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EDITORIAL ARTICLE

Medicolegal aspects of euthanasia regulation law in Spain☆

Aspectos médico-legales de la ley de regulación de la eutanasia en España

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From the point of view of bioethics and the law, the debate on euthanasia has been raging in Spain and surrounding countries over the last few decades, not only in academic circles but also in society. The debate is undoubtedly complex and interdisciplinary, with multiple approaches and perspectives, in which there are different ethical, cultural, social, and even deontological positions within the medical profession[1–4].

In this context, after decades of debate and four previous attempts, Organic Law 3/2021 of 24 March on the regulation of euthanasia[5] was passed, making Spain the sixth country in the world to have a law regulating euthanasia[6]. The law seeks to provide a legal, systematic, balanced and guaranteed response to a sustained demand from current society, recognising the right of every person, in accordance with scrupulous compliance with the principle of patient autonomy, to request and receive assistance in dying. In this regard, amidst possible subjective interpretations in the complex debate on euthanasia, we believe that polarised positions on the issue should be avoided. We feel, in any case, that there are two fundamental aspects that cannot be ignored before the Law itself comes into force in mid-June 2021. Firstly, adequate training is essential of healthcare professionals in all aspects related to the application of the law itself, and secondly, a palliative approach to serious and incurable illnesses must be promoted, to ensure the quality of life of patients and their families is improved at the end of life.

Quite apart from the existing debate, from collective or personal ethical or moral positions, the new regulation requires some comments on different aspects of medicolegal interest.

Firstly, with regard to assessing the competence to decide of those applying for the service provision regulated by the law, and in accordance with the position of the Spanish Society of Psychiatry[7], two situations should be differentiated: that of any applicant whose primary illness is not a mental disorder, in whom a compulsory psychiatric assessment should be carried out when state of mind, cognition, capacity, consent, will, comprehension or judgement are in question, and situations in which the applicant is diagnosed with a mental disorder. This second scenario, which may be frequent given the high prevalence of mental disorders and the potential major impact on quality of life that they can entail, deserves special attention. Of course, the mere presence of a psychiatric disorder does not invalidate the presumption of capacity[8], but in some cases, psychiatric disorders are accompanied by cognitive and emotional distortions, inherent to their psychopathology, which may compromise the mental functions that are essential to make

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relevant decisions, such as consciousness, thinking, sensory perception, experience of self or affectivity. The integrity of these functions is a sine qua non condition for assuming that a decision is freely made and is the true will of the person and not pathologically determined. Furthermore, there is no accepted standard to assess decision-making capacity, and although there are various assessment instruments and methods, the final decision is highly subjective. Therefore, professional standards and specific training in the assessment of competence are needed, to ensure that not everything rests on presupposed experience or capability[9].

Secondly, in terms of the right to conscientious objection of the health professionals involved in the provision of assistance in dying, Law 3/2021[5] clearly establishes the possibility of their conscientious objection, understood in a generic sense and comprising the set of services and assistance that healthcare personnel must provide, within the scope of their competence, to patients who request the necessary assistance in dying, guaranteeing legal protection and respect for the freedom of conscience of healthcare personnel. The law establishes that objection or refusal to perform the service for reasons of conscience is an individual decision of the healthcare professional directly involved in delivering it, which they must express in advance and in writing. This inclusion of the right to conscientious objection in the law coincides with the recommendation for protection proposed from a bioethical approach[10], which means that the requirement of the moral imperative to do no harm is upheld in healthcare, i.e., the right to refuse to harm in the area of health[11].

Thirdly, it is important to mention the modifications that must be made to the existing advance directives (AD) or advance directive document (ADD), considering the possibility that the law provides for assistance in dying by virtue of that expressed by the patient in their AD, when they have lost the competence to make such a decision. The AD or ADD is a written document that reflects an act of personal responsibility, and is of particular help in chronically ill patients who may progress to situations of dependency and cognitive deterioration[12]. Until the enactment of Law 3/2021, guidelines regarding the limitation or withdrawal of life-sustaining treatment had to be laid down in the AD or ADD[13]. However, medical measures in relation to the limitation or withdrawal of life-sustaining treatment, therapeutic futility or limitation of therapeutic effort[14] are not to be equated with euthanasia, although some may sometimes confuse the two. Therefore, it being possible for the request for assistance in dying to be presented through the ADD, the living will, the AD or legally recognised equivalent documents, previously signed by the patient, means that this situation must now be included in the AD. On this point, with regard to the AD or ADD in the case of people with mental disorders, it is also considered advisable to review the process of drawing up these documents, especially if they include a request for euthanasia, to ensure that the capacity for informed consent is accredited, and the clinical circumstances in which the request is to be executed and the time of validity of the document are specified[7]. Thus, an issue with a high bioethical content, such as advance end-of-life decision-making in the healthcare setting, will continue to require in-depth study[15].

Fourthly, it is appropriate to mention the legal consideration of death as a consequence of euthanasia. Euthanasia, as a death unequivocally brought about by the participation of agents external to the organism, is a death of violent medicolegal aetiology. The legal consequence of deaths with a violent medicolegal aetiology or suspected criminality, due to the application of the Law of Criminal Procedure, is a judicial autopsy. To avoid problems of interpretation in this sense, Law 3/2021 has rightly included the first additional provision which establishes that death as a consequence of the provision of assistance in dying will be legally considered a natural death. In other words, despite being a death of violent medico-legal aetiology, the legal consideration of natural death means that it is excluded from the obligation for a judicial autopsy which the Criminal Procedure Act attributes to this type of aetiology of death from a medicolegal point of view. In practice, regarding the care pathways that must be applied in relation to euthanasia, once the assistance in dying has been provided, the procedure for registering the death in the Civil Register should be a Medical Death Certificate (as it is a natural death from the legal point of view) and in no case should the judicial process be triggered.

As can be seen, this article only briefly addresses some of the most important medicolegal aspects of the regulation of euthanasia. There are many other issues that will need to be addressed, and therefore periodic reviews will be necessary of the most relevant medicolegal aspects of the application of Law 3/2021 on the regulation of euthanasia.

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