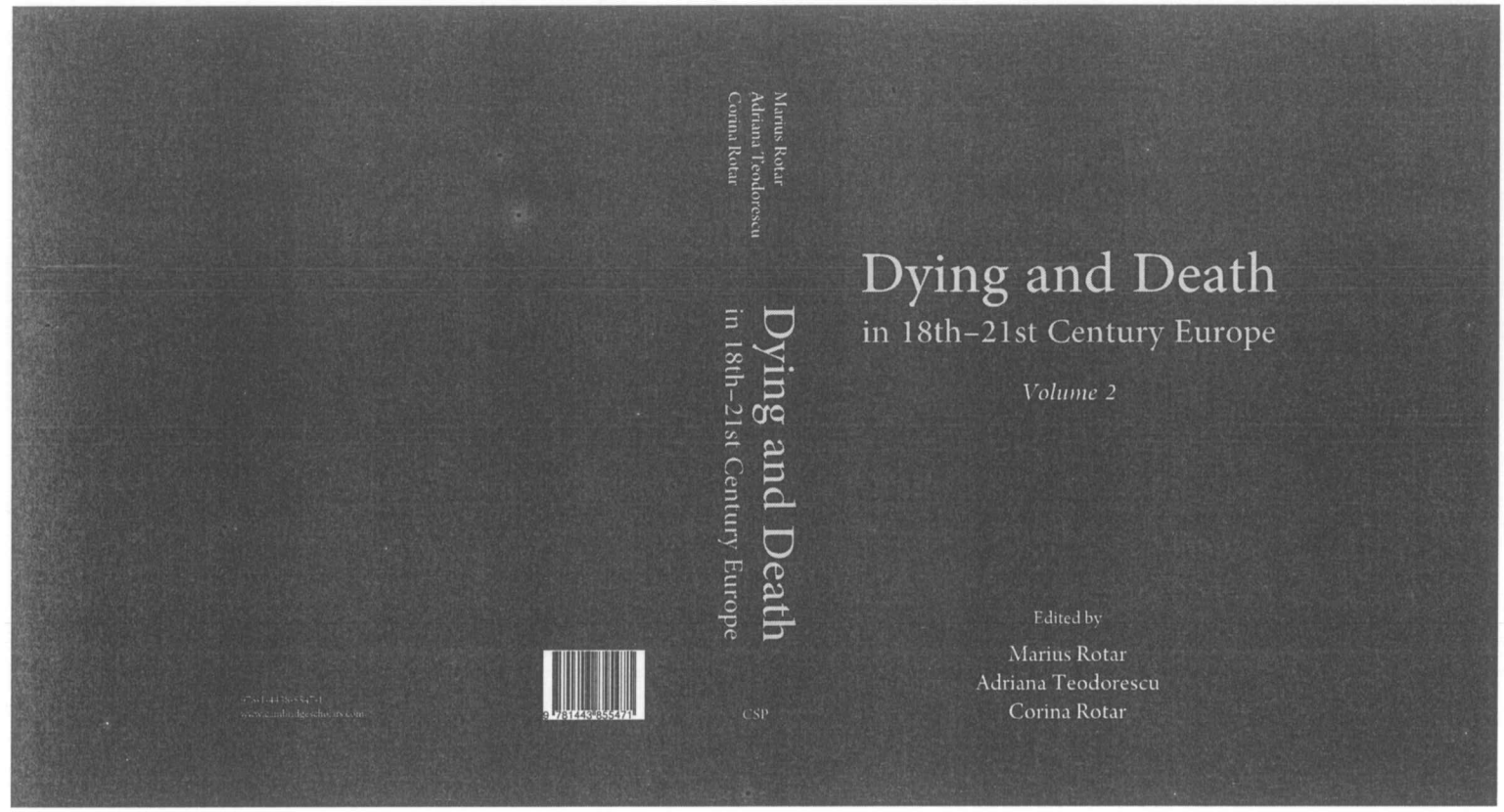

Dying and Death

in 18th–21st Century Europe

Volume 2

Edited by

Marius Rotar

Adriana Teodorescu

Corina Rotar

Dying and Death in 18th-21st Century Europe

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Second Volume

Edited by

MARIUS ROTAR, ADRIANA TEODORESCU AND CORINA ROTAR

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movements in the past - the same carry the characteristics of the period known as "administrating the euthanasia", in which the differences have not yet been set between causing death by taking active action or leaving or letting someone to die (Veatch, 1977, p. 317). So, according to the *manner of its execution* we have a conceptual distinction of euthanasia as: "active euthanasia", or as Stephen Holland calls it "mercy killing" (Holland, 2003, pp. 85-102), which implies active participation in non-painful termination of the patient's life (when given a lethal substance) or acting in any other way by which the patient is being killed. In other words, the active euthanasia comprises an active act of causing death of a patient whose bodily functions could be maintained without assistance. The same is also defined as "active direct euthanasia" which means taking away someone's life by the actions of another person and it is the most controversial one and for those reasons the same is banned in most of the countries (it is used only in the Netherlands and Belgium) (Wachter, 1989, pp. 3316-3319).

But there is also an "active indirect (intermediary) euthanasia" ~~when~~ where the patient is given drugs ~~that~~ to reduce the pain (morphine) but also to shorten ~~the~~ his/her life (principle of double effect). In this case, the quality of life (pain reduction) is placed above the life itself (extension of life with pain) (Klajn-Tatić, 2005, p. 452). In this case, the physician's main objective is to relieve the patient of the pain, ~~and~~ not ~~his~~ of death, which is to come as a consequence of the drugs, where the justification of this type of euthanasia is that the patient's death is not the desired cause, i.e. it is an unwanted side effect from the therapy having the goal to reduce or relieve the pain. This actually creates a distinction between the deliberate death (in active direct euthanasia) and the unintentional death (in active indirect euthanasia), although, in general, active euthanasia always involves the participation of another person (not just the patient), who executes this action (McDougall & Gorman, 2008, p. 2). (This type of euthanasia is applied in Switzerland, the Netherlands, Luxembourg and Belgium).[2]

"Passive euthanasia" is termination of those remedial actions that maintain the life of the patient, i.e. those which sustain the vital functions of the body. In other words, passive euthanasia means leaving the person to die, executed by not applying the usual methods of treatment that exist in a given situation, so consequently death appears. But passive euthanasia is also when one omits the provision of life-sustaining assistance, non-resuscitation, i.e. when the continuation of the life of the patient is

[2] ~~Where e~~Euthanasia is treated as ~~an exclusion~~exclusion, while the right of life and its protection are considered as a rule.

interrupted (McDougall & Gorman, 2008, p. 2). This enables calm and natural death.

Passive euthanasia is carried out on a positive and negative level. On positive level, there are two effects. The first is the desired effect - effective mitigation or complete elimination of the pain, allowing death in accordance with human dignity. ~~While~~ On the other hand, the second effect is the undesirable effect, act which appears in spite of our efforts. In fact, this is accelerating the process of dying, i.e. shortening one's life.

