human Dignity," *The United States Conference of Catholic Bishops*, last modified April 9, 2004, https://www.usccb.org/issues-and-action/human-life-and-dignity/end-of-life/euthanasia/popes-speech-is-about-human-dignity.

[205] Miles S. Marsala, "Approval of Euthanasia: Differences Between Cohorts and Religion," SAGE Journals 1, no. 11 (2019): 1, doi: 10.1177/2158244019835921.

[206] María Teresa García-Baquero Merino, "Palliative Care: Taking the Long View," *Frontiers in Pharmacology* 9, no. 1140 (2018): 2, doi: 10.3389/fphar.2018.01140.

and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spirit.'[207] Palliative care as complex multidisciplinary care, which is provided to patients in the terminal stage of incurable diseases, is able to ensure maximum physical, mental, and spiritual comfort, nevertheless, occasionally is unable to provide sufficient pain management, namely insufficient analgosedation as an instance of panic disorder and exhausting agony.

Initially, hospice palliative care made its debut in 1974 when the first American hospice was founded with the objective of reducing the pain of different intensities of cancer patients at the end of their lives.[208] In 2010, approximately five thousand palliative care programs available in all fifty American states enabled over one million terminally ill patients to receive care to the extent required for the achievement of relief.[209]

The aging population in developed societies, which need high-quality health and social care in the terminal phase of their lives as a result of polymorbidity, deterioration of self-sufficiency, and social insecurity, initiates the provision of higher financing costs "with estimates of spending in the last year of life ranging from 10% of all health care costs in The Netherlands and 13% in the United States of America (USA) to as high as 25% of Medicare hospice spending and 29% of English National Health Service hospital spending."[210] The funding model for the palliative care sector in healthcare and patient access to hospice care varies from country to country. In the United States, the exact criteria for hospitalization in a hospice care facility and subsequent admission "is only available when life expectancy is less than 6 months, and when active treatment is discontinued."[211] As a result, quality hospice care cannot be provided to every patient, and early access to palliative care services is not an easy matter for the patient and his family, and balance must be struck between demand and supply with respect to physical and psychological condition of the patient.

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[207] Ibid.

[208] Howard Ball, *At Liberty to Die : The Battle for Death with Dignity in America* (New York: New York University Press, 2012), 3.

[209] Ibid.

[210] E Iris Groeneveld et al., "Funding models in palliative care: Lessons from international experience," *Palliative Medicine* 31, no. 4 (2017): 297, doi: 10.1177/0269216316689015.

[211] Ibid, 299.

Countries that have adopted "activity-based funding"[212] may produce evidence on the rate of occurrence, potency, and length of hospice care that provide actionable insights and data acquisition that can deliver significant benefits to research. The financial policy of the United States has focused on the funding of hospice care facilities that have already been established and supporting the development of new hospice care facilities that depend on the legal financial resources of the state and primary sectors, therefore, according to this perspective, stable funding is a systemic model due to the nature of palliative medicine that is a natural part of comprehensive health care and has proven its indisputable importance and importance in a long-term time scale. By way of illustration, in Germany and Australia, the hospice care system has been integrated into the main palliative inpatient healthcare system operated by hospitals and thus the costs are covered by the main source of system funding at a substantial level as standard hospital care services.[213] Other countries, such as Spain, Sweden, or Wales, in relation to the issue of financing palliative facilities, apply the strategy[214] of "capitation-based resource allocation,"[215] which correlates with the size of the relevant population and operates independently of the range of services actually provided to these populations.[216] The financing mechanism of palliative care facilities in the United States is influenced by the economic component of close cooperation with health insurance companies and "is dependent on having a clear signal of palliative care provision in the administrative data generated"[217] with the aim of obtaining "a distinct insurance benefit."[218]

An opinion poll of society is one of the most fundamental yet highly impactful tools to obtain valid and up-to-date information with the aim of responding to systemic challenges that enable modeling of the whole picture of the distribution of opinions in society, including antagonistic tone. As part of this research, a recent study conducted by Montero in 2011 on American public opinion toward euthanasia has produced a dataset that reflects the development trends and can be traced back to 1947.[219] This

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[212] Ibid, 303.
[213] Ibid, 301.
[214] Ibid.
[215] Ibid.
[216] Ibid.
[217] Ibid, 303.
[218] Ibid.
[219] Miles S. Marsala, "Approval of Euthanasia: Differences Between Cohorts and Religion," SAGE Journals 1, no. 11 (2019): 2, doi: 10.1177/2158244019835921.

study reveals that since 1947 public acceptance of euthanasia in American society has been as high as 50%, approval has steadily increased, and 60% of Americans voted in favor of euthanasia for terminal patients in the final phase of life in 1977 before jumping to 75% in 2005 and remained continuously elevated until percentage has dropped to 70% in 2007.[220]

