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Euthanasia In Spain: An Interpretive Analysis Of The Current Regulations From The Health Social Work

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ABSTRACT

In Spain, the right to euthanasia has become a legislated act included in its legal system. Various draft laws had to be presented until several months ago the Organic Law 3/2021, of March 24, on the regulation of euthanasia saw the light. Even with good intentions, this regulation ignores the social dimension of the disease and does not contemplate aspects such as emanci- pation, minors, etc. It leaves aside the figure of Social Health Work in the Guarantee and Evalua- tion Commission that it establishes in its articles, a matter that falls exclusively on the autonomous communities. This fact generates disparities in the composition of this commission, since said figure is not always available. Such a situation, together with other aspects related to the situation of dependency of the applicant for aid in dying, requires an overall review of its content by legisla- tors. Situation that allows guaranteeing some of the legal gaps that have been produced.

Keyword: euthanasia, health legislation, health law, personal autonomy, social work

Eutanasia en España: Un Análisis Interpretativo de las Regulaciones Actuales Desde la Perspectiva del Trabajo Social Sanitario

RESUMEN

En España, el derecho a la eutanasia se ha convertido en un acto legislado dentro de su sistema legal. Se presentaron varios proyectos de ley hasta que, hace unos meses, se promulgó la Ley Orgánica 3/2021, de 24 de marzo, sobre la regulación de la eutanasia. A pesar de sus buenas intenciones, esta normativa ignora la dimensión social de la enfermedad y no contempla aspectos como la emancipación, los menores, etc. Además, deja de lado la figura del Trabajo Social Sanitario en la Comisión de Garantía y Evaluación que establece en sus artículos, un asunto que queda exclusivamente en manos de las comunidades autónomas. Este hecho genera disparidades en la composición de dicha comisión, ya que esta figura no siempre está disponible. Tal situación, junto con otros aspectos relacionados con la situación de dependencia del solicitante de la ayuda para morir, requiere una revisión integral de su contenido por parte de los legisladores. Esto permitiría garantizar algunos de los vacíos legales que se han producido.

Palabras clave: eutanasia, legislación sanitaria, derecho sanitario, autonomía personal, trabajo social

INTRODUCTION

In Spain, the right to clinical self-determination rests on the Council of Europe Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine; a convention signed in Oviedo in 1997, ratified in 1999, and coming into force on January 1, 2000. This instrument outlines in Chapter II (on Consent), Articles 5 to 9, the content and form of informed consent, guaranteeing the individual's right to express previously stated wishes. Implicitly, Article 9 stipulates that "previously expressed wishes regarding a medical intervention by a patient who, at the time of the intervention, is not in a position to express their will, shall be taken into account" (Instrument of ratification of the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine, 1999). In this way, the right to decision-making is protected.

In 2002, the Spanish legal system approved a regulatory framework for patient autonomy, namely Law 41/2002, of November 14, which serves as the basic regulatory framework for patient autonomy and the rights and obligations concerning clinical information and documentation. This law guarantees the individual the right to clinical information and informed consent. Moreover, it specifies the formal measures for exercising the right to self-determination. This refers to the advance directive, living will, or anticipated healthcare directive (hereinafter AHD), although its content does not elaborate on the process, limits, etc., of this legal precept. This situation obliges the autonomous communities of Spain to create specific regulations governing the AHD within their jurisdictions. Following the emergence of various regional regulations, the right of the individual to express their healthcare interests and preferences is upheld, materializing through the AHD declaration document. It should be noted that the content of Law 41/2002, of November 14 (which is limited on this specific issue) and

that of the regional regulations contradict each other in certain aspects, causing conflicts in the interests of those granting the right to self-determination. Thus, in Chapter V (on the clinical history), Article 8 (regarding advance directives), section 1, it establishes that:

The advance directives document is the document addressed to the responsible physician, in which an adult, with sufficient capacity and freely, expresses the instructions to be taken into account when they find themselves in a situation where the prevailing circumstances prevent them from personally expressing their will. In this document, the person can also designate a representative, who is the valid and necessary interlocutor with the physician or healthcare team, to substitute them in the event that they are unable to express their will themselves (Law 41/2002).

Taking as a reference Law 5/2003, of October 9, on the declaration of anticipated vital will, approved in the Autonomous Community of Andalusia, Article 4 (on the capacity to make an AHD declaration) establishes the following:

The declaration of anticipated vital will may be issued by an adult or an emancipated minor. Judicially incapacitated individuals may issue an AHD declaration unless otherwise determined by the judicial incapacitation resolution. However, if the responsible healthcare personnel question their capacity to issue it, they shall inform the Public Prosecutor's Office so that, if necessary, a new process can be initiated before the judicial authority to modify the scope of the already established incapacitation (Law 5/2003).

As can be seen, this regulation includes emancipation as a possible figure granting the right to AHD and self-determination, a provision not contemplated in the national regulations. This recognition is also included in the Advance Directives Law of the Autonomous Community of the Balearic Islands and the Valencian Community.

Just as the Autonomous Communities establish their regulations regarding AHD and the registry that incorporates it, some of them also create regulations concerning the right to a dignified death. Considering the Spanish regulatory map regarding the Dignified Death Law, currently only ten autonomous communities have their own, which is equivalent to 58.8%. The figure presented below shows the autonomous regulatory path of the dignified death (see figure 1). It displays the dates of the emergence of the various regulations, as well as the similarity in their nomenclature. As can be seen, Andalusia becomes the first Autonomous Community to contemplate this measure.

