END OF LIFE: A COMPARATIVE LAW APROACH

FINAL DE VIDA: UNA VISIÓN DESDE EL DERECHO COMPARADO

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Summary

The purpose of this article is to provide a summary of the current legal situation of individual healthcare rights when facing end of life from a terminal illness, as well as examining the legal consequences for patients, relatives, doctors and nurses. The analysis focuses on Spanish law, placing it in the context of comparative law.

Keywords: *euthanasia, assisted suicide, orthothanasia, living will*

Resumen

El presente artículo pretende realizar una síntesis de la situación legal de los derechos individuales a nivel sanitario cuando la persona se encuentra en situación de final de vida a causa de una enfermedad terminal, así como explorar las consecuencias legales para pacientes, familiares, médicos y enfermeras. El análisis se centra en la legislación española enmarcándola en el derecho comparado.

Palabras clave: *Eutanasia, Suicidio Asistido, Ortotanasia, Testamento Vital.*

1. Introduction

The idea about what is or is not a good death, and the possibility of deciding the time of one's own death, is a reality that was already present in the earliest civilisations. In this context, we know that euthanasia was practised in primitive societies, ranging from mercy killing euthanasia to eugenic euthanasia.

Euthanasia for social reasons was common in Greece, Sparta, India, Mesopotamia and other ancient civilisations (Vilches, 2001). In ancient Greece, the aspiration to a good death was related to a death that was not caused by anything but was accepted and expected at the time when nature took its course. Heraclitus prohibited doctors from taking patients' lives, even if they had asked them to. In the other great civilisation—Roman—the practice of euthanasia seems to have been common due to the belief that it was better to die than to live a life of suffering.

With the arrival of the Middle Ages and the start of the Renaissance (14th century), Christian beliefs took on greater relevance. In this context, euthanasia was linked to a good death, and death was viewed as the final process in human health and life. Help for the dying with all resources available for a death with dignity and without suffering was therefore advocated.

With the development of scientific medicine in the 13th century, doctors would become those who took responsibility for practising euthanasia, which became a medical practice that was allowed and common in medical procedures.

In the 19th century, Marx discussed the matter of euthanasia in his doctoral thesis "Medical Euthanasia" (Cruz, 1999), proposing the obligation to teach doctors technical and humane care for terminally-ill patients.

In the mid-20th century in Germany, under Hitler's dictatorship, euthanasia was practised in order to exterminate many physically and mentally disabled people with the 'merciful' excuse that their lives would only bring them useless suffering, without obtaining consent from the patients or from their relatives (López, Navarro & López-Guerrero, 1993).

Today, there is widespread ethical, moral and religious debate on what a good death is and what a death with dignity is. Concepts such as euthanasia, assisted suicide and orthothanasia are greatly discussed in ethical debates on the end of life. Modern positive law is involved in these situations and for some decades there has

been positive legislation, decriminalising certain acts and regulating others with differing degrees of restrictiveness. At present few countries have laws that allow euthanasia; in the vast majority of them it continues to be prohibited and considered a crime against life.

The purpose of this article is to give an overview of the positive legal situation, first by giving a brief summary of comparative law and then by analysing the various cases in Spain.

2. Comparative law: brief summary

Euthanasia and assisted suicide are illegal in most countries. In some US states, and in countries such as Colombia, Belgium, Luxembourg, Holland and Switzerland, euthanasia is allowed as long as certain conditions are met. In many other countries, such as Japan, Canada and Australia, it is currently a subject under discussion at legal, social and political levels.

2.1. United States

Euthanasia is prohibited, although in some states, such as California, Montana, Oregon, Vermont and Washington, doctors are allowed to help with assisted suicide, under strict conditions. In 1994 and following a referendum, Oregon was the first American state to allow assisted suicide for incurable patients. In 1997 the law was ratified by a second vote. To be able to carry it out, two doctors have to certify that the patient probably has less than six months to live; in addition, those affected have to be of legal age and to have left a record of their wish to die on several occasions both verbally and in writing. In 2006 the Supreme Court dismissed an attempt by the federal government to revoke the Oregon Death with Dignity Act (Parreiras, 2016).

2.2 Colombia

In the case of Colombia, it merits mention that it is the only country in Latin America where euthanasia is legal and has been since 2015. However, the procedu-

re is not accessible for all sectors of society, although it has recently been regulated for patients with terminal illnesses, of legal age and who have expressly stated their wish to submit to euthanasia (Delgado, 2017).

