EUTHANASIA AND PHYSICIAN-ASSISTED SUICIDE BETWEEN SANCTITY OF LIFE AND AUTONOMY

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Abstract: The aim of this article is to present arguments which are used by parties in the dispute concerning legalization of euthanasia and assisted suicide - from the point of view of neutral observer. It is important to emphasize, that the discussion on admissibility of shortening the life, has not concerned terminal illnesses only for long time now. The dispute concerning legalization of euthanasia and assisted suicide is strongly connected with two basic arguments: sanctity (inviolability) of life and individual autonomy. An absolute use of primacy of one of the points causes exclusion of the other, e.g. the prohibition of death acceleration based on protection of life excludes autonomy. When any of the principle is settled as absolute, it may lead to extreme situations, e.g. lack of reduction of use of medical technologies from one hand or causing the death on request not only in circumstances of incurable or deadly illnesses, e.g. with tiredness of life. The dispute itself about the admissibility of euthanasia and assisted suicide is still unresolved. However, the changes in society and legislation will be influenced by used arguments, as the contentions are resulting from the area of knowledge and morality of physicians, patients, their families, lawyers and decision- makers.

Key words: euthanasia, assisted suicide, sanctity of life, individual autonomy, ethical dilemma

The purpose of the present article is the presentation of two key arguments which are applied in the dispute over the legalisation of euthanasia and physician-assisted suicide, namely: the sanctity of life and the patient's autonomy.

At current development of medical technologies, to define euthanasia and physician-assisted suicide is rather problematic. Defining euthanasia and physician-assisted suicide as precipitation of death of a patient suffering from an incurable or terminal disease may turn out to be insufficient. The discussion on the admissibility of shortening of human life has long ceased to apply only to terminal diseases. The problem is broader and it applies to persons whose lives are prolonged by means of advanced technologies used in medicine. The boundary between a natural death and a death triggered by external factors is getting blurred. Supporters of legalisation of euthanasia and physician-assisted suicide argue that in fact in many countries the passive euthanasia is allowed in form of withholding a therapy or withdrawing of a therapy especially in a situation when a patient expressed such a wish (Stelmach, Brożek, Soniewicka, Załuski 2010: 195, 202)[1]. On the other hand, it is emphasized that there is a fundamental difference between withholding treatment or withdrawing from treatment on a patient's request and the active cooperation of a third party in inflicting a patient's death on his request

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[1] It is worth noting that the Pontifical Council „Cor Unum" in a document entitled Some Ethical Questions Relating to the Gravely Ill and the Dying of 27.06.1981 highlights the lack of precision of the "euthanasia" term and it suggests to abandon the distinction between the active and passive euthanasia, as these are ambiguous terms and unnecessary in relation to the progress of modern medicine. The text is available on the website: http://www.academiavita.org/_pdf/magisterium/councils/pontifical_council_cor_unum/fatally_ill_and_dying.pdf (access on 20.04.2015).

(Malczewski 2012: 148) There are still other cases which give rise to a controversy, as the withholding the supply of fluids and beverages by artificial feeding, lethal analgesia or terminal sedation.

Determining the border between the causing of death and the palliative care, the withdrawing from or withholding the life sustaining treatment - is extremely difficult.

If we consider all these aforementioned procedures as euthanasia we may encounter serious problems, associated, for example, with administering the analgetic drugs to patients in the last stages of cancers, cessation of further resuscitation or other painful treatment or a medical futility, even despite the protests of the patient. Determining the difference and finding the boundaries between the above mentioned situations and euthanasia and physician-assisted suicide is a serious problem in the discussion.

Another issue is the justification for separation of the euthanasia from the physician-assisted suicide. According to proponents of the distinction the physician-assisted suicide should be legalized as an alternative to euthanasia, as the final act is made by the patient and it releases other persons from the responsibility. Opponents of the separation between the two concepts, who are in favour of legalizing the death on request, claim that it is a kind of discrimination against patients who are unable to commit suicide (eg. to take pills, or to disable the button on the apparatus). Those against the legalization of death on request in turn claim that there is no difference between the physician-assisted suicide and euthanasia and both procedures, as a kind of murder, should be prohibited.

