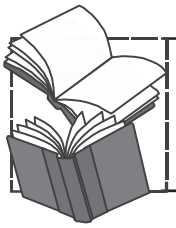

TIESĪBU FILOZOFIJAS APAKŠNOZARE

EUTHANASIA: DILEMMA OF LIFE AND DEATH

Candidate of Medical science ***Marzhan Myrzakhanova,***
Professor, Sh. Ualikhanov Kokshetau State University, Kazakhstan

Masters of Law: ***Alexsey Kuznetsov, Shingis Tulegenov,***
Sh. Ualikhanov Kokshetau State University, Kazakhstan

Introduction

The man, his life and health in Kazakhstan is recognized as the highest social value. This right is guaranteed by Article 1 of the Constitution[1], the Criminal and Civil Codes of Kazakhstan. That is why the question of legalization of euthanasia is not only social, moral and religious aspect, but also legal, the study of which is the purpose of this article. It will be appreciated that there is no single and precise definition of euthanasia. This word is of Greek origin from words «eu», which means "good" and «thanatos» – «death", that is – "good death". The term "euthanasia" was first used by Francis Bacon in the XVII century as an epithet for "easy death".

In the EU, there is euthanasia for animals and humans. In Kazakhstan – to humans is strictly prohibited. The first country that legally recognized permissible voluntary euthanasia was the Netherlands (1984 and since 2012 has outpatient team of specialists performing euthanasia at home), after then – Belgium (2002) and two US states: Oregon (1994) and Washington (2008). 40 – 70% of European physicians supported euthanasia, noting that the procedure must be well thought out. In the survey, conducted in October 2013 among 1000 respondents in different regions of Kazakhstan, it was found that 37.1% of respondents were strongly against painless death, and approximately 62% supported it in any form or situation. For comparison, in 2010 the number of opponents was 57%. Thus, to date, into move for euthanasia support joins more people. Mazhilis of Kazakhstan raised the issue of reviewing the draft law on the legalization of euthanasia, however, the arguments of the clergy have been addressed and the issue remained unresolved.

Actual problem of euthanasia is because nowadays people rarely die of natural causes, more from diseases in which the human body is in long struggle, causing suffer to his body and soul. In such situations, there is a problem of choice: whether to apply euthanasia to end suffering? Or whether even the suggestion of such an act? Before considering the present point of euthanasia, it is worth mentioning the historical aspect: the principle of the sanctity (inviolability) of human life, said in the oath of Hippocrates: "I will not let anybody if asked me a deadly drug and not show the path for such a plan". Thus, euthanasia – a direct violation of oath of a doctor, even in countries where it is legalized, contrary to the right to life, however, is not considered the same right – to death.

Euthanasia – a problem is not only medical but also ethical. On this score in the society there were two ideological concepts: religious-idealistic and materialistic-naturalistic. The first is that the human right to voluntarily withdraw from life condemn almost all the world's religions. To her supporters include: Islam and Orthodox Christianity. The movement "in defense of life", John Paul II, Johann Christian Reil, the Church of Scotland and much more. They lead such arguments: as a religious and moral values and the possibility of an almost complete rehabilitation of the disabled, moreover, with any degree of

limitation of their opportunities. They consider euthanasia as assisted suicide. The exception to this concept is the Japanese religious cults. To the supporters of the second flow are: Arthur Koestler, Bernard Kouchner, Jack Kevorkian, Nikonov Alexander, Richard Dawkins, Terry Pratchett, the Church of Euthanasia, and others. They insist on the fact that nowadays very often people are increasingly inclined to refer to himself as a "owner" and "creator" of his life and his personality. After all, not all people are willing to continue the "poor quality", "unworthy" life on the brink of death, while experiencing physical, psychological and moral suffering. Thus, the arguments "for" euthanasia can be a sense of caring for sick loved ones, as well as biological factors.