In this country it is established that the main health centres should create committees made up of a doctor, a psychiatrist and a lawyer who can verify the patient's wish to submit to an assisted death, as well as their condition as a terminally-ill patient who has previously received or been offered palliative care.

2.3 Holland

Holland was the first country in the world to legalise euthanasia in 2001 (Bremer, 2004). Doctors there can carry out euthanasia if the patient wishes, is suffering from unbearable pain and there is no hope of a cure. The doctors must obtain a second opinion and report each case to an ad hoc commission. Only if this commission, which is made up of a doctor, a lawyer and an expert in ethics, has any doubts concerning the correctness of the doctor's action, the matter has to be taken to court, otherwise the act takes place directly.

2.4 Belgium

In Belgium, euthanasia has been legal since 2002. The law allows adults with an incurable illness to choose to end their lives, as long as doctors certify that they are experiencing unbearable suffering (Bremer, 2004). In 2014 the law was extended to include terminally-ill minors, with their parents' consent.

2.5 Luxembourg

Similarly, in Luxembourg, euthanasia has been legal since 2009. The law explains that the 'doctor's freedom of conscience' is respected, but further states that the doctor cannot 'justify or force a patient with a terminal illness to continue to live in anguish and suffering'.

2.6 Switzerland

In the case of Switzerland, the situation is different. In this country, the right to decide to die is widely accepted, but euthanasia is prohibited. Therefore, the law allows assisted suicide, in that the terminally ill are provided with counselling and the lethal substances to cause death, which they must administer themselves.

2.7 Japan

On 28 March 1995, the Yokohama District Court found a doctor guilty of murdering a terminal cancer patient who was expected to die a few days later. He received a two-year suspended prison sentence.

The court set out four conditions under which it would be possible to end a patient's life in Japan:

- The patient suffers from unbearable physical pain.
- Death is inevitable and imminent.
- All possible measures have been taken to eliminate the pain.
- The patient has clearly expressed their consent.

The judge said that the doctor's actions did not meet all the conditions, arguing that the patient had not clearly expressed their physical pain or given theis consent. The doctor's action was not considered euthanasia, but an illegal termination of the patient's life.

2.8 Germany

In Germany, euthanasia may be authorised only when the patient's wishes are unambiguous, and it is approved by courts of protection (Parreiras, 2016).

2.9. Great Britain

The courts have authorised some doctors to suspend the treatment of patients artificially kept alive.

2.10. France

The Criminal Code distinguishes between active euthanasia (direct act to cause death) and passive euthanasia (withdrawal of treatment).

2.11. Denmark

A terminally ill patient may decide to have their treatment withdrawn.

2.12. Australia

In some states such as Victoria, the terminally ill patient may request assisted death through the intake of lethal drugs.

2.13. Cambodia

On 20 May 1997, the Constitutional Court partially legalised assisted death for terminally ill patients who had clearly shown their consent. What's more, it seems that the law is pending implementation, as judges will have to evaluate it on a case-by-case basis.

3. Situation in Spain

This section will explain the legal considerations in Spain for acts related to the death of a patient, which are conceptually very different and with highly differentiated actions.

3.1. Euthanasia

The term euthanasia derives from the Greek: *eu* (good) and *thanatos* (death). However, from a legal point of view, euthanasia is any act or omission in which responsibility falls on the medical staff or on individuals close to the patient who cause their immediate death in order to avoid unbearable suffering or the artificial

prolongation of their life. For euthanasia to be considered as such, the patient must be suffering from a terminal or incurable illness, and secondly, the medical staff must have express consent from the patient (Macià Gómez, 2008).

Article 143.4 of the Spanish Criminal Code considers euthanasia a crime (Organic Law 10/1995, of 23 November, on the Criminal Code. Official State Gazette no. 281, of 24/11/1995): '*4. Whoever causes or actively cooperates in the necessary, direct acts causing the death of another, at the specific, serious, unequivocal request of that person, in the event of the victim suffering a serious disease that would unavoidably lead to death, or that causes permanent suffering that is hard to bear, shall be punished with a punishment lower by one or two degrees to those described in Sections 2 and 3 of this Article.*'

Regarding the punishments, the full regulation is transcribed below:

'*1. Whoever induces another to suicide shall be punished with a sentence of imprisonment from four to eight years.*

2. A sentence of imprisonment of two to five years shall be imposed on whoever co-operates in the necessary acts for a person to commit suicide.