On a negative level, passive euthanasia means cancelling the already started process of dying or non-applying the technical potential interventions or termination of the already initiated ones, if they have proven to be useless or if they only prolong the process of dying. This division opens the discussion of the distinction between terminating or not-providing a medical treatment, as well as the debate on whether there is a moral difference between killing and leaving someone to die (Holland, 2003, pp. 85-102), although the more prevalent view is that there are no evident differences in the ethical sense, i.e. the ultimate intention is identical and is consisted of killing the ill person (Rachels, 1975, pp. 78-80).

At the same time, passive euthanasia can be also called orthotanasia (ortho-useful) which means dignified death at the right time, without shortening the life or additional sufferings, and the same represents the midpoint between euthanasia and distanasia (bad death = dys - wrongful act and thanatos-death) which means persisting on maximal application of all possible means to extend the life of a terminally ill person, without which the person could die i.e. excessive continuation of the agony, suffering and death of the patient just because the essential feature of the process is the request for artificial prolonging of life, striving as much as possible to slow down the natural course of dying.

Moreover, passive euthanasia can be considered as social euthanasia that exists when the old and terminally ill people are being prematurely discharged from hospital, decreasing the care for such patients to the minimum and thereby accelerating death (Davitkovski et al., 2009, p. 204). In both case, the motive is the sorrow and grief towards the human being which is suffering, considering that there are no chances for its curing or improving of its condition. Although there may be overlapping of the intentions, still euthanasia should be distinguished from the punishable act of "killing at request" (Rječnik Kaznenog prava, 2002, pp. 87-88). In this context, one should also mention the emergence of a form of inducing suicide known under the term of negative euthanasia, which is

manifested by leaving a large quantity of barbiturates next to the ill person.

There is also a third kind of euthanasia, and that is assisted suicide, which is providing the patient with the means to end ~~its~~ his/her life, but those means are not directly applied to the patient by the medical staff. It is a situation where the patient has drugs available which he/she may use to commit suicide. It is an act in which the physician performs all the previous preparatory actions, while the patient is the one who performs the final act of suicide. However:

> "assisting in suicide, as well as assisting in dying are identical with the helping as an accessory, and is consisted of facilitating the execution of suicide i.e. dying, providing an actual contribution to its realization" (Tupanchevski et al., 2012, pp. 100-101).

The same is a punishable act in most of the European countries (this type of euthanasia is permitted only in Switzerland, Belgium and the Netherlands).

On the other hand, depending *if there is consent from the patient* whose life is to be terminated, i.e. in accordance with the criteria for establishing the good for the individual, there is a voluntary and involuntary euthanasia (Beauchamp & Childress, 2001, pp. 102-103), and an unwanted euthanasia. Voluntary euthanasia exists in those cases where the patient's life is terminated with his/her explicit consent or at his/her explicit request, i.e. when the individual considers that his/her suffering is unbearable and wants to die or when the individual believes that his/her life does not fit him/her anymore, or soon will no longer fit according to his/her comprehension of dignity, hence requesting to be killed.

Involuntary euthanasia is when the person whose life is to end had no opportunity to state his/her opinion of the way in which he/she wants to be treated in case of terminal illness or near death. These are individuals without legal capacity, infants or a person in a coma. In this case, the decision for euthanasia is made by another person on behalf of the one who is not able to give consent for such decision.

Unwanted or forced euthanasia, which is imposed and carried out in order to end someone's unnecessary suffering, even though the same person had previously declared that it does not want to be subject of such procedure (Singer, 1989, p. 129).

This definition line-up can go on indefinitely, which only confirms the fact that the basis of the approaches, i.e. criteria by which the phenomenon of euthanasia is being defined, has deep roots going back to the earliest stages of especially the western civilization.

History of euthanasia

Throughout history, euthanasia ~~was~~ has been present in different social environments, which raises the question whether all can be called euthanasia. This in turn complicates the process of determining when and how the human being came up with the thought of euthanasia. However in the old and primitive societies, there are many examples and actions similar to euthanasia, in which the motive of mercy and grace was practiced in accordance with the religious aspects of termination of one's life, starting from a number of tribes in Paraguay, where the male offspring had a special duty and affection to kill the parents, who according to the beliefs and the created awareness, had no prospects for treatment and recovery. These are also the examples of Hottentots where the tradition was to stop giving food to their closest ones. In Malaysia, the sick, frail and the elderly were buried alive (Pazzini, 1951, p. 174). Also, the Vikings considered that only those who will die as a result of a violent death can go to heaven or Valhalla, where the greatest honor was to die in a battle, while suicide was the second best alternative. Furthermore, according to some records, the primitive Britons had a special "dedicated hammer" which was used to smash the heads of those terminally ill or to those ~~with~~ undergoing a lengthy process of dying (Popović, 1938, p. 178), while the old Prussians killed their old parents at their explicit request (Milovanović, 1976, p. 1952). Also, the Island of Sumatra has witnessed some practices according to which:

> "~~when~~When a man grows old, he climbs on a tree, and the relatives begin to envision, to shake the tree and speak: 'The season is upon us and the fruit matured, now it has to fall down!' At that moment, the old person would climb down from the tree and then the relatives would begin beating him to death and then eat him" (Pozaić, 1985, p. 11).

In Polynesia, even today, there are still some primitive tribes that intentionally deprive helpless old people from their life, especially women (Šercer, 1967, p. 481), while the Eskimos even today leave the ill, old and weak, to die alone in the snow.

In ancient times, however, euthanasia, viewed from the perspective of physicians, was unacceptable according to the Hippocratic oath, involving serene, painless and peaceful death, which never involved taking any actions that would shorten the life of the patient (according to the Hippocratic oath), but on the contrary, acting in order to make death as bearable as possible, painless and peaceful. But in this period Plato's standpoint should also be emphasized, expressed in "The State", which

represents a type of passive euthanasia – it is better to handover the terminally ill to death rather than to unnecessarily continue their sufferings, thus creating material damage to the community. In this context, the ancient Greeks carried out eugenics, i.e. exposing the underdeveloped children or children suffering from malformation to death, while one of the earliest examples of euthanasia from this period is the practice of leaving the premature infants and newborns suffering from malformation on the hill of Tajget, in ancient Sparta.

However, the concept of euthanasia in reference to the practical meaning in terms of commitment for active euthanasia was born in ancient Rome in the speeches of Seneca on the pestilence of freak children, as well as in the efforts of Cicero, citing the Law of the XII plates (Šercer, 1967, p. 482). But at the same time, ancient Rome witnessed another form of euthanasia, expressed through the attitude of the healthy human being towards death, which meant bravely standing and facing death or annihilation without help from others (Novaković, 1990, p. 194).

The Old and The New Testament as well as Early Christianity, have no knowledge on the issue of euthanasia. This is especially emphasized because:

> "these issues to a certain extent find a close religious base, in a sense that religious beliefs in relation to the issue of suicide had great influence on the formation of attitudes toward euthanasia as mercy killing, hence the general negative attitude for disapproval of suicide also fully referred to the problem of euthanasia" (Tupanchevski et al., 2012, p. 100).

In this context, the position and the attitude of today, in this regard, was best expressed by Thomas Aquinas, who said that suicide is contrary to the love for thyself and contrary to the community and God's power over human life. This indicates that later on, during the entire period of the Mid Christian Century, euthanasia remained unknown.