The theory identifies two types of euthanasia: passive (deliberate termination of medical maintenance therapy of the patient) and active (administering medications or other actions which entail a quick and painless death). In addition, it is necessary to distinguish between voluntary and involuntary euthanasia. Voluntary carried out at the request of the patient or pre voice his consent (in the US a common practice in advance and in a legally valid form express their will). Involuntary – without the consent of the patient, as a rule, is in an unconscious state, based on the decision of relatives, guardians, etc. But the chance of life of such a patient is not. But what the doctor if they refused to further fund the expensive treatment? Consider whether discontinuation of treatment murder? Kazakhstan legislation was not a word about such situations. Also, there are cases when doctors leave terminally ill patients without medical support, believing that they have nothing to help. Such omissions of doctors covered by Art. 118 of the Criminal Code of Kazakhstan[2] "not helping a patient to medical workers". A new way to solve the problem of medical death (cessation of death) is not included in the legal framework of modern health care under the influence of two main factors. First, the progress of medicine, in particular, under the influence of intensive care, could prevent the death of the patient, i.e. is in operation dying. Secondly, the change of values and moral priorities of modern civilization, the center of which is the idea of human rights. In fact, Kazakhstan recognizes the right to suicide, that is, self-focused and voluntary deprivation of life itself. Why, then, is not to legalize euthanasia? In this case, our legislation will be subject to major changes, starting with the Constitution until the local regulations. The law on the legalization of euthanasia must resolve all procedural matters (the presence of certain parties and their legal status, including responsibility), and provide the opportunity to challenge it, because in any case, the distinction between euthanasia and murder is very conditional. That is why in our country is the legalization of euthanasia would be much more negative aspects than positive. First of all, under the covert euthanasia of homeless, the lonely, the incompetent people and not necessarily terminally ill will be used as a material for making experiments and for forced organ donation. Such a system been established and well developed, and will be even and perfectly legitimate in the eyes of justice and enable doctors to abuse this right, according to the Association of Psychiatrists of Kazakhstan. "Maybe sooner or later Kazakhstan will still be introduced euthanasia, but today such a decision could lead to uncontrollable consequences, so we are enemies"[3].

Assuming that euthanasia is deemed legitimate action, the question arises, who will implement it? Doctors cannot provide such authority, since it does not accept the assertion of Hippocrates, which is contained in his "Oath".

From our point of view, now in Kazakhstan, any form of euthanasia is unacceptable, for the following reasons: 1) the practice is inevitably fraught with diagnostic error when the bad from the point of view of some patients get better medical standards. There is a certain percentage of errors related to the limited life sciences; 2) cannot ignore the danger of deliberate abuse; 3) euthanasia could have a demoralizing, and iatrogenic effect of a hitherto unknown scale and strength of the huge number of patients (French National Council on Medical Ethics considers acceptable use of euthanasia in exceptional cases and provided that the suffering patients are "permanently and clearly asking" let them die); 4) euthanasia – is a medical capitulation, and it can have a negative impact on the quality of care. It is not essential resolution of contradictions in life, as only removes them forcibly. This is not consistent with any dialectic, nor with our understanding of medical humanism. If this is positive, because truly humane medical attention to a dying man.

Our legislation excludes the legalization of euthanasia, considering it as the United Nations, contrary to the requirements of humanity (Art. 27 of the legislation on the health of citizens of Kazakhstan)[4].

The issue of euthanasia is not unique. Will this he is the subject of speculation in Kazakhstan in the near future is unknown. What is clear is that to ensure the preservation of all human rights in the country of such decisions is not possible. It is still medicine in Kazakhstan does not always guarantee the right to free medical care and treatment.

Euthanasia is usually defined as an act undertaken only under the supervision of a doctor who deliberately ends the life of a person at his or her request[5]. Therefore, the doctor prescribes a lethal substance. "The suicide with medical assistance" (hereinafter – the suicide) on the one hand, it seems like the patient's own decision to take a lethal dose of a drug prescribed by a doctor.

Today, in the Netherlands, Belgium and Luxembourg have legalized euthanasia[6]. The laws of the Netherlands and Luxembourg also allow euthanasia. In the US, in Oregon and Washington have legalized "suicide with medical assistance" in 1997 and 1999 respectively, but euthanasia is illegal[7]. The situation in Montana at the moment remains unclear; a bill legalizing suicide was accepted by the state legislature in 2010, but was recently abolished the state Senate Judiciary Committee.