A public opinion poll conducted by Gallup has tracked the public opinion of the Americans to gauge their support for physician-assisted suicide since 1996 and the percentage of Americans who supported legalizing physician-assisted suicide "has never fallen below 51 %"[221] whereas respondents were slightly more in favour of euthanasia than supporting the option of physician-assisted dying.[222] From a historical perspective, Gallup has studied the issue of ethics of physician-assisted suicide since 2001, which has been among the most controversial ethical matters.[223] The vast majority of advocates of euthanasia in American society in 2018 indicated that 72% are convinced that the legalization of euthanasia as a painless medical procedure upon patient request or the request of family members of a patient is beneficial to patients with infaust prognosis.[224] The format of questions related to tolerance and support for euthanasia and physician-assisted suicide in American society were presented in a broad unspecified sense in the absence of professional medical interpretation given broader areas of society in order to gain a better understanding of this phenomenon. According to Dr. Daniela Lieschke, LL.M., the Presiding Judge at the Regional Court of Neubrandenburg, "the real dilemma seems to be the conflict between society' s interest in preserving life and the respect for individual autonomy."[225]

According to a survey released by Gallup, an American consulting company, which conducts opinion polling to measure nonbiased public opinion, analytical overview of data used in current debate on euthanasia and physician-assisted dying can

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[220] Ibid.
[221] Megan Brenan, "Americans' Strong Support for Euthanasia Persists," *Gallup*, last modified May 31, 2018, https://news.gallup.com/poll/235145/americans-strong-support-euthanasia-persists.aspx.

[222] Ibid.
[223] Andrew Duggan, " In U.S., Support Up for Doctor-Assisted Suicide," *Gallup News*, last modified May 27, 2015, https://news.gallup.com/poll/183425/support-doctor-assisted-suicide.aspx.
[224] Megan Brenan, "Americans' Strong Support for Euthanasia Persists," *Gallup*, last modified May 31, 2018, https://news.gallup.com/poll/235145/americans-strong-support-euthanasia-persists.aspx.
[225] Daniela Lieschke, "Euthanasia in the Netherlands, The Policy and Practice of Mercy Killing by Raphael Cohen-Almagor," *Jahrbuch für Recht und Ethik* 14, no. (2006): 560. https://www.jstor.org/stable/43593329.

provide a synoptic analysis concerning the evolution of society and its approach to the ethics of euthanasia and physician-assisted dying in long-term perspective. In line with the continuous support since 1947, 37 % of Americans supported the euthanasia of patients in the case of incurable disease with the explicit informed consent of patients and their families, continuing a consistent trend up to 1997, a 53% majority were in favour of support for euthanasia in 1973, a 65% majority were in favour of support for euthanasia in 1990, including a record-high 75% of Americans have expressed support for this act in 1997, fluctuating between 65% and 75% from 1997– 2004. This period was marked by a 10% decline in support for euthanasia, whereas the period from 2004 to 2018 was marked by a 11% decline in support for euthanasia. The support for euthanasia declined to 64 percent in 2011. After a slight decline, support jumped to 72% in 2018.[226]

Furthermore, in accordance with the continuous support since 1996, a 52% majority were in favour of physician-assisted dying of patients with advanced incurable disease and severe pain with a gradual increase in tolerance of physician-assisted dying support jumped to 68% in 2001. Proponents of physician-assisted dying constitute the majority of surveyed entities in 2006, which constitute 64% of all people surveyed, showing a decline of 8% in 2006-2007, however, a 56% majority were in favour of physician-assisted dying in 2007. The period from 2008 to 2013 was marked by 11% decline in support for physician-assisted dying, fluctuating between 62% and 51%. Additionally, the period from 2015 to 2018 was marked by slight fluctuations between 68% and 65%.[227]

In summary, American public opinion polls have demonstrated a consistent upward trend among American public toward both practices, euthanasia and physician-assisted dying. It became evident that American society supports the moral permissibility of both practices for patients diagnosed with severe multimorbidity, incurable diseases, and an infaust prognosis with respect to patient autonomy based on empirical data. In the absence of legalization of euthanasia, this act keeps building credibility in American society, and furthermore, the research provides a vision of the possibility of legalizing euthanasia in the United States of America and the potential possibility of compatibility of euthanasia with medical ethics.

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[226] Megan Brenan, “Americans' Strong Support for Euthanasia Persists,” *Gallup*, last modified May 31, 2018, https://news.gallup.com/poll/235145/americans-strong-support-euthanasia-persists.aspx.
[227] Ibid.