Euthanasia was legalized in European countries such as the Netherlands in 2002, Belgium in 2002 (Pakes 2005) and Luxembourg in 2008[2] while the physician-assisted suicide (with the simultaneous prohibition of euthanasia) was legalized in the states of Oregon in 1997[3], Washington in 2009[4], Vermont in 2013[5], decriminalized in Montana (judgment of the Supreme Court of the Montana state of 2010)[6], and likewise in the New Mexico state[7]. In 2006 the Swiss Supreme Court issued a decision which specifies the conditions of admissibility of the physician's assistance in the patient's suicide. A physician may prescribe a recipe for lethal drugs if the following conditions are met: the patient's life comes to an end, the alternative measures were considered, the patient is competent, his request is well thought out and free of outside pressure or insistence (Delbeke 2011: 155). In 2015 the

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[2] The text of the Luxembourg Act of law is contained on the website: http://www.legilux.public.lu/leg/a/archives/2009/0046/a046.pdf#page=7 (access on 20.04.2015).

[3] *The Oregon Death Dignity Act*, text available on the website: http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ors.aspx (access on20.04.2015).

[4] *The Washington Death with Dignity Act*, text available on the website: http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct.aspx (access on 20.04.2015)

[5] *No 39. An Act Relating to Patient Choice and Control at End of Life*, text available on the website: http://www.vtethicsnetwork.org/downloads/ACT039-Patient-Choice-At-EOL-Law.pdf (access on 20.04.2015).

[6] *Baxter v. Montana*, text of the judgment available on the American Bar Association service website: http://www.americanbar.org/content/dam/aba/migrated/aging/PublicDocuments/baxtr_v_mont_sum.authcheckdam.pdf (access on 20.04.2015).

[7] The state of works on the physician-assisted suicide in particular states of the USA available on the website: http://www.deathwithdignity.org/advocates/national (access on 20.04.2015).

Supreme Court of Canada has opened the legal possibility of the physcician-assisted suicide. The relevant provision of law shall be decided [enforced] by the Parliament in the beginning of 2016.

The most important and the oldest argument used by the opponents of the legalization of shortening the patient's life is the argument of the sanctity of life in religious and secular versions.

The assumption of this argument in the religious version is the immorality of killing. In the case of revealed religions. ie. Judaism, Christianity and Islam, life is a gift from God. Therefore, one cannot have it freely at will. A particular obligation is to nurture this gift. A strong emphasis is also laid on the prohibition on taking one's life also through a suicide, a physician-assisted suicide and euthanasia. Even in the case of suffering associated with an incurable disease one must not request terminating one's life, one must not, either, assist in precipitating somebody else's death, even being guided by the intention to interrupt the suffering and by the compassion for a sick person. By destroying human life a man is opposed to the principles established by God, arbitrarily deciding on the moral order (John Paul II 1995: 39-40, Dorff 2005: 862, Markwell 2005: 1132, Puchalski, O' Donnell 2005:116, Sachedina 2005: 774). In theology there are no detailed rules for implementation of modern discoveries in biological and medical sciences (there are no explicit mentions in the Bible and in the Koran of euthanasia and a physician-assisted suicide) therefore it is necessary to refer to philosophy. Since the dispute at this point is not so much of a religious character as rather anthropological one (Chyrowicz 2015: 63,196,207). What is meant here is a specific concept of humanity, not only the ideological dispute, concerning the outlook on life (Chyrowicz 2015: 209), what is more, the religious beliefs and convictions should not be refused rationality but they are binding only on the followers of a particular religion and may not be imposed on others (Chyrowicz 2015: 208).

Another version of the argument about the sanctity of life[8] is the argument from natural law. It does not assume the existence of God as the foundation of the moral norms. Their sources should be sought in the nature of man, his conscience or practical reason. It takes the assumption of the inherent value of life, therefore it should be protected. While the Revelation is for non-believers an abstraction, the "do not kill" norm contained in the Ten Commandments is not such an abstraction at all. It may have a religious reference, but does not have to, it is also justified by reasons of philosophical nature (Chyrowicz 2015: 197, 210-211, 346). One should bear in mind that this norm is defended both by national and international legal systems.