In the Netherlands, euthanasia and suicide were formally legalized in 2001 after a 30-year period of public debate[8]. Since 1980, the guidelines and procedures for the control of euthanasia have been developed and adapted several times of the Royal Dutch Medical Association, in cooperation with the national judicial system. Despite the opposition of the Belgian Medical Association, in Belgium legalized euthanasia in 2002, after 3 years of public debate, which included members of the government commission. Luxembourg legalized euthanasia and suicide in 2009. In Switzerland, suicide, although not formally legalized, but has adopted an amendment to the law in the early 1900s, which excludes suicide.

Euthanasia, however, is illegal[9]. Man commits suicide may do so with the help of an assistant as long as the assistant has no selfish motives, and nothing to gain personally from death. Unlike other jurisdictions that require the implementation of euthanasia or assisted suicide only doctors in Switzerland allowed promoting suicide, not only doctors.

In all of these jurisdictions there are no guarantees, the criteria and procedures to monitor in practice, to ensure public order and to prevent the abuse or euthanasia, or its improper implementation[10]. Some criteria and procedures for euthanasia are common to all jurisdictions; other countries vary from[11]. In order to prevent abuse of the practice of euthanasia cases, particular care must be exercised in the legalization of euthanasia in those countries that intend to legalize it. In a review article explores the effectiveness of safeguards and the "side effects" in the practice of euthanasia.

Guarantees, their effectiveness

All legal documents, request for euthanasia or suicide should be voluntary, deliberate, conscious, and stable over time. The requesting person must provide written consent and must be competent at the time of the request. Despite these assurances, more than 500 people in the Netherlands involuntarily euthanize every year. In 2005, a total of 2410 deaths via suicide or euthanasia is 1.7% of all deaths in the Netherlands. More than 560 patients (0.4% of all deaths) were injected lethal substances without their explicit consent[12]. From each patient 5, 1 euthanize without their explicit consent. Attempts to bring these cases to court have failed, suggests that the judicial system has become tolerant over time to such criminal acts[13].

In Belgium, the rate of forced rather than voluntary euthanasia deaths (that is, without explicit consent) is 3 times higher than in the Netherlands[14]. By "involuntary euthanasia" are situations in which a person has potential, but has not provided consent to the "non-voluntary euthanasia, and the situation in which a person is unable to give consent for reasons such as dementia or coma. A recent study showed that in the Flemish part of Belgium, 66 of the 208 cases of "euthanasia" (32%) occurred in the absence of a request or consent to euthanasia[15]. The reasons for the termination of life without the consent were as follows: the patient is in a coma (70% of cases) or dementia (21%). In 17% of cases, doctors have performed euthanasia without the consent of the patients, because they believe that euthanasia was "clearly in the interest of the patient", and in 8% of cases, doctors decided that the discussion of euthanasia with patient would harm him. These findings are consistent with results of previous studies, in which 25 of the 1644 sudden deaths were the result of euthanasia without the explicit consent of patients[16].

Bypassing the law provides some evidence from social research "side effects" of euthanasia, Keown described[17]. So far there are no known cases of euthanasia, which would be forwarded to

the judicial authorities for further investigation in Belgium. In the Netherlands, in 16 cases (0.21% of all reported cases) were referred to the judicial authorities in the first 4 years after the law on euthanasia came into force, with a single case of euthanasia was not prosecuted[18]. In one case, the consultant who advises terminally ill on how to commit suicide was acquitted[19]. Consequently, the adoption of the law on euthanasia shows the change of social values after the legalization of euthanasia and assisted suicide. In 1987, in the preamble to the Royal Dutch Medical Association in its guidelines on euthanasia, says: "If there is a request from the patient, then the decision to terminate his life [legally] qualifies as murder or suicide, not euthanasia." In 2001, the Association supported the new law, which says the wish for euthanasia advance directive as acceptable, while the representatives of the judicial system tolerant of non-voluntary euthanasia[20]. However, decisions based on a preliminary application for the disposal or the will can be ethically problematic, because the request does not coincide with the act cannot be a proof of the will of the patient at the time of euthanasia.