According to a 2000 study on public perception towards euthanasia and physician-assisted dying in the case of persons with progressive diseases of irreversible nature and an infaust prognosis from 1977 through 1996, DeCesare found that support rose above 62% in 1977 before hitting approximately 70% in 1996.[228] Research has shown that the data presented in this study indicate changes in American society towards public interest regarding the concept of a right to die and the legalization of the "initial Death With Dignity Act in 1994, suggesting a period effect"[229] in Oregon.[230] DeCesare pointed out that, in the course of social development, two basic directions emerged; overall societal frustration with the healthcare system and an increase in perceived personal autonomy, especially taking into account the implications of autonomy by means of shaping their own lives.[231]

11. Conclusion

Strict compliance with the ethical standards and legal measures, thoroughly articulated medical indications, and a transparent rigorous approach to patients in health care management are the fundamental principles for a rational and justified choice of the voluntary termination of life in sporadic cases. A decision of a patient to withdraw life-sustaining treatment is influenced by a range of fundamental diseases, pain, mental health condition, medications, particularly antipsychotic medication, social and ethical factors, fear of being a burden and lack of family cohesion into the bargain. Pathological external factors such as social discomfort, loneliness, stigmatization, and self-stigmatization increase the risk of abuse of the approach to physician-assisted suicide as a choice of undergoing voluntary termination of life with the prevalence of social and ethical reasons, in particular during socioeconomic uncertainty.

According to multiple surveys of the opinion of the American public in relation to the issue of euthanasia and physician-assisted suicide, including the reasons of the applicants, it was found that the opinions are diverse, ambiguous and differ from the opinion of the representatives of the American medical diaspora. In the debates about euthanasia and assisted suicide in the context of the observance of fundamental human

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[228] Miles S. Marsala, "Approval of Euthanasia: Differences Between Cohorts and Religion," SAGE Journals 1, no. 11 (2019): 2, doi: 10.1177/2158244019835921.
[229] Ibid.
[230] Ibid.

rights, the argument of autonomy can be understood as a determining condition regarding the ability of a human being to reflect on his own morally ethical requirements and preferences and from the patient perspective, he shall be capable of adapting his preferences and self-governing abilities to current situations. A moderate continuous dynamic is observed in the context of the development of trends in public attitudes toward the issue of tolerance to euthanasia and physician-assisted dying and with regard to global human rights that enable the worldwide promotion of human rights and international social interactions. The doctor is an autonomous human being and there exist significant risks that the legalization of these practices in accordance with his own predilections and tolerant approach to these practices of euthanasia and physician-assisted dying may cause a violation of individual and professional integrity with self-destructive consequences. Impulses for primary motivation for physicians to perform euthanasia and physician-assisted suicide were concerns about the deterioration of the quality of life as a result of serious diseases with the consequence of unbearable pain, loss of dignity, hypomobility, immobility, whereas representatives of the medical diaspora are aware that the enactment of euthanasia or physician-assisted dying can cause uncontrolled and undesired extension of this practice in the context of vulnerable socially disadvantaged groups.

The concept of unbearable suffering is a personal and subjective phenomenon to a greater extent and perception of the concept of unbearable suffering by each patient varies. Pain assessment and the nature of pain is highly challenging, despite the fact that the physician has various expert criteria including pain assessment tools for the objectification of the assessment of pain. In addition, it is extraordinarily difficult and problematic to carry out a differential diagnosis between physical pain, which the patient is unable to influence, and complex pain, including psychological distress, which the doctor is able to reduce to a large extent by administering sedatives and antidepressants. However, supporters of euthanasia argue that unbearable suffering in the context of a complex moral understanding is a completely sufficient reason for requesting euthanasia.

The dilemma of choosing between life and death is a fundamental multi-factorial issue and a partial ban on physician-assisted suicide limits the rights to life in sporadic cases as it can initiate a premature suicide attempt by people with severe physical

[231] Ibid.

disorders as a consequence of fear of potential unbearable suffering stemmed from a loss of self-reliance and self-sufficiency in the terminal phase of their lives. Prohibition of assisted dying practices prevent competent polymorbid persons with serious illnesses from making decisions about their bodily integrity and medical care, which subsequently limits their individual freedom, freedom of choice and self-governance.