The next period of human history testifies that cultural currents during the Renaissance period were focused on the art of dying, which indicates to the fact that there are number of examples in which euthanasia is mentioned, but in the context of debates about it, ~~and there are not examples~~ of its practice. Thomas More in 1516 in his book "Utopia", advised that if the patient is terminally ill or is exposed to degradation of the humanity ~~within him~~, it's for the best if the doctor terminates such a life (Schepens, 2000, pp. 63-85). In his utopian vision, ~~the same~~More imagined a community that will ease the death of those to whom life is a burden because of the tormenting and long-term pain. Much more direct approach is presented by Martin Luther in his Tischreden from 1530's,

where speaking of the children with malformation states that: "if I were a prince or God, I would have thrown such children into the river Moldava ... under the risk of committing murder" (Schepens, 2000, pp. 63-85).

Francis Bacon gives the first far more precise terminological definition of the euthanasia in his book "Novum organum" dated 1620, stating that physicians should pay more attention and use more skills to prolong or extend the life of a person, but also that physicians should be allowed the opportunity to ease or speed up death in those cases where death stands nearby and when any delay can cause the patient only suffering and pain. Somewhat later, in 1721, Montesquieu also publicly advocates the right of suicide for people who are overwhelmed by pain and torment.

During the 19th century, physicians generally refused to perform eased killing of the severely wounded patients, believing that their duty is to heal, and not to kill. But despite their disagreement, still, this was a time when euthanasia again caused a widespread debate in the world, and already in the 20th century, the world witnessed the rise of its promotion and legalization movement. Although illegally and partly in secret, the euthanasia bloomed in Nazi Germany during World War II. The idea of life that is not worth living, in order to provide life for the pure race (racial hygiene), served quite well to Hitler for the realization of his plans, so in 1939 Hitler signed a decree authorizing Bouhler and the physician Carl Friedrich Brand the possibility or the authority to issue permits to certain doctors ~~for~~ to kill~~ing~~ people that have been proclaimed as terminally ill. However, the goal of Hitler and of the Nazi movement did not stop only at terminating the life of those who are dying in suffering from an incurable disease (because that was not the actual purpose), but to find a way of killing those who were considered to be inferior, but would have lived for a longer period of time (Friedlander, 1997, p. 20). Namely, the German physicians thought that it would be better for some people to face their own death, rather than to continue to exist among the living, due to the lower quality of their life (Alexander, 1949, p. 49), applying the argument of the so-called "worthless life" (Lifton, 1986, p. 45).

His conception and the execution of such idea were partially assisted by the blindness of certain individuals, as well as the hibernated public opinion, including the cleverly designed brainwashing process using the means of communication. Apart from the eugenical actions which were considered as euphemistic, as well as the removal of hereditary evil and harmful features or malformation, there were other specific actions which were performed on the politically dangerous, racially unwanted and economically unusable individuals (sent to special institutions where gas was ejected from the showers). Besides the regime state apparatus, there

were doctors and psychiatrists who were participating in all these actions of eased killings, despite the Hippocratic principle: Do no harm!

But, the horrors executed under the veil of euthanasia, in the name of mercy and humanity, very soon fell into oblivion. After the war, a number of associations and movements appeared fighting for the right of merciful killing (Pozaić, 1985, p. 21), but the modern age was the time when euthanasia received the meaning of intentional murder, and as such has become a form of Eugenics, i.e. form of killing the patient who is in mortal agony in a state of unbearable pain and suffering or has a certain handicap due to which is considered useless to society. The so-called "eugenical euthanasia" which was executed by the Nazis in concentration camps during World War II, after this period became a paradigm of repugnance in terms of the violation of the fundamental human rights, in relation to the misuse of the medical science and depravation of the medical profession.[3] This awareness was present in the minds of people immediately after the Second World War or somewhat later, but the same gradually declined, so today we are facing a new set of pressures and demands for legalization of euthanasia, thus allowing the terminally ill patients the possibility of eased death, avoiding the agony of death, i.e. the unbearable pain and suffering.

Although some scholars see the process of euthanasia as care for the sick and not as a wish of a certain environment to stop taking care~~ing~~ for the sick, considering that euthanasia is a rational option for resolving the patient's unbearable pain after being proven that all medical procedures are unsuccessful (Quill, Lee, & Nunn, 2000, pp. 488-493), in today's modern society, which is a consumer based society of everyday pleasures, even though death is rarely mentioned, there is persistence on the issue of death being adhered and legitimized as right, the same as the right to live, where the new term "right to death" (Zečević et al., 2004, pp. 330-333) is introduced in the concept of euthanasia. This idea gained particular significance through the Movement ~~of~~ for the Right to Death, and this movement draws strength and viability from the conflict between individualism and collectivism, so in that reference, the place, the role and the importance of euthanasia is also determined. Namely,

> "while the ultimate collectivism overemphasizes the general interest at the expense of individualism, i.e. the human life enjoys a primary social value, hence the duty to preserve the health and maintenance of life at any cost,

[3] ~~It is about number of~~Approximately 275.000 people ~~which~~ under the term of euthanasia were killed in Nazi Germany, directly under the responsibility of Karl Friedrich Brand.

> while assisting in suicide and euthanasia are considered to be prohibited - the ultimate individualism respects the human will in absolute terms, and in accordance, advocates the right to death of every man, as well as the impunity for assisted suicide and euthanasia" (Tupanchevski et al., 2012, pp. 102-103).

The advocates of the right to death consider that this right is a human right as well as the right to life and they are requesting the same to be legalized. They see the reason for this in the protection of individuality and human dignity, in the protection of its physical and psychological degradation that inevitably comes from the lingering death. These are the exact reasons why one should accept the right of the terminally ill patients to an eased death. These advocates for the right to death also believe that it is the physician's duty not only to provide aid in healing, but also aid in dying.

Besides this fundament, the same movement draws its valid power from the field of Anglo-Saxon legal system and is associated with dramatic events in the health care system in United States of America, especially the case of Karen Anne Quinlan, which stirred the public with an ultimate finish – the enactment of the first Law on Right to Death in California dated 1977, which prescribed the possibility for the terminally ill individuals to make a decision for termination of the so-called "pointless therapy" and conditional extension of life.[4]

At the same time, despite the rejection by the UK Parliament of the petition dated 1936, endorsed by the supporters for legalization of euthanasia united in the Association of friends of euthanasia (Zečević et al., 2004, pp. 330-333) formed in 1935, still the European Convention of Human Rights makes a move foreword linking euthanasia with personal freedom, i.e. autonomy of the individual, all the way to the highest and ultimate form which is today found on the territory of United States of America where a number of associations advocate for the right to dignified death, relying on the idea of legalization of euthanasia, despite the fact that there are still differentiations in terms of this issue in the USA.[5]

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[4] Especially ~~it is~~ interesting is the case of Jack Kevorkian, the so-called Dr. Death, for which the ~~american film industry even made a movie~~American film industry even made a movie, ~~under the name~~titled "You don't know Jack", with Al Pacino in the main role.