In Oregon, although incurable disease with a forecast of less than 6 months of age must be present unbearable suffering, which cannot be released medication, for euthanasia – it is not the main requirement (again recognizing that the concept of "unbearable suffering" itself is ambiguous). This definition allows doctors to assist in suicide, without referring to the medical, psychological, social circumstances and concerns, which typically underlie the request for assisted suicide. Doctors are obliged to indicate that palliative care is a viable alternative, but are not required to be knowledgeable about how to relieve physical and emotional suffering.

Until 2001, the Netherlands adults only allowed access to euthanasia or suicide. However, in 2001 the law allows euthanasia for children aged 12 – 16 years, with the permission of parents killing children, although this age group is usually a group of patients who are considered unsuitable for such a decision[21]. The law even allows doctors to begin euthanasia if there is disagreement between the parents. By 2005, in Groningen Protocol was adopted, which authorizes euthanasia of newborns and young children, who should not have "no hope for a good quality of life". In 2006, lawmakers in Belgium announced its intention to amend the law to include euthanasia of infants, teenagers, and people with dementia or Alzheimer's disease[22].

Statistics show that in HIV-infected children, 1,200 times higher risk of diseases such as lymphoma, non-Hodgkin's lymphoma – 65%, leiomyoma and leiomyosarcoma – 15%, leukemia – 6%, KS – 5%, Hodgkin's lymphoma – 3%, carcinoma – 2%. Without treatment of HIV-infection mortality rate increased by 40 – 70%. About 80% of HIV-infected children occasionally found Pneumocystis pneumonia.

In Belgium, the experts chose to ignore the requirement that, in the case of non-terminally ill patients should be observed interval 1 month from the date of the first request to the moment when euthanasia is performed. One expert said that his unit takes into account the average time from admission of the patient to the moment of the euthanasia, seemingly "hopeless" situation of patients was about 3.5 days[23]. This person claimed that it was a fundamental principle of beneficence. Initially, euthanasia in the Netherlands has, as a last resort, when no other treatment options. Surprisingly, however, palliative care consultant is not required in jurisdictions that permit euthanasia or assisted suicide, although uncontrolled pain and symptoms are among the reasons for requesting euthanasia or suicide[24].

From 2002 to 2007, in Belgium, palliative care is carried out at a doctor's advice (in – the second turn), only 12% of all cases of euthanasia. Palliative care team of doctors carried out more than 65% of cases of euthanasia. In addition, palliative care services declined. In 2002, palliative care teams of doctors were consulted in 19% of cases of euthanasia, but by 2007 it had dropped to 9% of cases. Finding that in Belgium, legalization is accompanied by significant improvements in palliative care in the country[25]. Other studies have reported a reduction of palliative care[26, 27]. It should be noted that the legalization of euthanasia or suicide is not required in other countries such as the United Kingdom, Australia, Ireland, France, and Spain, where palliative care is more developed than in Belgium and the Netherlands. There are other examples, that "social slippery slope" as a phenomenon does exist. In Switzerland, in 2006, at the University Hospital in Geneva was carried out reduction of employees engaged in palliative care (from 1.5 to 2 full-time doctors) hospital after the decision on the resolution of suicide, palliative care center was also closed. 15% of doctors in the Netherlands have expressed concern that economic pressures may encourage

them to consider euthanasia for some of their patients; already dying patient was euthanized to make a hospital bed[27].

In the UK parliamentary hearing on euthanasia few years ago, a Dutch physician asserted that "we do not need palliative care, we practice euthanasia"[28]. Supporters of euthanasia tend to ignore these concerns about "socio slippery slope" and decided to refute this "slippery slope" argument on the grounds that the legalization of euthanasia and suicide has not led to an exponential increase in cases of euthanasia or disproportionately large number of vulnerable people[29]. Nevertheless, there is evidence that these statements are unreliable.