The transformation of the socio-demographic profile associated with elderly population, improvement of the overall efficiency of health and social services, especially the optimization of therapy of chronic diseases with the consequence of increasing the length of life, initiate the development of an effective model of financing high-quality palliative care as an alternative solution for quality care at the terminal phase of life with the preservation of human dignity. The autonomous behavior of the individual is influenced by society and social expectations and based on the right to self-determination of a patient who is capable of rational behavior and actions. "Autonomy is essentially understood as the ability to choose between an adequate range of valuable options, while in possession of the appropriate capacities to make such choices and while sufficiently independent of others."[232] The dilemma is whether a patient in the terminal state of a serious illness is able to reflect on his preferences and apply them to current situations. In essence, a physician in a palliative care facility has the duty to limit the suffering of a patient and alleviate the condition of the dying person with continuous palliative analgosedation with a subsequent change in consciousness. Hence, an undesired intervention in patient autonomy is initiated with the risk of abuse of the situation and vulnerability of the dying person. In debates on euthanasia, the argument for autonomy is applied[233] as "a non-idealist moral requirement, rather one based on real situations."[234]

The debate on the decriminalization of euthanasia as a means of eliminating unbearable suffering is a long-term issue, and the idealization of this act, including moral judgment and the idea of justification in sporadic and precisely defined situations, which is contained in the approach of public opinion, demonstrates the gradual predominance of proponents of euthanasia and the restriction of individual freedom. In

[232] "The Limits of Law," *Stanford Encyclopedia of Philosophy*, last modified January 29, 2022, https://plato.stanford.edu/entries/law-limits/.
[233] Josef Kuře, *Everything Under Control: How and When to Die - A Critical Analysis of the Arguments for Euthanasia* (Brno, 2011), 136, https://www.intechopen.com/chapters/19615.
[234] Ibid.

this context, it is noteworthy to point out that "Organ Donation Euthanasia,"[235] as an alternative solution to maximize the acquisition of a donor organ, would be a rational advancement compared to the current practice regarding the withdrawal of life support and curative therapy, and regardless of certain moral and ethical aspects of the issue inclusive of the observance of basic human rights, non-compliance with the current legal norms of transplant surgery remains a source of ambiguous controversy and represent a starting point for further professional and public debates. This approach to the issue of "Organ Donation Euthanasia"[236]proposes a boundary of the law focused on the fundamental right of an individual to decide on his own life and death while respecting the autonomy of the individual; then the decriminalization and justification of this act is based on professional and public reasons, focused on the moral status of the act and matters of basic justice. The severity of the problem of organ shortage initiates standardization of access to dying patients and legal status on an international scale.

A number of methods of organizational improvement of the procedure of organ collection from patients-donors have been evaluated. The changes concern the simplification of the consent of the patient-donor to the removal of an organ after death or a strategy such as the removal of solid organs immediately after brain death, which is inconsistent with the current legal norms of transplant surgery. The dilemma of this procedure is the real observance of respect for the autonomy of the patient-donor who as a result of impaired consciousness, is unable to express verbal or written consent to organ donation after death and is thoroughly educated about the consequences of his decision; whether the principle of beneficence, which understands the actions of physician in the best interests of the patient, and the principle of non-maleficence, which interprets the actions of physician without the consequences, which cause damage has been evaluated.

The controversy of the medical practice of euthanasia in the case of demented patients and persons with mental retardation is, in the context of the analyzed phenomenon is of the utmost importance; currently accentuated from the point of view of global social trends in social interaction in the sphere of respect for fundamental human rights and with regard to the Dutch and Belgian practices, enabling performing

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[235] Dominic Wilkinson, Julian Savulescu, "Should we allow organ donation euthanasia? Alternatives for maximizing the number and quality of organs for transplantation," *Bioethics* 26, no.1 (2012): 46, doi: 10.1111/j.1467-8519.2010.01811.x.

euthanasia for demented patients in an advanced stage who have previously given written consent to be killed.

Referring to the Dutch and Belgian practices, the interpretation of the information is very questionable and uncertain, including the previously expressed informed consent to the procedure regarding euthanasia in the case of incompetent patients with dementia due to the impossibility of transparent assessment of whether the patient with dementia currently even has a basal comprehension of the procedure of euthanasia and the act itself and whether he agrees with it. The argument of respect for autonomy based on the human right to self-determination of a patient and the freedom of expression is one of the basic points for the moral justification of active requested euthanasia when the patient expresses his personal choice and realizes his autonomy. In an ideal case, patient autonomy shall be in harmonious balance with the basic right to life, and the individual doctor-patient interaction shall be in accordance with the interests of society on a moral, ethical and legislative scale. The right of 'capacitated'[237] individual to refuse any performance without rational consideration is the basis of autonomous self-determination with all the possible consequences including injury or death, assuming that the individual is valid and sane.[238]

Persons with dementia and mentally retarded persons lack the capacity for autonomy, but it is plain as day that they can be harmed, something the[239] 'setback to autonomy'[240] or 'prospect harm'[241] conception seems ill equipped to account for.[242] Based on the complex historical development and the current approach of the American public and the American medical diaspora to the issue of the legalization of euthanasia, it can be assumed that the legalization of euthanasia exposes doctors to a high degree of risk of potential criminal penalties. In an analysis of the most important European legal systems, the Netherlands and Belgium, which actively perform euthanasia and physician-assisted suicide with a flexible legal component in common practice,