This assumption is universal, the sanctity of one's own life and of that of other persons is of fundamental nature, therefore an incurable disease and the suffering involved are not circumstances which can justify the precipitation of death. The principle of the sanctity of life is one of the fundamental principles of the functioning of society, and regardless of religious premises the killing of a man is evil. The departure from this principle would mean a reduction of respect for life, one must

[8] The "sanctity of life" term has got not only religious reference, it is also used to emphasize the particular value that life has.

not make an exception to this rule, legalizing euthanasia and physician-assisted suicide. Allowing for the shortening of the sick persons' lives, even at their request would be a dangerous balancing on the edge of morality (Alichniewicz 2007: 106-108, Chyrowicz 2005: 7). Everyone has the right to protection against making attempts on his life (Keown 2002: 41.45). One of the human rights considered as fundamental stipulates that an innocent person must not be killed, injured or mutilated. The above assumption justifies the prohibition of abortion, euthanasia or killing of hostages (George 2010: 12). The principle of the inviolability of life is justified not only on religious grounds, therefore it can be used in a secularized society. Universality of this principle can become the basis for the binding norms of statutory law, without risking the accusation or objection that the adopted solution will reflect the viewpoints of only a certain social group, church or religious association [union] (Chyrowicz 2015: 67). The principle of the sanctity of life is universal, in all cultures it is recognized that taking the life of another human being is evil, regardless of religious premises (Paterson 2008: 3-4).

Each person intuitively seeks to protect one's own existence. It is worth noting that the right to life is not something abstract, so the attempt on the life does not affect the abstract, but the reality (Hervada 2011: 94).

Suicides are saved and provided with help, rather than assisted or facilitated in parting with their lives (Alichniewicz 2007: 107, -108). A very important task of the law is to protect the weak and vulnerable individuals, and the crippled, disabled, incurably or terminally ill must be undoubtedly considered as such persons. Human life is basic good, the respect for life does not mean naive vitalism (Paterson 2008: 65,73, Keown 2002: 231). Everyone has the right not to be killed, regardless of mental impairment or disability, old age, clumsiness or awkwardness (Keown 2002: The cornerstone of the state should be the good of a human being, not just the preferences of the society majority (Paterson 2008: 165, -167). Otherwise there is a risk of moral scepticism and relativism, and from this point the abuse is readily available. The assumption of the sanctity of life is the point of departure for the intervention of the legislature in the form of the prohibition of shortening life, including in the form of euthanasia and the physician-assisted suicide. According to C. Paterson both euthanasia and the physician-assisted suicide mean the destruction of human life and its intrinsic value. The normative status of human life must have objectively conditioned source and should not result from convention or subjective opinions (Paterson 2008: 55, 83). If we give up these standards, and the justification of positive law will be only preferences of the majority, it may mean that certain groups of people that will not be able to defend themselves shall be vulnerable to abuse (Paterson 2008: 165, -167).

The problem is expanding the principle of the sanctity of life. Although such legal acts as the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights and the European Convention for the Protection of Human Rights and Fundamental Freedoms, contain provisions enabling to deduce the norm of human dignity and the right to life vested in each of us (Finnis 2001: 241, 250-252). The provisions contained in the aforementioned acts are the foundation

of human rights, but they are too general and cannot be applied to specific decisions in extreme situations associated with the disease and dying.

The objection in relation to the sanctity of life argument says that even if most of us would like to preserve one's existence, it does not mean that it is always so. The particular situation is the state of pain and suffering associated with the disease which can justify the repealing of the inviolability of life principle. If there is a pressure-free will of those who are sick, why not legalize the exception to the principle of the inviolability of life in form of euthanasia and the physician-assisted suicide?

Supporters of euthanasia and the physician-assisted suicide maintain that the argument of the autonomy of the individual is an expression of respect for a man and choices made by him. Everyone has the right to decide when his own life ceases to be valuable for him, especially in the case of sickness and suffering. The patient therefore has a right to euthanasia or physician-assisted suicide and it is not asking for pity or begging for mercy (Malczewski 2012: 142). The proponents of this argument state that the principle of autonomy can be just as important or even more important than the sanctity of life principle, and at the same time it is also a response to the medical paternalism. It should be noted that the self-determination of a sick person has never had earlier such great importance as it has now. It has become a value to which the whole therapeutic process is subordinated (Hornett 1998: 306). J. F. Beauchamp and T. L. Childress mention autonomy as one of the key principles of medical ethics, it is a reaction to the events that took place in the past, and they were, among other things, criminal experiments carried out on humans in concentration camps, or abnormalities in research on hepatitis and venereal diseases in the United States (Beauchamp, Childress 1996: 132, Chyrowicz 2015: 118). According to A. Jansen the principle of autonomy when settling the disputes in bioethics in a secularized society would gradually replace the principle of sanctity of life (Chyrowicz 2015: 118).