The number of deaths by means of euthanasia in Flanders has doubled since 1998[30]. Of the total number of deaths in the Flemish part of Belgium (population 6 million), 1.1%, 0.3% and 1.9% by euthanasia occurred in 1998, 2001 and 2007, respectively (620, 500, and 1040 people respectively in those years). Chambaere et al[31] reported in its report of the Canadian Medical Association that in Belgium, euthanasia without consent decreased from 3.2% in 1998 to 1.8% in 2007. However, a closer review of original research shows that the euthanasia rate dropped to 1.5% in 2001 and then increased again to 1.8% in 2007.

In the Netherlands, the overall rate of euthanasia accounted for 1.7% of all deaths in 2005, compared with 2.4% and 2.6% in 2001 and 1995 respectively, but did not differ from 1990 when the figure was 1.7%[32]. However, the Dutch Government, referring to the official data, indicates an increase in euthanasia by 13% in 2009 compared to 2008; Euthanasia is currently 2% of all deaths. Given the growing numbers interested institutions providing euthanasia (similar cases were reported in the Swiss assisted suicide group Dignitas professional's thanks). In Oregon, although in some cases the percentage of euthanasia is very small in relation to the population of 24 prescriptions were written in 1998 (16 of which resulted in the deaths of – because of the associated suicide), 67 such cases registered in 2003 (43 of which resulted in deaths due to suicide), and 89 similar cases found in 2007. In Belgium, services involuntary euthanasia has decreased; they accounted for 3.2%, 1.5% and 1.8% of all deaths in 1998, 2001 and 2007, respectively (1800, 840 and 990 patients, respectively, in those years)[33,34]. [17] In the Netherlands the practice of euthanasia fell from 0.7% in 2001 to 0.4% in 2005[34]. The actual figure is probably higher, because of the large number of unreported cases.

Conclusion

The United Nations has established that the right to euthanasia in the Netherlands found in violation of the Universal Declaration of Human Rights, because of the risk to humans and the threat to the integrity of every human life. The UN has also expressed concern that the system cannot detect and prevent situations in which people may be exposed to undue pressure to give consent to euthanasia and can bypass the warranty. Independence and choice are important values in any society, but they are not without limitations. Our democratic society is legalized a lot of laws that restrict individual autonomy and choice of the person so that the Company provide for a larger community. Legislators in some countries and jurisdictions, last year voted against the legalization of euthanasia and assisted suicide in part because of concerns and evidence described in this review article. To those jurisdictions include France, Scotland, England, South Australia, and New Hampshire. They chose to improving palliative care services and education of health professionals and the general public[35].

References

1 The Constitution of the Republic of Kazakhstan (adopted at the national referendum on 30 August 1995) (with amendments and additions as of 02.02.2011).

2 Article 118 as amended by the Law dated 18.01.2011 № 393-IV (entered into force after ten calendar days after its first official publication); from 09.11.2011 № 490-IV (entered into force after ten calendar days after its first official publication).

3 The Constitution of the Republic of Kazakhstan (adopted at the national referendum on 30 August 1995) (with amendments and additions as of 02.02.2011).