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[236] Ibid, 33.
[237] Andreas Fontalis, Efthymia Prousali, and Kunal Kulkarni, "Euthanasia and assisted dying: what is the current position and what are the key arguments informing the debate?"*Journal of the Royal Society of Medicine* 111, no.11 (2018): 408, 10.1177/0141076818803452.
[238] Ibid.
[239] "The Limits of Law," *Stanford Encyclopedia of Philosophy*, last modified January 29, 2022, https://plato.stanford.edu/entries/law-limits/.
[240] Ibid.
[241] Ibid.
[242] Ibid.

additional arguments place the proper emphasis on the continuing relevance of the slippery slope argument.

The arguments that have been identified facilitate understanding of the function of the clear consensus of the religious denominations in the United States on the issue of euthanasia and physician-assisted dying that points to the continuous negativist position of the Catholic and Protestant Churches in respect of of both practices of euthanasia or physician-assisted dying. Transparent condemnation of both practices is based on the assumption that the legalization of euthanasia and the further expansion of physician-assisted suicide would initiate a violation of fundamental human rights and an amoral transformation of the concept of medical ethics, in which a physician as a rational actor in the doctor-patient relationship can choose treatment or death according to his own convictions. Representatives of both churches, the Protestant Church in the United States of America and the American Roman Catholic Church prefer the development of comprehensive palliative care, which has medical and psychological techniques to eliminate alarming manifestations of the dying process.

The debate about the evolution of euthanasia and assisted suicide in the United States with an emphasis on human rights in the context of globalization trends and social interactions concerns the argumentation and counterargument of this phenomenon and the development of legislative norms, whereas it is equally important to consider a deep philosophical conception of the authentic values of life and death on the basis of the alarming moral transformation of basic human values that have been subsequently demonstrated. It is evident that in the current global world there exist a tendency to deepen the dissonance of basic human rights depending on the social position of a person and his physical and mental condition. Vulnerable socially disadvantaged group of people with serious mental or physical illnesses and impaired quality of life or with a weaker social background in the current context is interpreted in a broad sense of the examined issue, whereas the same group is interpreted on a smaller scale in the context of healthcare. Nevertheless, it is neither effortless nor well judged "to say to the person suffering unbearably, who does not see any sense of such terrible suffering and of her destroyed life, that suffering has its place in the process of personal development."[243]

[243] Josef Kuře, *Everything Under Control: How and When to Die - A Critical Analysis of the Arguments for Euthanasia* (Brno, 2011), 148, https://www.intechopen.com/chapters/19615.

Currently, there are certain concerns that in the present world, influenced by globalization trends, fundamental human rights, the right to life and freedom of expression will reflect social issues such as concerns about financial issues, family burden, social deprivation, and chronic fatigue. This social issue is of a subjective nature, in which a physician cannot rationally assess and critically examine the condition of a patient and hence is not capable of providing a patient with a clear analysis of the subjective data concerning the overall condition of a patient. Nevertheless, quality medical care is capable of limiting certain symptoms and achieving resolution of issues with the timely intervention of psychiatric or psychological assistance with respect to patient autonomy. Autonomy is one of the main arguments for the ability of a competent person to manage his life according to his beliefs and self-determination. Human autonomy is interpreted in different contexts, nevertheless, in its essence, it reflects individual free choice of a valid person without any limitations. Respect for patient autonomy is based on his basic values and requires a thoughtful attitude to his judgment, even in the case of a mistaken judgment.

As an illustration of the debate, an example of doctor-patient interaction in the context of observing human rights and respecting the autonomy of a patient with a serious incurable disease can be given. It is worth emphasizing that in case of patient who expresses the right to die as a result of unbearable suffering, a physician must understand this right as a morally justified choice in certain cases supported by law. The right of a human being to die as a justified moral choice must be respected by a physician and interpreted according to the overall condition of a patient, the state of his cognitive functions, and perspectives on the development of disease. Furthermore, the absence of any influence or pressure on the person that is capable of influencing or distorting this choice is important. In fact, in the healthcare sector, there is a risk of influencing and abusing vulnerable individuals who, as a result of various circumstances, have deep-rooted social problems and are unable to provide an adequate response to social pressure.

At present, individual and public opinion is influenced by various social trends that contribute to the transformation of basic social values. This shift towards the trend of modern society, which is unable to protect its citizens from social deprivation, initiates the perception of basic human rights, interpreting it as the fact that the basic right to life is less valuable than the quality of life. The current health care system in the United States is different from the health care and health insurance system in most

European countries where every member of society has access to health care covered by health insurance.