In fact, what is meant here is the scope of the "do not kill" norm. Supporters of euthanasia and the physician-assisted suicide do not maintain that one can get away with murder without any punishment. They assume, however that life is not always a value, one should consider situations related to illness, infirmity and what the person interested himself thinks of them at any given moment (Chyrowicz 2015: 208, 310-312). Euthanasia is regarded by supporters of legalizing this procedure as a special medical practice, which does not have to be evil, if one estimates what is best for the patient and he expresses a request to shorten his life. It is just the patient's request that would constitute his protection against abuse by other persons (de Haan 2007: 159, 161-163, 171). In support of their argument, the proponents of the euthanasia legalization cite the stories of terminally ill patients who struggled for their right to die. One of the patients, completely paralyzed 25-year-old Canadian Nancy B. wanted to be disconnected from the respirator supporting her alive. The court pointed out here to the conflict of two values: the social interest which is the protection of life and the patient's autonomy; however, since the patient was fully aware of the consequences of her decisions, the court allowed to

disconnect the respirator, treating it as the resignation from the therapy, and not the euthanasia (Morgan, Veith 2004: 115-117, 119-120, Dworkin 19928: 210). Another example is the case of a British citizen Dianne Pretty[9], who suffering from the last stage of the neurological disease wanted to get assisted in suicide which she was not able to commit by herself because she was completely paralyzed. Before the European Court of Human Rights Ms Pretty adduced the right to privacy under Article 8 of the European Convention for the Protection of Human Rights and Fundamental Freedoms, arguing that it implies the right to autonomy. The Court decided that a sane adult patient may refuse treatment, even if the proposed therapy prolongs life. The Court also held that the prohibition of the physician-assisted suicide in force in the United Kingdom is proportional to the protected interest which is the interest of the vulnerable individuals, and therefore particularly sensitive (Makarczyk 2003: 274)[10]. The Court did not give in this case the primacy to the autonomy principle.

One of the counterarguments in relation to the principle of autonomy is the bringing the freedom of the patient's decision into question as well as the form in which it is to be expressed. Is a person who feels the pain and suffering associated with the disease capable of making a rational decision? One must approach a patient's requests to speed up his death with extreme caution because they may be the result of pressures on the part of other persons, and the ability to make decisions may be impaired by medication taken or by depression. Supporters of the principle of autonomy argue that it is possible to construct such regulations by law, which will enable the patient to make decision(s) on a voluntary basis. But what if the diagnosis is wrong? After all, the patient is not a physician. What to do in a situation, when the patient asked for euthanasia as a person capable of making decisions, and then he lost this ability (eg. due to the loss of consciousness occurring at the nervous system damage, or dementia caused by medication)? It is not certain whether he would uphold his request (Stelmach, Brożek, Soniewicka, Załuski 2010:199, Hornett 1998: 306). How to assess the situation of patients who have never been able to express their decision, eg. because of mental retardation? Is it not in fact contrary to the principle of autonomy, as the ability to express [make] decision(s) by the patient will be evaluated by other persons, no longer relying on the principle of autonomy of the patient, but on the calculation what is best for him. Hence there are examples of famous cases, eg. those of Karen Quinlan, Nancy Cruzan, Tony Bland, Joe Fiori, persons who were in persistent vegetative state and

[9] They were not the only trials relating to the "right to die" settled by the European Court of Human Rights, because earlier, in 1994, based on factual circumstances as in the case of Diane Pretty and the advanced arguments there was lodged a complaint of [by] *Sampedro v.* Spain, which, however, was considered inadmissible due to formal reasons. In this case the complainant showed the non-compliance of the law binding in Spain with then ECHR, preventing the exclusion of liability of a doctor assisting a person [patient] not able to commit suicide in the suicide commitment. CEHR in the case filed by Sampedro against Spain, the complaint 25949/94 decision of 14.05.1995.

[10] CEHR judgment of 29.04.2002 in the case filed by *Pretty v. against the United Kingdom,* the complaint 2346/02.

therefore were not able to make decisions about their fate[11]. The premise of autonomy may turn out too weak.