[5] On a federal level, there is still ~~isn't~~ no unified view on the question of euthanasia.

Bioethical approach and aspects of the euthanasia

It seems that there is an insurmountable gap, irreconcilability between the two general attitudes and approaches, i.e. the religious and the philosophical, in terms of justification or non-justification of the euthanasia – the religious standpoint and the rational argument of the philosophy that relies on the rationality. That is because the issues of life and death throughout history have always been one of the basic questions which philosophy and religion tried to answer, although their arguments, especially on the issue of euthanasia, often overlap.

Death is one of the main subjects of all religions, ~~that~~ offering an explanation for the same, as well as rituals and ceremonies for remembering the deceased ones, but at the same time they also speak of death as a base for understanding the human life. When this is taken into account, it is not surprising that all religions have strongly expressed views in opposing euthanasia. This is especially visible within the four main religions which have one supreme God, challenging and prohibiting the euthanasia in accordance with their view that there is a contradiction in playing the role of God, who is the only one who has the right and power to give and take life away ("Euthanasia and physician assisted suicide"). In this context, when speaking about Western society and civilization, about Christianity, which throughout history has shaped the moral norms and thus proved to be the most relevant on the issue of euthanasia, is very strictly opposing the "mercy killing". This standpoint, through Catholicism, is clearly stated in the *Evangelium vitae* by John Paul II dated 1995, in which he states that: "Euthanasia is a violation of God's laws because it is a deliberate and morally unacceptable killing of a human being" ("Religion and euthanasia").

On the other hand, sometimes religious and philosophical views tend to overlap. One such example is the Thomas Aquinas philosophy of religion which significantly influenced the standpoint of the church on the issues of suicide and euthanasia, synthesizing the best philosophical knowledge and connecting them with the Christian beliefs, i.e. merging the elements of Plato, Aristotle, and even some elements of the Jewish and Islamic thought (Magee & Kinderslay, 1998, p. 80), making the best example of connection between the philosophy and religion in the Middle Ages. His approach to euthanasia is a straightforward combination of the philosophical thought about the duty and obligation that we have towards ourselves, which is first introduced by Socrates and later on used by Plato, with the religious belief in the duty and obligation we have towards God, expressed in the view that euthanasia is a wrongful act because it violates

the duty and obligation the person has towards himself and the natural inclination toward self-preservation, i.e. which endangers other people and threatens God's authority over life.

David Hume (1711-1776) made a significant shift to this mindset. He believed that a person has the right to end ~~their~~ his/her own life when it wishes to, trying to find sufficient arguments (Cavalier, 2001) for it. For Kant, suicide offends the moral responsibility, while the utilitarists dissect the question whether human happiness is to be increased or decreased if offered a quick and painless death to those who are dying in agony. It is clear that they have concluded that the only consequence of this action is to reduce the suffering and misery in the world and therefore euthanasia must be morally acceptable (Cavalier, 2001).

Certainly, there are many more examples that underpin the fact that through history, the philosophers guided by rationality, not by religious tradition, advocate euthanasia. Yet, it seems that the biggest shift forward in recent times has been made by the Australian philosopher and ethicist Peter Singer, bringing to light new arguments in favour of euthanasia.

Singer writes about euthanasia as a rationalist, utilitarist and atheist. In the midst of his views there are two ethical principles, i.e. the first, stating that unnecessary pain to any living being should not be imposed, and second, that self-awareness is a feature that determines the human being, which means that his arguments for euthanasia are related with the consent and the awareness. Thus, he cites four principles that can be used as sufficient arguments in favour of euthanasia:

1. self-conscious beings are afraid of death and their killing has a negative effect on the others;
2. a person who suffers great pain is not afraid of death by consent, but it is more afraid of the painful death that is to come;
3. the wish to live is a reason against life, because in the event of a terminal illness, the same turns into a wish to die, which is a good argument for euthanasia;
4. if death is autonomously chosen, then out of respect towards the autonomy, one should help ~~someone~~ another to commit suicide.

In essence, Singer justifies active euthanasia on the basis of the utilitaristic principles, but also his arguments are associated with Kant's theory of autonomy, in which the basic strength lies in the respect for the preferences or the autonomy and the pure rationality of the decision. This theory certainly poses some additional questions such as: where is the final line of the individual freedom, or where is the difference between the decision to take heroin and the decision to die. But still, the key differentiation is located in the standpoint that "despite the doctor's best

knowledge, the person is still suffering from an incurable, painful and stressful disease or disorder" (Singer, 2002, p. 200).

However, as in many theories and attempts to defend euthanasia, in the case of Peter Singer there are a number of reasons and objections as that of the Rev. Richard Harris, indicating that one needs to take into account the fact that autonomy may not be the most important human characteristic. Also there is the objection on the "slippery downhill", i.e. euthanasia could lead to genocide, as in the case of World War II and similar cases. To these reactions and objections, Singer responds by stating that there is very little historical evidence to suggest that the concessive attitude towards the killing of one category of people would lead to collapse of the limitations of killing other human beings (Singer, 2002, p. 222).

The review with the religious and philosophical arguments goes on forever, as the same with the principle and example of evidences for the (non)existence of God by Anselm of Canterbury. But one thing is certain, and that is the understanding that in the 21st century, the best approach in the reviewing of the complexity of this issue is the bioethical approach, because of its multidisciplinary and pluriperspectivity, i.e. because of the bioethical nature of the approach, which uses the patient's personal autonomy (Beauchamp & Childress, 2001, pp. 57-69) as a basic direction, on the grounds of the dignity of a human being[6].

Simultaneously, the same means a required need for stepping away from the medico-religious simplification which in a reductionistic and short-sighted way narrows down the problem to two basic standpoints: FOR or AGAINST. For these reasons, the bioethical approach seeks to perceive the issue of death and dying principally through three perspectives (Baccarini, 2002, p. 183):

1. the quality of life perspective, a standpoint according to which the fundamental essence in the moral debate is the crossroad on whether someone's life is worth living;
2. the perspective of the sanctity of life, according to which life is a gift, a unique one and it must not be subjected to any violence;
3. the liberal approach, according to which everyone has the right to determine the values which are to design the course of life and the end of life, individually.

The fact that this is necessary, these observations and analyzes, is shown by the reality that the modern man, at least the one in the developed world, usually lives with style and rhythm of life which completely

[6] ~~According to that and t~~The difference between biological death ~~from~~ and the death of a person, i.e. ~~that~~ the person and the human ~~creature~~ being are not equal entities~~y~~.

exclude death from the consciousness of the individual. Within such logic, the ruling principle is the idea that life should be lived as long as it's worth and the same should cease to be worth living at the point when the already established style and rhythm of life are no longer possible. For such a person, the seeming heavenly life suddenly or gradually turns into a real hell-life with not only unbearable, but unacceptable and meaningless pain, suffering, torment, and often swept by the feeling of abandonment by everyone, even the closest ones, and the loneliness, despite all the medical care. In such life events and dramas, an individual's life is worth living only within the qualities of the same, defined on the grounds of the criteria such as standard of living, purpose, happiness, mobility, non-painfulness, absence of suffering, etc. Once the individual's quality of life starts to deteriorate, especially when it comes to a process of dying with a relatively short death outcome, the individual wants to shorten that agonizing process by using euthanasia, requested for to outsmart and forever prevent the death agony.