3. Punishment shall involve a sentence of imprisonment from six to ten years if such co-operation entails executing the death.'

As can be seen, the punishment is graduated depending on the behaviour of the person who takes part in the action. Therefore, direct action is considered more serious than co-operation.

Recently, the plenary session of the Congress of Deputies debated on 10 May 2018 on whether to take into consideration a draft bill from the Parliament of Catalonia to reform the Criminal Code and legalise euthanasia and assisted suicide. The initiative was supported by all parties in parliament except for the PP, UPN and an abstention from Ciudadanos. Thus, it does not appear that the road towards this process will be an easy one.

The legislative bill which is now at the start of a long parliamentary process proposes to amend section four of Article 143 of the Criminal Code to keep free from harm those who, 'in an indirect manner or by co-operating', help someone to die in a 'safe, peaceful and painless way' if they have requested it 'specifically, freely and unequivocally'. Further, it states that the patient must be suffering from a 'terminal illness' or an 'incurable disease' that causes them 'serious physical or

mental suffering that is expected to be permanent'. These proposed amendments have to be taken as mere guidelines, since they may undergo a lot of changes during the parliamentary process.

At present, people who execute, induce euthanasia or co-operate in carrying it out are punished, so that the act of a person committing suicide without causing further damage would be legitimate. According to legislation, the person who chooses euthanasia to end their life is a person who is in a vulnerable and probably easily-influenced state, so the influence exercised on them is punished. The decision to commit suicide must be personal, the person's own, and not made due to the force exerted by other people to make them do it. The legislator punishes both assistance in carrying out the act, which is supposedly more serious, and induction and co-operation, which are less serious.

In the case of induction, those who induce are considered perpetrators. Those who induce collaborate morally by aiding the subject in carrying out euthanasia. In this respect, the interpretation is that the influence is at a psychological level. This influence must be direct; it cannot be in sequence from one person to another; and it must be exercised directly on the person who commits the act. The influence must lead to the desire to commit suicide, in other words, they must want to take their own life as a result of the influence received.

Moreover, in co-operation with necessary acts, actions aimed at a person being able to effectively take their own life are punished. Co-operation is the help given before the euthanasia takes place, in other words, acts need to take place that serve to carry out the euthanasia and it must be help given prior to death. This action must be the cause of death and must be something that leads to death taking place. In addition to these requirements, these actions must also be actions aimed at the death of the person occurring as a result. For co-operation with necessary acts to be considered as such, it must be co-operation with an element that is necessary for the act to take place, for example, handover takes place of some elements that are difficult to obtain, such as a drug.

Finally, there is executive assistance, which is euthanasia strictly speaking. This is also covered by Article 143 of the Criminal Code, which determines that whoever causes or actively cooperates in the necessary, direct acts causing the death of another, at the specific, serious, unequivocal request of that person, in the event

of the victim suffering from a serious disease that would unavoidably lead to death, or that causes permanent suffering that is hard to bear, shall be punished with a punishment lower by one or two degrees to those for co-operation with necessary acts or co-operation that leads to the death of the person.

In executive assistance, suicide is not in the hands of the person who wishes to commit suicide but in the hands of another person. This executive assistance is euthanasia, which in turn may be active or passive euthanasia.

a) Active euthanasia consists of carrying out positive actions that lead to the death of the person. It may be direct, when it takes place with actions aimed at causing the death of the person; or indirect, which is what happens with actions that are not mainly aimed at causing death but at relieving pain.
b) Passive euthanasia takes place when negative actions are carried out for the purpose of doing nothing and omitting treatment, but that are for the purpose of causing death.

Euthanasia is punished by Article 143 of the Criminal Code. For this, it is necessary for there to be proof that the necessary assumptions that cause death are in place. These are:

1. The person is suffering from a serious illness that leads to death. Or they are suffering from a serious illness that causes permanent suffering that is hard to bear.
2. There must be a specific, serious, unequivocal request from the patient. Therefore, minors or people who are unconscious cannot give their consent.
3. The behaviours considered to cause euthanasia are: co-operation with necessary acts, which would be direct active euthanasia or executive assistance, which would also be direct active euthanasia.

3.2. Assisted suicide

Shifting the responsibility for the act onto the patient is termed 'assisted suicide', which acknowledges the patient's autonomy (Vilches, 2001). In general, assisted suicide consists of providing the means or procedures for the person to commit suicide at their specific request. There does not have to be a prior life-threatening

illness and it is summed up as active assistance with imminent death for someone who wishes to die.