The absence of health insurance for a certain part of American citizens contribute to the permanent support of Americans towards the legalization of both practices, euthanasia and physician-assisted suicide. However, a more acceptable model of health care and health insurance in developed European countries such as Belgium and the Netherlands manifests explicit popularity and extension of legalized euthanasia and physician- assisted suicide with the continuous risk of abuse and violations of human rights. As can be seen, the impulses to legalize and carry out both practices, euthanasia and physician-assisted suicide, are rooted in human nature and the organization of global society as a whole, regardless of the model of health care, access to health services, and the health insurance system. "Specific legal applications of the public reason approach are, however, already in existence (for example Flanders 2016) and the approach continues to develop."[244]

In the current global world, there is a great risk of legalizing euthanasia, and the subsequent expansion of the practice of physician-assisted dying initiates the abuse of medically disabled people. In addition, the financially demanding treatment and the financial incentive may cause the professional deformation of the personality of a physician, therefore, this deformation can result in immoral conduct concerning the certain strategy of a therapeutic procedure, which ultimately will result in undesired decisions that will contradict free choice in favor of the patient. Furthermore, the results of general public opinion regarding the issue of legalizing euthanasia and physician-assisted suicide in the United States may, therefore, be distorted by the opinion of people, who are experiencing difficulties with health insurance, low financial income, other social problems, and are more likely to support the spread of legalizing euthanasia and physician-assisted suicide.

The absence of health insurance for a certain part of the American society in the context of a certain social and financial imbalance can initiate genuine concern for supporting the legalization of euthanasia and the expansion of the practice of physician-assisted dying in the United States. From an economic point of view, the need for expensive therapy and quality medical care can initiate behavior change in personalities

[244] "The Limits of Law," *Stanford Encyclopedia of Philosophy*, last modified January 29, 2022, https://plato.stanford.edu/entries/law-limits/.

of socially vulnerable persons without health insurance and stable financial resources to make an involuntary choice toward support of both practices.

These findings suggest that in general this controversial issue goes beyond the scope of the valid paradigm, and within the current globalization trend, unexplored precarious situations, deviations, and risks, which accompany the newly formed globalized world have been appearing around. In the final analysis, the humanitarian basis of the justification of paradigms of death good in the context of the legalization of assisted death and physician- assisted suicide in sporadic cases does not currently allow the transparent integration of both practices into the context of American health care without the risk of abuse of vulnerable members of American society.

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Appendices

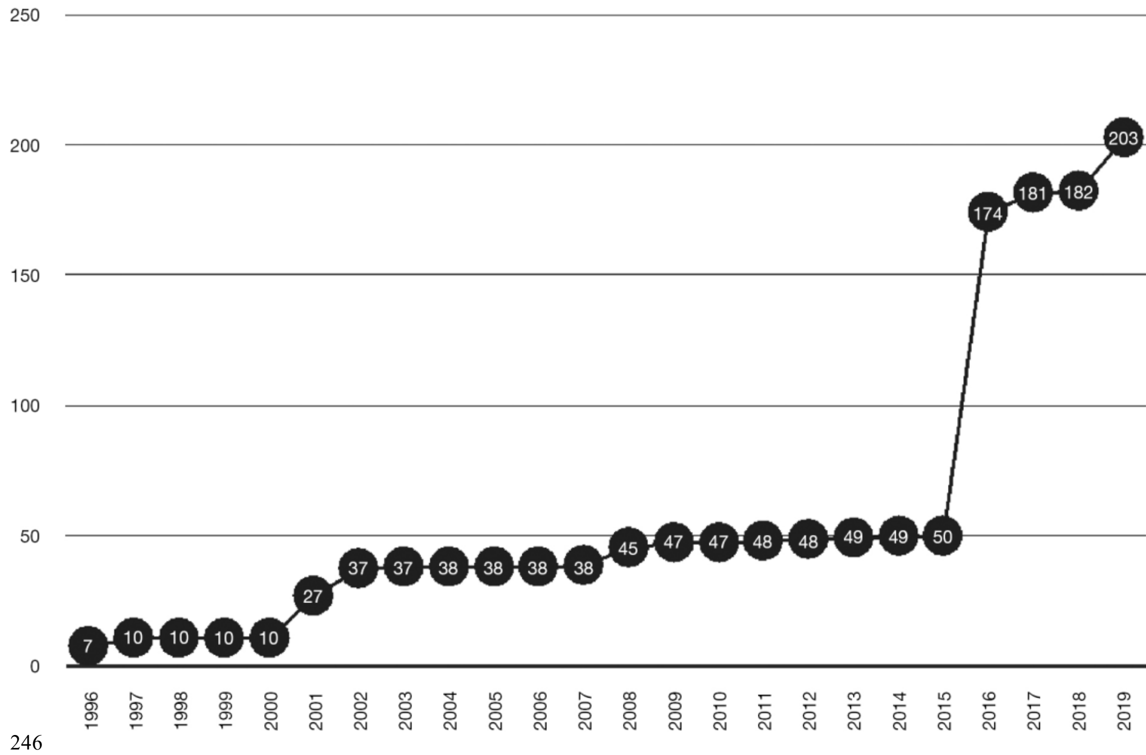
Appendix 1: A summary of arguments for and against euthanasia (table)