By ~~that~~doing so, the quality of life becomes the keystone on the basis of which life is being respected. Notably, this approach argues that life itself is not a worthy aspect and it does not have intrinsic value, so one should investigate whether the individual's life has enough qualities which would provide him the value. According to the proponents of this ethics of quality of life, of which the most famous is Peter Singer, the only question refers to the way in which euthanasia is to be performed, i.e. whether the quickest way is also the best way (Kuhse, 1991, p. 298).

The previously stated indicates that euthanasia is above all associated specifically with the conscience of people who do not see any sense in accepting the last stages of life, more or less unbearable, with the same death outcome.[7] As James Kennedy explains, there is a "collective consensus" about what actually quality of life means. Namely, when a certain quality of life declines, it is unclear whether sufficient, i.e. exemplary care will be offered until death. Such care may be terminated prematurely, at an early stage, when considered that the patient is living a "meaningless life" or "is terribly suffering". In such cases, passive euthanasia and the double effect are those mechanisms that are used to stop the treatment.

Against such perception, on the basis of which awareness for the right to euthanasia according to the quality of life can be raised, there is a perception based on the foundations of the ethics of the sanctity of life,

[7] A very important factor in creating ~~of~~ such culture is the ~~exsistance~~existence of one organization which ~~in~~ at the moment ~~counts~~ has over 100.000 members - Society for Voluntary Euthanasia, <www.nvve.nl/news/>

suggesting that awareness for the right of euthanasia cannot be raised on the same ethics, because within its foundations lays the faith in the kingdom of God over life, and not the initial rational evidence, referring to the fact that God is the master of life and death. The historians of the western moral generally agree that Judaism and the rise of Christianity greatly contributed to the widely held standpoint that human life is sacred and that the same must not be deliberately terminated. To take away an innocent life, according to this tradition, means interfering in God's right to give and take away life. Influential Christian writers see this issue as a violation of natural law and this notion of absolute inviolability of an innocent human life exists unquestionably all the way until the 16th century when Thomas More published his "Utopia".

Today, although there is wide support for certain forms of euthanasia and an extensive number of contemporary philosophers prove that euthanasia is morally defensible, still the official religious opposition (for example, the Roman Catholic Church), remains unchanged. Against the legalization of euthanasia, in terms of the Christianity[8], a very precise statement was endorsed by the Catholic Holy Word on learning faith on May 5th, 1980 through the Declaration on Euthanasia, according to which: any act of euthanasia is to be condemned as a violation of God's law, violation of the dignity of human being, a crime against life and assassination of the human race. Moreover, on the relativistic features of the psycho-sociological fundaments which justify the application of euthanasia and its types and forms, the Pope John Paul II quite consistently speaks in his "Evangelium Vitae" about (John Paul II, 1995, p. 64):

- negativistic blindness for the transcendental;
- hedonistic refusal of the endurance;
- utilitarian obsession for efficiency;
- panic fear from the medical treatment;
- libertarian absolutization of the human as his own master.

As already mentioned above, the ethics of the sanctity of life most often is identified with the religious approaches (Battin, Rhodes, & Silvers, 1998, pp. 323-372). But this standpoint is also represented even without the religious background. Namely, if we neglect the particularly sophisticated philosophical proposals, there is an excuse or justification for the ethics of sanctity of life in the debate about euthanasia, which among others, is relating to the intuitive acceptability of the ban on killing and with the inability to connect the practice of euthanasia with the

[8] ~~Because~~ Considering that the Orthodox Christianity ~~urch~~ is ~~much~~ far more ~~close~~ distant for the public ~~that~~ than the Catholicism ~~Church~~.

principles of the medical profession, as well as with the normative force of the value of life (Reichlin, 2002, p. 156).

However, the approach of the ethics of sanctity of life, which argues that life is inviolable and that there is no justification for its deprival, although prohibits euthanasia, allows for a single way of accelerating death, i.e. when the patient's pain requires stronger and stronger means for its appeasement, than it is morally allowed to increase the dose of these means to the point of lethal dose. This attitude results from the theory of double effect, according to which sometimes certain procedures that have certain foreseen bad effect are allowed to be performed, but only if such effect is an unwanted concomitant occurrence (the second of the double effect), and not the effect to which aspired. In other words, the theory of double effect is applicable when (Baccarini, 2007, p. 35):

- the bad consequence is not desired (the doctor must not want to kill the patient, but only to ease his pain);
- the good consequence, which is desired to be achieved, is not a direct consequence of the bad consequence (easing the pain does not stem from the death of the individual);
- the procedure itself does not advocate condemnation (easing pain does not advocate condemnation);
- the good that is being achieved is proportional to the evil (the release of the terminally ill patient from the unbearable suffering is proportional to causing death).

The previous speaks that in general we are facing an obvious dilemma. Let us suppose there is a person who is suffering great pain and wants to die. Those who believe that life is intrinsically valuable, the deprivation of life or the undertaking of any action in relation to the deprivation of life of an individual is something reserved only for the nature, i.e. this type of decisions are not granted to human beings. However, this type of objection ignores the autonomy of the decision of the one who wants to die, with the justification that the only thing he/she does is merely living in pain. So, can life be intrinsically valuable, independent of the interests of the individual? Does the state have the right to impose its will over the will of the individual? This is the dilemma we face, the dilemma that the liberal approach is trying to resolve nowadays.

Under the same approach, the basic rule is the right of everyone to determine what the meaning of their life is. Hence, every individual has also the right to determine the death so that the last moment of his life would be in accordance with his entire lifestyle. This means that the person who struggled all of his life to be effective and successful, can seek

death at the moment when he is no longer able to meet the standards and values imposed by ~~himself~~him.

This clearly points out to the fact that under the liberal approach, everyone has the right to determine the values according to which the course and the end of life will be mapped, i.e. that everyone has the right of choice in accordance with their personal value system (Dworkin, 1993). The same derives from respecting the value of freedom and autonomy of each individual in choosing a good way of life, of from the assumption that respecting the right and freedom of the individual is the key borderline in the arrangement of a good and just society. Hence, the autonomy of the individual in all aspects of his life is not at all contrary to the social interest for creating a well-arranged community, just as the fears and accusations, according to which liberalism and individualism lead to abuse, irresponsibility and disregard of the values of life, are considered groundless.

In summary, the settings of the liberalism on the issue of euthanasia can be summarized through the following several points: 1. the right of choice as essential for liberal democracies; 2. economic reasons, i.e. hospital capacities, drugs and ~~doctors engagement~~workforce should be used for those patients whose lives can be saved, instead of continuing the life of those who want to die; 3. the quality of life reappears as a key argument in the liberal approach, because due to the disease, there is a change in the quality of life that leads to physical pain and suffering, as well as mental pain due to the loss of independence in the performance of life functions, hence requiring preservation of dignity in death; 4. the ban on legalization of euthanasia indeed means violation of Article 3 of the European Convention on Human Rights (prohibition of torture, inhuman or degrading treatment or punishment), i.e. when the patient is suffering unbearable pain, as well as Article 8 of that Convention (each person has the right of respect for private and family life), when the patient has explicit wish, a request for ending his life.