Therefore, when a person is provided with the necessary means (information, doses, resources, instruments or medicines) to take their own life, as long as the person has made their own decision to do so, we can speak of assisted suicide.

Usually, healthcare professionals (doctors and nurses) are indirectly involved in assisted suicide. It should be pointed out that in assisted suicide it is the patient who carries out the procedure to end their life and therefore the participation of the healthcare professional or counsellor is passive, meaning it is limited to providing the information, means and resources so that the patient can do it.

Its legal consideration is also subject to article 143.3 of the Criminal Code, although depending on the actual specific situation it may be covered by either point 4 of article 143, or 1 and 2:

'*1. Whoever induces another to suicide shall be punished with a sentence of imprisonment from four to eight years.*

2. A sentence of imprisonment of two to five years shall be imposed on whoever co-operates in the necessary acts for a person to commit suicide.'

At the moment, punishment is given to people who induce another to commit suicide or who co-operate so that it can take place, and therefore the action of a person who commits suicide without causing further damage would be legitimate. The interpretation is that the person who commits suicide is in a highly vulnerable state and easily influenced at a psychological level and therefore the person who exercises the influence over them is punished. The decision to commit suicide must be personal and not made due to the force exerted by other people. The legislator punishes both assistance in carrying out the act, which is supposedly more serious, and induction and cooperation, which are less serious.

The requirements to be met in the three cases are:

– For suicide to have taken place: the death wished by a person for himself/herself has occurred, and this decision must be made by a person who is accountable. In other words, a decision taken by minors or the mentally ill is not valid.

– The suicide must have effectively taken place, meaning the actions planned for it have been carried out. Finally, death must have occurred, in other words, it must be the result of the action of committing suicide.

From a legal point of view, those who induce are considered perpetrators. Those who induce suicide collaborate morally so that the subject commits suicide, having a psychological influence on them. This influence must be direct, cannot be in sequence from one person to another, and must be exercised directly on the person who commits suicide. The influence must lead to the desire to commit suicide and they must want to take their own life as a result of the influence. As noted above, induction is punished with a sentence of imprisonment of four to eight years.

In the case of co-operation with necessary acts, punishment is given for actions aimed at effectively causing a person to commit suicide. It is also punished under Article 143 of the Criminal Code with a sentence of imprisonment of two to five years. Co-operation with suicide is the help given before the suicide takes place, in other words, acts need to take place that serve to carry out the suicide and it must be help given prior to suicide. This must be something that leads to the suicide taking place. In addition to these requirements, as with euthanasia, these actions must also be actions aimed at the suicide taking place, with death of the person occurring as a result.

Also, as in euthanasia, for co-operation with necessary acts to be considered as such, it must be co-operation with an element that is necessary for the act to take place, for example, handover takes place of some elements that are difficult to obtain, such as some type of drug.

3.3. Orthothanasia

Orthothanasia, or death with dignity, is defined as the action before death by those who care for those who suffer from an incurable or terminal illness respecting the right of the patient to die with dignity, without the use of disproportionate and extraordinary means to maintain life. In this respect, care should be taken to deal with incurable and terminal illnesses with palliative treatments (nursing, medical care and treatments and pharmacological

treatments given to patients in the advanced stage and with terminal illness in order to improve their quality of life and to ensure that the patient is pain-free) to avoid suffering, resorting to reasonable measures until death takes place. Orthothanasia never deliberately intends to hasten the death of the patient.

Orthothanasia is always achieved by rejecting the use of disproportionate means to maintain life. It consists of allowing death to take place in incurable and terminal illnesses, treating them with the maximum palliative treatments to avoid suffering, making use of reasonable measures. It is distinguished from euthanasia in that it never deliberately intends the death of the patient.

The legal situation in Spain is very confusing, as there is no legislation at a state level and we only find regional regulations (Galicia, Basque Country, Aragon, Balearic Islands, Canary Islands, Asturias and Madrid) (Moreno, 2004; Suárez, 2012). In this context, as pointed out before, Catalonia has approved a motion that decriminalises euthanasia and urges the Congress of Deputies to amend the Criminal Code on this issue. The legal process for this decriminalisation has already been started in the Congress of Deputies. The rest of the regions have registers of advance directives. In general, these regional regulations recognise certain rights and obligations for patients and professionals. For the former, the aim is to guarantee legal certainty in the decision-making process on this matter. For the latter, the aim is to free them from liability and to obligate them to comply with the wishes and intentions of the patient. The regulations also state that patients have the right to die at home and to receive palliative care. In addition, the right to be informed at all times and also the right not to be informed is included. Patients may refuse to receive life-prolonging treatment. In addition, both patients and family members may have psychologists and social workers to support them. Also included is the possibility of making a living will in hospitals and health centres.