Another objection weakening the autonomy argument is such that while the suicide commitment does not require the help of a third party, euthanasia or assisted suicide involve third party's participation, therefore we are dealing here with some form of homicide. If euthanasia and assisted suicide shall be legalized, a certain group of persons involved in those acts will be granted protection. At the same time it is exactly the respect for the principle of autonomy that was one of the arguments that was used for justifying the legalization of the physician-assisted suicide in some states of USA. Supporters of the legalization of the physician-assisted suicide emphasized that in this case the patient himself decides when and how his death shall take place, which is an expression of full autonomy; the patient may also at any time change his mind, the physician will only provide the necessary guidance and resources to shorten life and shall not be involved in the final act. The patient has not a possibility of full taking decisions in the case of euthanasia, which s a medical act, which is decided by the patient's attending doctor. It is just this difference between euthanasia and assisted suicide that is the reason that the first of these procedures is prohibited and the other allowed.

One must also bear in mind that the precipitation of death in the case of terminal and incurable disease ceases to be a private matter and becomes a part of the social system. Assistance in suicide or carrying out the euthanasia is no longer an act of individual self-determination, but it requires making a common decision, of at least the doctor and the patient. In this case, the physician has got a greater decision-making power because he prescribes a recipe for pharmacological agents intended for taking the patient's life, or he makes the lethal injection. 32). On the other hand, the patient's requests puts a physician, who is committed to saving human life, in a rather difficult situation which involves breaking the prohibition of killing. The patient became a client who wishes the shortening of his life on the basis of the experienced suffering (Callahan 1993: 175-176, 179).

In the countries that have legalized the physician-assisted suicide and euthanasia, the legitimacy of the patient's decision who desires to exercise his right to die is verified and evaluated by the committee appointed for this purpose or by consultants. This collides with the principle of the patient's autonomy (Salem 1999: 33). Similar situation occurs when the matter is resolved by the court, as in the cases of Nancy B. and Diane Pretty.

Opponents of euthanasia legalization put forward a doubt why it would be just the principle of autonomy to replace the principle of the sanctity of life or to take priority over the latter? The absolute primacy of autonomy could lead to a situation where for the execution of euthanasia it will only be necessary to have the patient's request to precipitate his death, as in the case of the Dutch Senator

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[11] These cases are often cited in the relevant literature and the following works [articles] can be given as examples: P. Singer, *Rethinking Life and Death: The Collapse of Our Traditional Ethics*, St. Martins Griffin 1996, G. Tulloch, *Euthanasia- Choice and Death,* Edinburgh University Press 2006, M. Szeroczyńska, *Eutanazja i wspomagane samobójstwo na świecie*, Universitas 2004.

Edward Brogersmy who justified his request only with being tired of life and received the help from psychiatrist, doctor Chabot. The fatigue of life has become a new kind of suffering. (117, 119-120).

Moreover, one should bear in mind that in situations associated with the disease, it is the patient who is the weaker party, and therefore exposed to a risk of abuse by other persons (Gomez 1993: 162). Is it possible to refer to autonomy, in order to abolish the prohibition of euthanasia in situation where medicine can no longer offer help? Those premises are, however, too weak, since the legalization of euthanasia adopted on their basis would put the seriously and terminally ill persons in a situation where they would have to justify their existence. Therefore one may not consider the autonomy in terms of its having an absolute value and an advantage over other values (Safjan 2003: 254-255, 262), especially that the risk of abuse of patients is too high, whereas those to whom it is impossible to provide medical help constitute a very narrow margin of all cases (Callahan 1993: 181). The legalization of euthanasia can lead to the compelling of the patients to die earlier, it is in contradiction with the subjectivity of human being and of the uniqueness of life (Bołoz 2007: 218). The principle of the sanctity of life determines the possession of any other rights and freedoms, including autonomy. One should bear in mind that we are not dealing here with ordinary choice but the one between existence and non-existence, ie. the state not experienced earlier by us (Chyrowicz 2015: 326).