In any case, if imposing death to someone who does not want to die is considered a crime, according to the argumentation of the liberal approach, than imposing the will to live to someone who does not want to live is also a crime. It is an authoritarian procedure that is completely inappropriate for the free community and creates some form of discrimination in the freedom of choice, which rejects one of the biggest objections towards this approach on the issue of euthanasia - the creation of Eugenics of a Nazi type. Namely, the right to choose the method of arranging death in one free community is legitimate or at least a necessary evil. Even though, according to the critics of euthanasia, this causes indirect dire

consequences like creating Eugenics of a Nazi type, still, this is exaggerated, just because of the fact that the Nazi Eugenics at its beginning was a program of grim ideology, and not a final result of the previous understanding of euthanasia. In today's world, nobody even talks about a perception that doctors could reach to such level of crime (Glover, 1977).

Debate and arguments FOR and AGAINST euthanasia

Since the second half of the 20th century, there is a growing concern regarding the role of medicine in our lives. As technology progresses, and medical knowledge and expertise advances, the technological ability to sustain and prolong life improved tremendously. This advancement of technology evoked new ethical questions in reference to the end of life: Should the life of a patient be sustained no matter what, regardless of the wishes of the patient, regardless of the quality of life of the patient? Who should decide when the treatment is to be stopped? Is the patient the one to decide for his/her own life? What is the role of the autonomy, the self-determination and the informed consent in the decision-making process? What is the role of the physician?

These and other questions occupy the ~~thinking~~thoughts of philosophers, bioethicists, lawyers as well as of decision-makers: legislators, government officials, and judges. Although the general public in many democracies, including the United States (Carroll, 2006; Taylor, 2005), England (Ward & Carvel, 2007, p. 9), Australia (ERGO News List, discussion group on end-of-life, 2007), Canada (The Ottawa Citizen, 2001), and even Croatia (Groenhuijsen & Laanen, 2006)~~,~~ out of the Balkan countries, believe that life should not be prolonged at all costs, and that the law should satisfy the wishes of the patients at the end of their life, most countries in the world refrain from legislation on euthanasia and medically-assisted suicide.

The initial and decisive step, but as well as the attempt to answer these questions, at least on European soil[9], was made by the Netherlands, through the process of decriminalization of euthanasia, in a case dated 1971, when a doctor killed her terminally ill mother by injection. Already

[9] The Nederland is the first European country, and second in the world after Australia (North Australia, which even for a short period of time, ~~in~~ has legalized euthanasia in 1995 ~~legalize euthanasia when it bring~~with the enactment of the Bill ~~for rights~~of rights of terminal ill patients), which together with Belgium and Luxemburg has legalized euthanasia with the ~~Bill~~ Law for ~~shortening~~ deprivation ~~life~~from life ~~on~~ at request and assisting in suicide, enacted in 2001.

at the beginning of the 80' of the last century, public opinion surveys in the Netherlands showed that 75% of citizens are willing to accept a law that would permit doctors to terminate (out of mercy) the life of a terminally ill person at their own request (Gevers, 1996, pp. 26-33). Since January 2001, euthanasia is decriminalized in the Netherlands on the basis of the criteria of the Dutch Royal Medical Chamber which were defined in 1984 on what needs to be met for the application of euthanasia and its versions (Zurak, 2001, pp. 39-46):

- the request for euthanasia or assisted suicide must come from the patient, based on his or her free will;
- the patient must repeat the request after 7 days;
- the suffering of the patient should be unbearable, without any hope for possible improvement;
- the active termination of the life must be the last resort and should only be applied when no alternative solutions for the situation of the patient are at disposal;
- the physician must consult another independent colleague who must confirm that the situation of the patient is hopeless and is an unbearable nature of suffering, i.e. lack of alternatives;
- there must be a written notice (stating the diagnosis, prognosis, therapy, healing perspective, data from another independent medical practitioner, the request of the patient, as well as the way the life of the patient was terminated).

But despite this, the researches and numeric indicators from the application of euthanasia in the Netherlands show that in 1995, a total of 25,656 patients were killed by euthanasia or by any of the forms of euthanasia, which is 19% of the total annual number of deaths in that country. Among the reasons for such requests is the dominant feeling of loss of dignity, dependence on others, tiredness of life, while unbearable pain as the only reason to perform euthanasia is found only in 6% of the requests, which are typically three times higher than the number of performed euthanasia procedures (Gevers, 1996, pp. 26-33; Mass, Wal et al., 1996, pp. 699-705; Schepens, 2000, pp. 63-85). This means that the decision for using euthanasia for the terminally ill person does not stem from the biological area of unbearable pain, but the essence of the problem is of a psychological and social character.

This on the other hand, further fuels the debate on accepting or opposing the euthanasia, because the human component of the same cannot be compressed and create a belief within the public of the social viability of its application. This is why the following arguments are most

commonly cited when attempting to create a positive climate FOR euthanasia:

- *the right of choice for our own life and death*, which is essential for the liberal democracies;
- *it is humane to terminate the sufferings of a man "sentenced" to death*;
- *the quality of life*, due to the fact that the disease creates a change in the quality of life that leads to physical pain and suffering, as well as mental pain due to the loss of independence in the performance of life functions, hence preservation of dignity while dying is requested;
- *economic reasons*, i.e. hospital resources, pharmaceuticals and the ~~engagement~~ efforts of the physicians should be used for those patients whose lives can be saved, instead of continuing the life of those who want to die;
- *with the legalization of euthanasia, the various types of misuse, malpractice and gray areas of euthanasia will be avoided.*

...while the most commonly cited arguments AGAINST euthanasia are:

- *the question of the right and the scope of the same in relation to the physical integrity of every individual*;
- *the professional role of the physicians*, when performing their duties, are sworn to the Hippocratic Oath, which excludes euthanasia;
- *the relativity of the medical skill,* which is best reflected in the possibility of recovery and healing, particularly in the modern conditions of constant successful development of the medical science;
- *moral reasons* - the understanding of euthanasia as a murder, because the right to live is inviolable human right which cannot be violated under any circumstances, nor can be yielded by the holder of the right, especially in cases when the decision for consent has been given under the influence of heavy pain and torment (Pozaić, 1985, pp. 98-108);
- *the ability of people to freely express their will and give consent for euthanasia* i.e. the questionable capability for judgment of the patient who is in a state of impaired consciousness;
- *the consent of the patients for euthanasia* is most often reached under psychological and/or financial pressure;
- *the possible abuses from the decriminalization of euthanasia* known as "the pin argument" or "the slippery downhill argument" (Cavalier, 2001);
- *the legalization of euthanasia as diametrically opposed to the universal principle of supporting life...*

And while the debate is still underway and with increased intensity, especially when one of the strongest motives is introduced in the game, being socially and humanly accepted - the value of human dignity, i.e. while the battle is still on about the fact that the severe conditions of illness and dying are in an irreconcilable opposition to the human right to dignity in dying, the definition of Guenther Duerig is the one being generally accepted, according to which:

> "~~the~~The human dignity is violated if a person is diminished to a pure object, to a simple mean, to disposable quantity. Examples of the worst violations of human dignity are: torture, enslavement, mass exile, genocide, deprivation of the opportunity for equal access, forced labour, terror, mass killing, and abuse with experiments on people" (Schmoller, 2000, pp. 171-211).