At a state level, we only have two aspects regarding the 'process of dying'. On the one hand, there is the Criminal Code, which criminalises both euthanasia and assisted suicide, as explained above. On the other hand, there is the Patient Autonomy Act of 2002, which recognises patients' rights such as refusing to receive treatment.

In fact, Article 2 of Act 41/2002 of 14 November, which regulates patient autonomy and the rights and obligations regarding information and clinical documentation, reads:

'Article 2. Basic principles

1. The dignity of the human person, respect for the autonomy of their will and their privacy will guide all the activity aimed at obtaining, using, archiving, safekeeping and transmitting information and clinical documentation.

2. Any action in the field of health requires, as a general rule, the prior consent of patients or users. This consent, which must be obtained after the patient receives adequate information, will be given in writing in the cases provided for in law.

3. The patient or user has the right to freely decide, after receiving the appropriate information, from among the available clinical options.

4. All patients or users have the right to refuse treatment, except in the cases determined by law. Their refusal of treatment shall be made in writing.'

3.4 Palliative sedation

In the field of palliative care, the practice of **palliative sedation** merits mention. Palliative sedation is the deliberate administration of drugs in the doses and combinations required to reduce the awareness of a patient with an advanced or terminal disease in order to relieve their symptoms if they cannot be mitigated in any other way.

Regional regulations govern this practice. For example, the Community of Andalusia Act states in its articles 13 and 14:

'Article 13. Patients' right to pain treatment

Patients have the right to receive the appropriate care that prevents and alleviates painz including sedation if the pain is resistant to specific treatment.

Article 14. Patients' right to the administration of palliative sedation

Patients in terminal situations or dying have the right to receive palliative sedation, when they require it.'

3.5 Palliative care

The World Health Organisation (WHO) defines palliative care as the coordinated set of healthcare interventions aimed, from a holistic point of view, at improving the quality of life of patients and their families. It involves the prevention and relief of suffering by means of early identification and treatment of pain and other problems, physical, psychosocial and spiritual. It takes place both at home and in hospital.

Regional regulations govern this issue in Spain. For example, Article 12 of the Region of Andalusia Act states:

'*Article 12. Right of patients to receive holistic palliative care and to decide to receive it at their home*

1. All people who are suffering from a terminal illness or dying have the right to receive quality holistic palliative care.

2. Patients who are suffering from a terminal illness or dying, if they wish, have the right to be provided, at the address that they designate in the territory of the Region of Andalusia, with the palliative care that they require, as long as this is not contraindicated.'

3.6 Limitation of treatment

In healthcare with patients in a situation of advanced disease and end of life, it is common to consider the practice of limitation of therapeutic effort (LTE). LTE is understood as the act of withdrawing therapy or not initiating therapeutic measures that are useless in the patient's specific situation and only serve to prolong their life artificially, but without providing a functional recovery. Limitation of therapeutic effort allows the patient to die, but neither produces nor causes it.

Regional regulations govern this issue. For example, articles 8 and 13 of the Region of Andalusia Act states:

'*Article 8. Right to refuse and withdraw medical intervention*

1. Everyone has the right to refuse the intervention proposed by healthcare professionals, after an information and decision process, even if this could endanger their life. This refusal must be in writing. If they cannot sign, another

person who will act as a witness at their request signs it, leaving a record of their identification and the reason that prevents signature by the person who is refusing the proposed intervention. All of this must be written down in the medical record.

2. Patients also have the right to revoke the informed consent issued for a specific intervention, which will necessarily imply the interruption of the intervention, even though this may endanger their lives, without prejudice to the provisions of article 6.1.ñ of Act 2/1998 of 15 June 15 on Healthcare in Andalusia.

3. Revocation of the informed consent must be made in writing. If the person cannot sign, another person who will act as a witness at their request signs it, leaving a record of their identification and the reason that prevents signature by the person who is rejecting the proposed intervention. All of this must be written down in the medical record.'

'*Article 21. Duties regarding limitation of therapeutic effort*

1. The doctor responsible for each patient, in the exercise of good clinical practice, will limit the therapeutic effort, when the clinical situation so advises, avoiding therapeutic obstinacy. The justification for limitation should be set down in the medical record.