PRO	*CONTRA*
Autonomy	Competence
Right to die	Inviolability of human life – a human right
Unbearable suffering	Sanctity of life doctrine
Compassion	Prohibition of killing (Hippocratic tradition)
Human dignity	Risk of abuse
Patient's best interest	Slippery slope
Quality of life	Quality palliative care – as a/the alternative to euthanasia
Health care costs	Patient's good – as an counterargument to the pure economical calculation
Legalization	The compromised role of the physician
Transparency	Vulnerability – social pressure

[245]

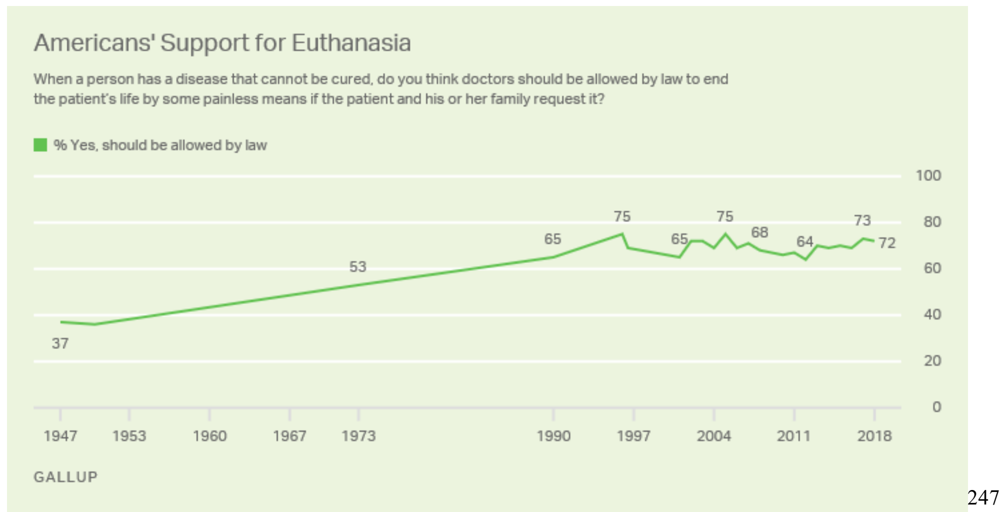
Appendix 2: Synopsis of physician-assisted dying in jurisdictions around the world (graph)

[245] Josef Kuře, *Everything Under Control: How and When to Die - A Critical Analysis of the Arguments for Euthanasia* (Brno, 2011), 131, https://www.intechopen.com/chapters/19615.



[246]

Appendix 3: American support for euthanasia (graph)



[247]

Appendix 4: American support for physician-assisted suicide (graph)