The primacy of autonomy not only enables a patient to renounce his right to life but also it allows to deprive a sick person of that right. This may cause that the fundamental right to life shall become relative. Euthanasia and physician-assisted suicide are irreversible acts, and thus they destroy the capability of self-determination. The principle of the individual's autonomy itself does not provide any justification for precipitating death in form of euthanasia or the physician-assisted suicide. In the European jurisprudence, there is a reluctance to sanction the choice of death prior to life. Courts substantiate this with a public interest, which is to protect human life, ranking this interest higher than the private interest of the patient, thereby giving priority to the principle of the inviolability of life (Hormon, Sethi 2011: 368).

Supporters of legalization of euthanasia emphasize that one should be allowed to have an individual choice of the moment of ending one's life and this problem should be treated as a private matter between the patient an the physician and the interference of the state in this sphere should be kept to the minimum (Tulloch 2006: 45, Paterson 2008: 26). In a free society citizens themselves decide on their fate, the MPs or official do not do it for them. According to R. Dworkin a desire for a quick and peaceful death does not mean the rejection of the sanctity of life. Death may be the expression of greater respect for life than its unconditional protection. In certain situations people may not benefit from keeping them alive, and the prohibition of euthanasia can be hurtful to many persons (Dworkin 1993: 238, 198). Therefore, death does not always mean harm to the patient (G. Dworkin 2003: 213, -214). The right to death, in the opinion of euthanasia supporters is one of the greatest values (Beauchamp 2006: 643). Voluntary euthanasia and the physician-assisted suicide may be

justified in some circumstances, what is important is the balance of profits and losses, especially if the patient is experiencing pain that cannot be appeased; of course, such a person may be offered the hospice care and palliative therapy, but the final decision should be made by the patient anyway (Chyrowicz 2015: 214, -215).

For opponents of the legalisation of euthanasia and physician-assisted suicide, what is important here is the respect for another person, regardless of his/her status, and it should be a fundamental value in extreme situations between life and death (Barilan, Weitraub 2001: 18, -19). The autonomy of the individual is undoubtedly important as the ability to make decisions, but it is only one of the values, and even not the most important one, and certainly not ultimate, therefore it may not be used as a justification for the precipitation of death (Callahan 1984: 42).

The argument of the autonomy of the individual is one of the most important arguments used in bioethical discourse. None of the parties to the dispute provides sufficient justification for the primacy of one of the opposing principles over the other. It should be noted that this argument is not merely personal to the individual but it also has a social dimension, because decisions made by particular persons are not without an impact on the society and on changes occurring therein.

The argument of autonomy is not only used for debunking or weakening of the sanctity of life argument, both these arguments do not have to be mutually exclusive. Without respect for patient's choices resulting from autonomy, there would not exist the present doctor-patient relation, in which the patient becomes a partner in the therapeutic process. In the dispute relating to the early termination of life in the form of euthanasia and the physician-assisted suicide, the question remains still open which of the principles in question, namely the sanctity of life or autonomy has to be limited in relation to the other one.

The parties involved in the discussion point out that considering of life as fundamental good, and therefore subject to special protection is also valid in cases of disability or incurable and terminal disease. It does remain a fundamental value, but not the most important one, its protection does not mean vitalism in form of recognizing the biological duration as a value in itself ["per se"] and this duration would be extended in all conditions and saved (Chyrowicz 2015: 280, -281). Not always must the patient benefit from all available solutions and resist death at all costs. The patient can resign from treatment even if it is not completely in vain, one may not require heroism from anyone (Chyrowicz 2015: 312, 340-341). Sanctity of life is also the starting point for searching for solutions in the care of particularly vulnerable members of the community, who are helpless and defenceless. It is very easy to cause abusing persons, especially those unable to defend themselves, by questioning the equal value of every human life. Our attitude to the seriously ill and disabled persons is a measure of our humanity. Besides, for carrying out the assisted suicide and euthanasia the involvement of other persons is required, such as: doctors, nurses, family or friends.

One should bear in mind, that by adopting certain legal solutions, in this case permitting euthanasia and assisted suicide, they are the result of consensus adopted by the parliamentary majority

and they constitute the outcome of moral convictions of both parties to the dispute (Stelmach, Brożek, Soniewicka, Załuski 2010: 23), they may form some type of catalyst in bioethics. In the secularized world the law becomes a determinant of conduct, and at the same time one should remember that it is the result of values believed by the decision-makers. In the event of the dispute about euthanasia and assisted suicide, which seems to be insoluble, the most important thing is what we shall accept as the measure of humanity, assuming that it is a value.

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