This leads to the necessity in the bioethical considerations of euthanasia and the context in which the same is carried out, taking into account the considering of L. M. Martin (Martin, 2004, pp. 202-210) who sets the following parameters and aspects:

- *the final result of the act* - is supposed to be protection of the dignity of the individual through the elimination of suffering and pain. But there is a problem - from the standpoint of the codified medical ethics and from the standpoint of moral theology - when euthanasia is not only eliminating the pain, but is also the holder of the pain. Hence, when condemning euthanasia, one is not condemning the elimination of pain, nor the defence of the dignity of the patient or the one who is dying, but the part of the final result which ends with murder of the person, with the objective of killing his pain.

- *the intent or the motivation* – for an act to be characterized as euthanasia, it is very important that the intention originates from the patient, whereby the act of euthanasia is seen both sided: 1) real intention with a wrongful result (alleviating pain resulting in death), and 2) wrongful intention with a real result (killing the patient resulting in absence of pain). This indicates that the issue of intention is of great importance in the moral valuation of the procedure (Martin, 2004, pp. 202-210).

- *the nature or the character of the act and the circumstances* – the ambiguities that appear in relation to the nature of the act of euthanasia is a result precisely of the question whether euthanasia is exclusively a medical act. If in its definition, the final result (the removal of pain) and motivation (compassion) are considered as decisive factors, then this term can have a really wide connotation. If we add the third factor – the nature

of the act – and the act is defined to be of medical or therapeutic nature, then the term becomes clearly defined. In reference to the reality of bioethical pluralism, this appropriate conception of the medicine and the health care may help in the redimensioning of the conflict between the nature of the act and the circumstances in which euthanasia is performed.

- *the objectively perceived moral value* - which can be attached to the act of euthanasia in the ethical or legal guilt. Namely, in the Western legal tradition, medical deontology and moral theology, there is no doubt that euthanasia is objectively considered to be an evil act. But that however does not mean that these traditions would not uphold the subjective component in the individual act. The existing differences between crime and punishment in the law, as well as the sin and guilt in the moral theology, can help in specific cases in which a person performs what is considered objectively evil (according to the criteria of the legal and moral systems), while at the same time, the individual considers that it's the right thing to do because it is guided by proper and just intention. The act therefore remains to be a crime, but the person who committed the crime under certain circumstances is not punished, not because the euthanasia would not be an objectively evil act, but because there are other factors included in the creation of moral-legal-theological judgment.

Palliative medicine and care as an opposite response to the requests for euthanasia

Regardless of culture, civilization and time, dying is always difficult, regardless of the speed with which human life relentlessly rushes towards its end - death. Sometimes human life ends as a long-term process of dying in sickness, suffering, pain and agony, which inevitably and of great importance to the individual and the society, raises the question of the meaning, the way, and the living of this last stage of life. It is so because illness and death today, as always, are and will be an inevitable and integral part of human experience. The way in which we try to determine and respond to the unique and individual needs of those who are dying and their families while struggling with illness and the loss of a close one is actually an indicator of the maturity of one society in which medicine plays a great part.

Hence, there are several viewpoints in terms of the role and importance of euthanasia in the process of dying. In accordance with the possibilities of modern medicine, which by all means and costs can prolong life, for a certain number of authors this becomes meaningless, because it also means continuing the process of dying and suffering (Šeparović, 1990, pp.

297-307). Hence, it is considered that euthanasia is a way to helps the individual to be saved from suffering.

On the other hand, burdened with the forced identification of the achievements of the Western civilization, we have failed to separate the positivity from the negativity, and recklessly accept the consequential products of the modern society and spiritual alienation, as well as of the moral crisis. The impoverished emotional generational solidarity leads us to the loss of our individuality, faith in helping, empathy, support of our loved ones in moments of illness or declining age, in the destruction of the basic nucleus – the family and its values. Hence, according to the thesis of the opponents of euthanasia, the one complete and worthy solution related to the question of the sick ones and elderly is the hospice, where the palliative medicine is applied, i.e. the approach of the palliative care and treatment.

The hospice is also a philosophy of care but as well a modern health institution, with a number of levels of offering help to people who are at the very end of life, ~~while~~ through its caregivers, even after the death, during the mourning time. In the middle Ages, the term "hospice" was used to describe the place where the injured passengers and those who went on a pilgrimage were stationed. In Europe, the relation between hospice and the care offered to those who were dying, appears in 1842 (Clark, 2000, 50-55) and is associated with the name and work of Jeanne Garnier who founded *L'Association des Dames de Calaire* in Lyon, France, in 1842. It is a movement later on continued by the Irish Sisters of Charity with the opening of Our Lady's Hospice in Dublin in 1879, as well as with the opening of St. Joseph's Hospice in Hackney, London in 1905.

Regarding to the establishment of the first modern hospice, the same is associated with the name of Cicely Saunders, who opened the hospice St. Christopher in London in 1967, and has connected the compassion in the sufferings of the terminally ill and those who are dying, with the highest medical advances, creating the basis for the development of the hospice movement and palliative medicine, where the pillar is the autonomy of the personality of the ill patient who alone has the right to decide on where to die, to take the drugs or not, to adhere to the cultural customs and traditions or not and other.

For this type of activity (hospice), nowadays the term “palliative care” or “palliative medicine” prevails. The palliative medicine is a type of medicine that deals not only with the disease, but attends also to the moment of suffering, i.e. the patients. This type of medicine is able to understand that at a given moment, the priority is no longer the fight against the disease, but against the pain and sufferings, favouring the

natural process of end of life, i.e. trying to end the life in a less painful way. Hence, this type of medicine aims to control pain and suffering of those who are dying i.e. relieving the process of dying and death. This shows that palliative medicine is not used for monitoring the process of dying, but for recovery of the patient's remaining life capabilities. The centre of gravity of this type of medicine is focused on raising the quality of life before death, regardless of its length, which indicates that the main goal of palliative medicine is to emotionally and spiritually stabilize the physically and mentally affected patients, thus enabling their normal functioning and interaction with their family and the medical staff.

With the advancement of the pharmaceutical therapy in the second half of the 20th century, combined with the growing understanding of the psychosocial and spiritual needs of the dying patients, the development of the palliative care paved its way, which indicates the approach of improving the quality of life to the patients facing terminal illness and their families. This is considered to be an active, inclusive and complete care of the patients whose disease no longer responds to curative treatment, so consequently the attention is focused on control of the pain, the other symptoms, as well as on the psychological, social and spiritual problems as main ones (World Health Organization, 1990, p. 11). Therefore, palliative care includes all treatments that are designed to ease the suffering: psychological, mental and physical i.e. the same is done through prevention and relief of the symptoms with means of early detection, assessment and treatment of pain, as well as through the facilitation of other socio-psychological problems.