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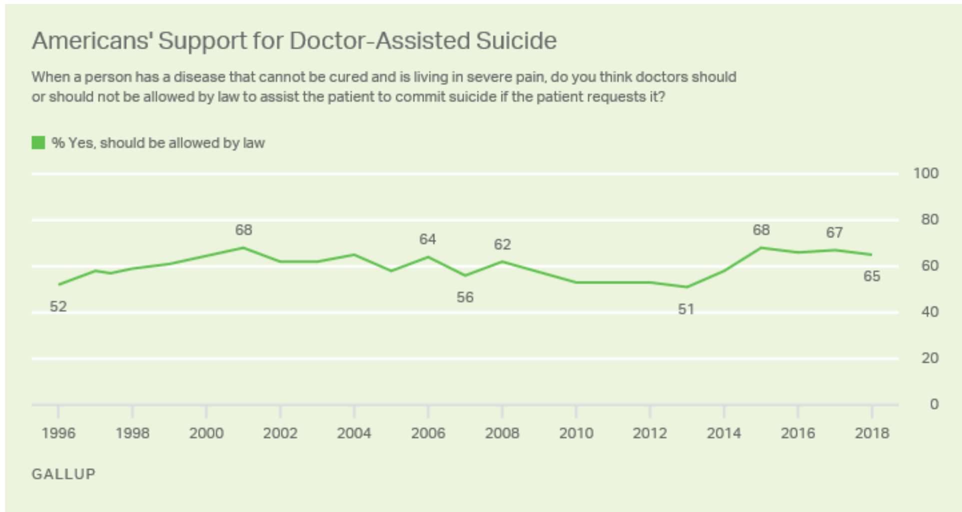
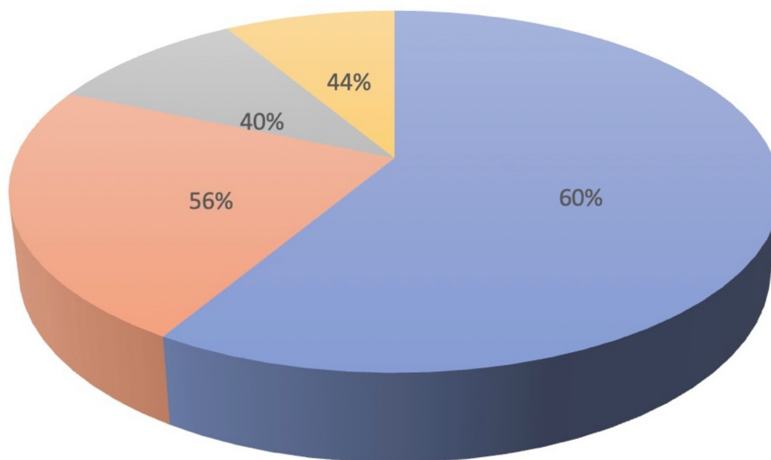
[246] Sarah Mroz, Sigrid Dierickx, Luc Deliens, Joachim Cohen, Kenneth Chambaere, "Assisted dying around the world: a status quaestionis," *the Annals of Palliative Medicine* 10, no. 3 (2021): 3548, doi: 10.21037/apm-20-637.

[247] Megan Brenan, "Americans' Strong Support for Euthanasia Persists," *Gallup*, last modified May 31, 2018, https://news.gallup.com/poll/235145/americans-strong-support-euthanasia-persists.aspx.



[248]

Appendix 5: Moral acceptability by physicians of euthanasia and physician-assisted dying (graph)



[248] Ibid.

Appendix 6: Number of published and reported reports of cases in patients with dementia in the period of 2012-2020 (table)

TABLE 1

Number of published and reported cases of euthanasia in dementia (2012–2020)

	Dementia		
Year	Published	Reported	%
2012	5	42	11.90%
2013	14	97	14.43%
2014	13	81	16.05%
2015	9	109	8.26%
2016	12	141	8.51%
2017	12	169	7.10%
2018	19	146	13.01%
2019	10	162	6.17%
2020	21	170	12.35%
Total	115	1117	10.30%

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[249] Antonie Stef Groenewoud, PhD., Ellen Leijten, and Theodoor Adriaan Boer, PhD., "The ethics of euthanasia in dementia: A qualitative content analysis of case summaries (2012–2020)," *Journal of the American Geriatrics Society* 70, no. 6 (2022): 1706, doi: 10.1111/jgs.17707.

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Expected date of submitting: **05.08.2022**
Head of the Seminar: **doc. PhDr. Jiří Vykoukal, CSc.**
Supervisor: **doc. PhDr. Mgr. Francis Raška, Ph.D.**
Title: **The problematics of the evolution of euthanasia and assisted suicide in the United States of America in relation to the development of global human rights.**
Short description of the topic: **The development of the approach to euthanasia and physician-assisted dying in the United States of America is based on an analytical synopsis of arguments and counter-arguments in the context of social, religious, economic, and ethical predispositions. The analyzed issue reflects the development of public opinion in relation to the issue, and therefore reflects the professional medical opinion inclusive of an insight into the risk of abuse of these acts.**
Proposed structure: **Obsah** **INTRODUCTION** **LITERATURE REVIEW** **HISTORICAL BACKGROUND** **WHAT IS EUTHANASIA AND PHYSICIAN-ASSISTED DYING?** **THEORETICAL FRAMEWORK / METHODOLOGY** **RATIONAL CHOICE THEORY** **Qualitative research** **Quantitative research** **THE CONTEXT OF HUMAN RIGHTS AND THE RESPECT FOR INDIVIDUAL AUTONOMY IN AMERICAN SOCIETY** **THE GLOBALIZATION OF HUMAN RIGHTS IN THE CONTEXT OF TRANSNATIONALISM** **RELIGIOUS ASPECTS** **PROTESTANTISM** **CATHOLICISM** **THE CONTEMPORARY DEBATE REGARDING THE CONTROVERSIAL ISSUE OF EUTHANASIA AND PHYSICIAN-ASSISTED SUICIDE : A VISION OF PUBLIC HEALTH IN AMERICA / THE AMERICAN SOCIETY** **CONCLUSION** **BIBLIOGRAPHY**