2. This limitation will be carried out after hearing the professional judgement of the nurse responsible for the care and will require an opinion coinciding with that of the doctor in charge from at least one other doctor from among those who take part in the healthcare. The identity of these professionals and their opinion will be set out in the medical record.

3. In any case, the doctor in charge, and the other healthcare professionals who care for patients, are obliged to offer them the necessary health interventions to guarantee their adequate care and comfort.'

3.7 Obstinacy (or medical futility). Dysthanasia

On the other hand, and what could be considered as the opposite extreme, there is obstinacy, therapeutic cruelty or dysthanasia.

This term refers to disproportionate treatment that prolongs the agony of terminally ill patients. The treatment can be refused by the patient or by his/her fa-

mily and this request must be fairly and suitably assessed by professionals, as explained in the previous section.

3.8 Living Will

Finally, in this context, we consider it important to highlight the document known as a *living will*. A living will, also called an Advance Healthcare Directive (AHD), is a document, for medical use, through which a person leaves written instructions and the health care that they would like to receive in the event that they end up in a situation where they cannot express their will personally. Therefore, a living will has no effect as long as the person can express himself/herself.

Its regulation is detailed at an autonomous community[1] and state level in Article 11 of the 41/2002 Act, of 14 November, which provides general regulations on patient autonomy and rights and obligations regarding information and clinical documentation[2]:

'*1. Through the document of prior instructions, a person of legal age, capable and free, expresses their will in advance, so that it can be fulfilled at the time when situations arise and under the circumstances they are not able to express them personally, on the care and treatment of their health or, once death has occurred, about the fate of their body or its organs. The grantor of the document can also appoint a representative so that, if necessary, this person can serve as their spokesperson with the doctor or the healthcare team to ensure compliance with the prior instructions.*

1. Galicia: Law 5/2015, of 26 June, on the rights and guarantees of the dignity of terminally ill people.
   Government of Navarra: Regional Law 8/2011, of 24 March, on the rights and guarantees of the dignity of the person in the death process.
   Aragon: Law 10/2011, of 24 March, on the rights and guarantees of the dignity of the person in the dying and death process.
   Andalusia: Law 2/2010, of 8 April, on personal rights and guarantees of the dignity of the person in the death process.
   Balearic Islands: Law 4/2015, of 23 March, on the rights and guarantees of the person in the dying process.
   Canary Islands: Law 1/2015, of 9 February, on the rights and guarantees of the dignity of the person before the final process of their life.
   Madrid: Law 4/2017, of 9 March, on the guarantees and rights of people in the dying process.
2. Act 41/2002 of 14 November, which regulates patient autonomy and rights and obligations regarding information and clinical documentation (Official State Gazette of 15-11-2002)

2. Each health service will regulate the appropriate procedure so that, if necessary, compliance with the prior instructions of each person is guaranteed, which must always be in writing.

3. Prior instructions that are contrary to the legal system, to the "lexartis", or those that do not correspond to the factual assumption that the interested party has foreseen at the time of issuing them, will not be applied. The patient's medical records will contain a reasoned record of the annotations related to these provisions.

4. Prior instructions may be freely revoked at any time and this must be recorded in writing.

5. In order to ensure the effectiveness throughout the national territory of the prior instructions expressed by patients and formalised in accordance with the provisions of the legislation of the respective autonomous communities, a National Register of prior instructions will be created in the Ministry of Health and Consumption, which will be governed by the rules that are determined by regulation, after agreement of the Interterritorial Council of the National Health System.

4. Conclusions

Considering that 84% of Spanish people agree with being able to decide on when and how they want to die[3], it appears that the legislative initiative that is being processed in the Congress of Deputies should result in an amendment of the Criminal Code and make Spain another member of the small number of countries that do not consider therapeutic suicide or euthanasia a crime. Until that time comes, both relatives and healthcare professionals should think carefully about their actions so as not to commit a crime with significant consequences.

Both euthanasia and assisted suicide continue to be considered a crime in Spain, with the rest of the possibilities still in a somewhat confusing state, as there is no clear regulation that grants legal certainty for patients and healthcare professionals.

The variety of regulations that have been implemented in Spanish Regions does nothing to enhance this legal certainty.

3. http://metroscopia.org/muerte-digna/

In any case, pending significant regulatory developments, it seems entirely appropriate to promote among civil society the idea that a living will is an adequate tool for individual rights to be respected at the end of life.

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