The term "palliative" comes from the Latin word pallium, which means a mask or a cape, and from an etymological standpoint, the palliative care indicates "masking the results of the incurable disease", or the "one that provides a cape, an overcoat for those left out in the cold", because they cannot be helped with curative medicine.

Given the fact that the palliative care is an active complete care of the patients whose disease no longer responds to treatment, this type of care includes the medical, ethical and social aspects, as well as the psychological help, because the main objective is better quality of life for the patient and its family. In this sense, the palliative care accepts death as a normal process, as the last stage in the life of a dying person, as a special time for integration and reconciliation, hence accepting the need of those who are dying to live completely, proudly and comfortably until they die, which means that this medicine neither accelerates nor postpones death, while providing support for the grieving family and friends (Jušić et al., 1995, pp. 1-3).

The previous indicates that on the issue of euthanasia, there is an alternative that exists today! Although there are attempts for legalization of the euthanasia, the best solution seems to be an ethical alternative - palliative medicine i.e. care that strives to be an integral part of every health system and an irreplaceable element of the right of the citizen to health care. This is undeniable due to the fact that the palliative medicine is trying to promote a culture of life at the end of it, and to connect the highest medical advances with the empathic care for the patient and its family, with emotional and spiritual support, which significantly reduces the demand for euthanasia that is already supposed to become unnecessary or redundant. Moreover, according to the proponents of this idea, it is so because the practice of euthanasia destroys the foundation of the value system, and thus the entire human community. Euthanasia, as act of violence over human life, regardless of the motive for it, is contrary to the human dignity. Dignity in dying, which is provided by the concept of hospice via the palliative care for those who are dying, and the emotional warmth which soothingly eases the pain and eradicates the burdens of dying, are the only human and humane solution at the end of life. The goal is for the person who is dying to not feel abandoned, undesired and worthless. The example of Mother Teresa speaks in favor of this (Kudo, 2006).

The hospice and its movement in the world are not considered as an alternative to euthanasia, but as some followers care to say, they are the only proper human care proceedings of care and treatment for those who are at the end of their life. As stated, it must not be allowed for the public to easily accept the fashion of euthanasia, but it must be ready to offer the right solution – hospice (Jušić, 1997, pp. 214-215)! This is confirmed furthermore with the fact that today's so-called justification of euthanasia for the proponents of the palliative care is neither ethical nor medical, but only social according to which the terminally ill are an excessive financial burden to the society.

Finally, the euthanasia is not a solution! The only ethical alternative to euthanasia is the palliative medicine which helps the terminally ill to enjoy the last moments of life with the help of the latest medical achievements, and most importantly, with sincere human compassion and love towards the close ones, where the human dignity is raised to a pedestal until the moment of death. In this context, as the pain becomes a significant factor in the decision of the patient to die, the palliative care should become an imperative.

Conclusion

Euthanasia, unfortunately or fortunately ~~alike~~, is still a punishable act in most of the countries in the world. But euthanasia is not just a legal issue, but above all a human and ethical issue. The same results from the lack of a single generally accepted standpoint on euthanasia, which in turn is quite understandable if we take into account the large number of cultural, civilizational and historical burdens, as well as the influence of the dominant philosophical, religious, ethical and moral beliefs related to the approach towards life and death, human dignity, the fundamental duties of a physician and medical deontology, the progress of medicine...

According to the prevailing trends, although the demand for legalization or decriminalization of euthanasia is ever growing, the counter-response to euthanasia expressed through the hospice is increasing as well, indicating that hospice is considered as more humane, retaining the reliability and authenticity of the human existence, while the euthanasia is treated as violence against human life that regardless of the motive, is non-compliable with the human dignity. That is why many insist on the palliative care as a counter-response, a counterweight for the increased demand for decriminalization of euthanasia. In this context, opposed to the promotion of the right to a dignified "mild" death, there is an increased persistence on teaching the younger generations about the dignified death and the return of the emotional warmth, as the example left by Mother Teresa, as well as about the awe of life by Albert Schweitzer.

This means that every life, at all stages, is worth living and is in need of all the medical care and human attention. In context of this, the Declaration of the World Association of Physicians (WMA - World Medical Association), which was enacted at the General Assembly in Madrid in 1987, in relation to this question stipulates that: "Euthanasia, i.e. willingly terminating the life of a patient, either at the request of the patient or at the request of his close relatives, is unethical" (The World Medical Association Resolution on Euthanasia). But that does not prevent the doctors, out of respect for the patient's wish, to not allow for the natural course of death in the terminal stage of the illness (Iglesias, 1998, p. 31). With this, the World Association of Physicians specifically indicates the awareness of all developments on the issue of euthanasia, which is a medical-ethical problem.

Hence, what will the modern time accept as an appropriate response and practice for the future, in the meantime, represents a bioethical problem to which the bioethics seeks in an interdisciplinary and pluri-perspective manner to approach and offer a possible solution. In this

context, a clear terminology is the first step in trying to offer ethically "correct" solution because people are social beings. We communicate with one another, converse, exchange ideas and different points of view via languages and signs. The language designs affects and changes the reality, speeds up the communication, promotes understanding, helps to build bridges between cultures. That is why in bioethics, the concepts and the categories should convey a clear meaning and should not be opened for interpretation. This is so because the phenomenology is especially important – the language has and does play a critical role in the birth and shaping of our existence i.e. it is important to be reflected in the language people use to describe their experiences, especially those referring to life and death (Cohen-Almagor, 2000, pp. 267-278).

It is so, because we are talking about a relation between euthanasia and the palliative care which is very confusing: the first one refers to the ending of life, while the second refers to the improvement of the quality of life, and the experience across countries shows that these two concepts tend to converge and mix when it comes to deciding about the end of life.

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HOME MEMORIALS AFTER STILLBIRTHS IN SWEDEN

ANNA DAVIDSSON BREMBORG AND INGELA RÅDESTAD

***Abstract**: Home memorials and home rituals are not connected with Scandinavian bereavement culture. However, in a survey among parents of stillborn children, 61% of the 1000 mothers said they have a memorial place in their home, with candles, photographs, angels and other things. These places were connected with various rituals. Memorial places and rituals seem to be important tools in coping with the immense grief of the child. In this chapter a model for home memorials is presented.*

Introduction

Some rituals seem to have existed for a long time without being objects for researchers' interest; maybe because they have not been classified as rituals, maybe because they have been considered too private or individualized, maybe because they do not belong to a specific religious tradition. One of these practices is home memorial ritualization, performed by the bereaved in memory of a deceased family member, relative or friend. Only a few studies have been made about them, though they seem to be fairly common.

In a Dutch national survey made in 2005, Joanna Wojtkowiak and Eric Venbrux (2009) found that one third of the households had a memorial place at home. Regardless of religious denomination or affiliation at all, home memorials had a strong position in the Netherlands.

In Sweden no such study of home memorial among the general population has been made. Nor does this study have such a general approach, but focuses on home memorials for stillborn babies, i.e. children who have died before birth, in Sweden. The result is however of interest for more generalized studies on domestic ritualization.