[4] Article 27 of the determination of the moment of death. Terms off life-sustaining equipment.
[5] Deliens L, van der Wal G. The euthanasia law in Belgium and the Netherlands. Lancet. 2003; 362:1239–40.Watson R. Luxembourg is to allow euthanasia. BMJ. 2009; 338:b1248.
[6] Breitbart W, Rosenfeld B, Pessin H, et al. Depression, hopelessness, and desire for hastened death in terminally ill patients with cancer. JAMA. 2000; 284:2907–11.
[7] Steinbrook R. Physician-assisted death–from Oregon to Washington State. N Engl J Med. 2008; 359: 2513–15.
[8] Deliens L, van der Wal G. The euthanasia law in Belgium and the Netherlands. Lancet. 2003; 362: 1239–40.
[9] Ibid. Inghelbrecht E, Bilsen J, Mortier F, Deliens L. The role of nurses in physician-assisted deaths in Belgium.CMAJ. 2010;182:905–10.
[10] Watson R. Luxembourg is to allow euthanasia. BMJ. 2009; 339:b1254.
[11] Steinbrook R. Physician-assisted death–from Oregon to Washington State. N Engl J Med. 2008; 359:2513–15.
[12] Hurst S, Mauron A. Assisted suicide and euthanasia in Switzerland: allowing a role for non-physicians. BMJ. 2003; 326:271–3.
[13] Watson R. Luxembourg is to allow euthanasia. BMJ. 2009; 338:b1248.
[14] Smets T, Bilsen J, Cohen J, Rurup ML, De Keyser E, Deliens L. The medical practice of euthanasia in Belgium and the Netherlands: legal notification, control and evaluation procedures. Health Policy. 2009; 90: 181–7. Caplan AL, Snyder L, Faber–Langendoen K. The role of guidelines in the practice of physician-assisted suicide. University of Pennsylvania Center for Bioethics Assisted Suicide Consensus Panel. Ann Intern Med.2000; 132:476–81.
[15] Van der Heide A, Onwuteaka–Philipsen BD, Rurup ML, et al. End-of-life practices in the Netherlands under the *Euthanasia Act*. N Engl J Med. 2007; 356:1957–65.
[16] Smets T, Bilsen J, Cohen J, Rurup ML, De Keyser E, Deliens L. The medical practice of euthanasia in Belgium and the Netherlands: legal notification, control and evaluation procedures. Health Policy. 2009; 90:181–7.
[17] Watson R. Luxembourg is to allow euthanasia. BMJ. 2009; 338:b1248.
[18] Van den Block L, Deschepper R, Bilsen J, Bossuyt N, Van Casteren V, Deliens L. Euthanasia and other end-of-life decisions: a mortality follow-back study in Belgium. BMC Public Health. 2009; 9:79.
[19] Smets T, Bilsen J, Cohen J, Rurup ML, Mortier F, Deliens L. Reporting of euthanasia in medical practice in Flanders, Belgium: cross sectional analysis of reported and unreported cases. BMJ. 2010; 341:c5174.
[20] Hurst S, Mauron A. Assisted suicide and euthanasia in Switzerland: allowing a role for non-physicians. BMJ.2003;326:271–3. Chambaere K, Bilsen J, Cohen J, Onwuteaka–Philipsen BD, Mortier F, Deliens L. Physician-assisted deaths under the euthanasia law in Belgium: a population-based survey. CMAJ. 2010;182:895–901.
[21] Watson R. Luxembourg is to allow euthanasia. BMJ. 2009; 338:b1248.
[22] Caplan AL, Snyder L, Faber–Langendoen K. The role of guidelines in the practice of physician-assisted suicide. University of Pennsylvania Center for Bioethics Assisted Suicide Consensus Panel. Ann Intern Med.2000;132:476–81.
[23] Chambaere K, Bilsen J, Cohen J, Onwuteaka–Philipsen BD, Mortier F, Deliens L. Physician-assisted deaths under the euthanasia law in Belgium: a population-based survey. CMAJ. 2010;182: 895–901.
[24] Smets T, Bilsen J, Cohen J, Rurup ML, Mortier F, Deliens L. Reporting of euthanasia in medical practice in Flanders, Belgium: cross sectional analysis of reported and unreported cases. BMJ. 2010; 341:c5174.
[25] Burgermeister J. Doctor reignites euthanasia row in Belgium after mercy killing. BMJ. 2006; 332:382
[26] Smets T, Bilsen J, Cohen J, Rurup ML, De Keyser E, Deliens L. The medical practice of euthanasia in Belgium and the Netherlands: legal notification, control and evaluation procedures. Health Policy. 2009; 90:181–7. Van den Block L, Deschepper R, Bilsen J, Bossuyt N, Van Casteren V, Deliens L. Euthanasia and other end of life decisions and care provided in final three months of life: nationwide retrospective study in Belgium. BMJ. 2009; 339:b2772.

[27] Steinbrook R. Physician-assisted death–from Oregon to Washington State. N Engl J Med. 2008; 360: 2517–18.
[28] Caplan AL, Snyder L, Faber–Langendoen K. The role of guidelines in the practice of physician-assisted suicide. University of Pennsylvania Center for Bioethics Assisted Suicide Consensus Panel. Ann Intern Med.2000;132:476–81.
[29] Van der Heide A, Onwuteaka–Philipsen BD, Rurup ML, et al. End-of-life practices in the Netherlands under the *Euthanasia Act*. N Engl J Med. 2007; 356:1957–65.
[30] Smets T, Bilsen J, Cohen J, Rurup ML, De Keyser E, Deliens L. The medical practice of euthanasia in Belgium and the Netherlands: legal notification, control and evaluation procedures. Health Policy. 2009; 90: 181–7.
[31] Van der Heide A, Onwuteaka–Philipsen BD, Rurup ML, et al. End-of-life practices in the Netherlands under the *Euthanasia Act*. N Engl J Med. 2007; 356:1957–65.
[32] Chochinov H.M., Wilson K.G., Enns M., et al. Desire for death in the terminally ill. Am J Psychiatry. 1995; 152:1185–91.
[33] Emanuel E.J., Fairclough D.L., Emanuel L.L. Attitudes and desires related to euthanasia and physician-assisted suicide among terminally ill patients and their caregivers. JAMA. 2000; 284: 2460–8.
[34] Smets T, Bilsen J, Cohen J, Rurup ML, Mortier F, Deliens L. Reporting of euthanasia in medical practice in Flanders, Belgium: cross sectional analysis of reported and unreported cases. BMJ. 2010;341:c5174. Breitbart W, Rosenfeld B, Pessin H, et al. Depression, hopelessness, and desire for hastened death in terminally ill patients with cancer. JAMA. 2000; 284: 2912–14.
[35] Verhagen AA, Sol JJ, Brouwer OF, Sauer PJ. Deliberate termination of life in newborns in the Netherlands; review of all 22 reported cases between 1997 and 2004 Ned Tijdschr Geneeskd. 2005; 149:183–8. Sheldon T. Dutch law leads to confusion over when to use life ending treatment in suffering newborns. BMJ.2009; 339:b5474.

Anotācija

Raksts veltīts eitanāzijas pieļaujamības aspektu izpētei, ievērojot Kazahstānas tiesību tradīcijas un pasaules valstu pieredzi. Aiz līdzjūtības izdarīta asistēšana nedziedināmi slima cilvēka pašnāvībai novērš slimības radītas bezjēdzīgas ciešanas. Vienlaikus pastāv daudzas ētiska, tiesiska un medicīniska rakstura problēmas. Juridiski šis jautājums ir daudzšķautņains, jo tiesību normu piemērošanai nepieciešami objektīvi kritēriji, bet eitanāzijas gadījumā nākas operēt ar daudziem subjektīvi vērtējamiem kritērijiem. Pakļaujot citu cilvēku nāvei, vienmēr pastāv ļaunprātīgas rīcības risks. Nobeigumā secināts, ka daudzas valstis neatbalsta eitanāzijas legalizēšanu, uzskatot, ka vairāk jāattīsta paliatīvā aprūpe, kā arī par šiem jautājumiem jāizglīto mediķi un sabiedrība.

Аннотация

Статья посвящена исследованию аспектов допустимости эвтаназии с учётом традиций правовой системы Республики Казахстан и опыта стран мира. Совершённое из сострадания ассистирование при самоубийстве неизлечимо больного человека устраняет порождённые болезнью бессмысленные страдания. В то же время существует ряд проблем этического, правового и медицинского характера. В юридическом плане данный вопрос представляется многогранным, так как для применения норм права необходимы объективные критерии, а в случае эвтаназии приходится оперировать многими имеющими субъективную оценку критериями. При принятии решения о прекращении жизни другого человека всегда существует риск злонамеренных действий. В заключение сделан вывод о том, что многие государства не поддерживают легализацию эвтаназии, считая, что следует в большей мере развивать паллиативный уход за пациентами, а также вести просветительскую работу по данным вопросам среди медиков и в обществе.