Figure 1. Regulatory Map on Dignified Death in Spain. Source: (Jiménez, 2020a).

Range	Autonomous community	Denomination
Law	Andalusia	Law 2/2010, of April 8, on the rights and guarantees of the dignity of the person in the process of dying.
Law	Aragon	Law 10/2011, of March 24, on the rights and guarantees of the dignity of the person in the process of dying and death.
Law	Navarre	Regional Law 8/2011, of March 24, on the rights and guarantees of the dignity of the person in the process of dying.
Law	Canary Islands	Law 1/2015, of February 9, on the rights and guarantees of the dignity of the person before the end-of-life process.
Law	Balearic Islands	Law 4/2015, of March 23, on the rights and guarantees of the person in the process of dying.
Law	Galicia	Law 5/2015, of June 26, on the rights and guarantees of the dignity of terminally ill persons.
Law	Basque Country	Law 11/2016, of July 8, on the guarantee of the rights and dignity of persons in the end-of-life process.
Law	Madrid	Law 4/2017, of March 9, on the rights and guarantees of persons in the process of dying.
Law	Asturias	Law 5/2018, of June 22, on the rights and guarantees of the dignity of persons in the end-of-life process.

Law	Valencian Community	Law 16/2018, of June 28, on the rights and guarantees of the dignity of the person in the process of end-of-life care.

Source: (Jiménez, 2020a).

Nineteen years had to pass until, after various attempts at a draft bill, a regulation governing euthanasia was approved in Spanish territory. For several decades, the National Health System has relied on a single regulation to govern the right to a dignified death and the clinical-health aspects surrounding it. This circumstance has caused limitations and clinical difficulties for health professionals and patients, including situations where the latter, in palliative care, has been subjected to certain iatrogenesis.

The new Organic Law 3/2021, of March 24, on the regulation of euthanasia, seems to address these deficiencies. However, its brief existence and lack of experience could pose challenges; not to mention that the Spanish regulatory framework transitions from a law guaranteeing patient autonomy to another regulating the right to euthanasia, without having prior national experience on specific regulations concerning AHD and dignified death. This is something that the autonomous communities do contemplate. This situation could generate discrepancies among autonomous communities, which have the power to implement such rights. Just as Law 41/2002, of November 14, the basic law regulating patient autonomy, did not implicitly consider the social aspect of illness, the Euthanasia Regulatory Law also fails to do so; a condition that complicates the comprehensive approach to this precept, as well as the sense of its motivation and part of the causes that originate it (Jiménez, 2020b).

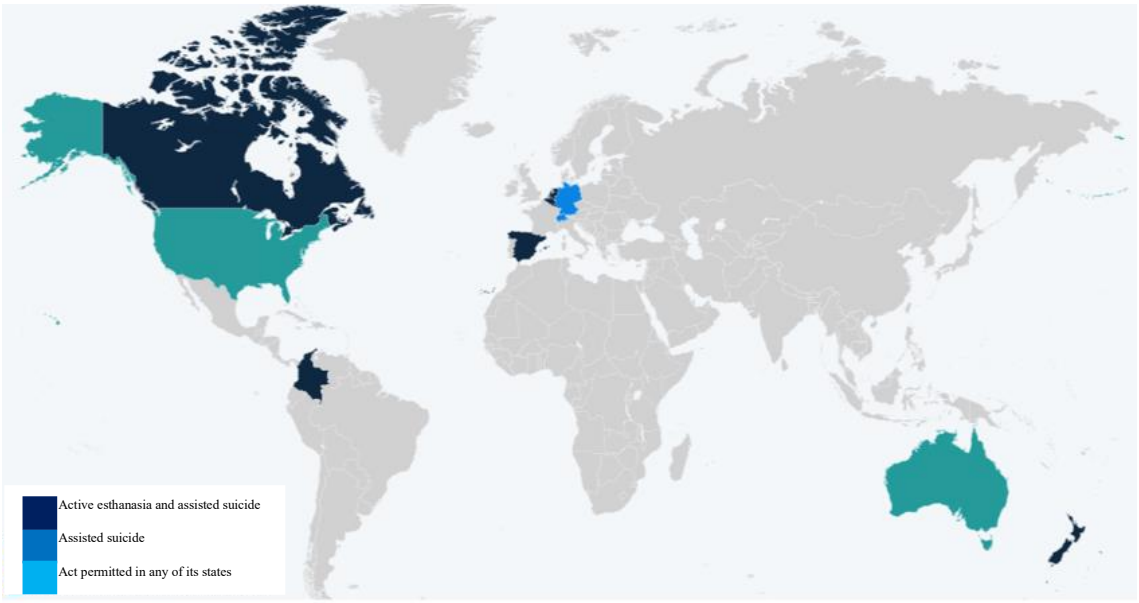
Social And Healthcare Analysis Of Organic Law 3/2021, Of March 24, On The Regulation Of Euthanasia

On the Statement of Reasons

Euthanasia has been a punishable act subject to numerous debates, particularly among more conservative social movements. A highly controversial act, its approval has been repeatedly rejected by the Congress of Deputies, a situation that has led to the subjection of palliative patients to therapeutic coercion. In its latest amendment, with 202 votes in favor, 141 against, and two abstentions, Organic Law 3/2021, of March 24, on the regulation of euthanasia, becomes the first regulation in the Spanish legal system to legitimize the right to programmed death. Thus, euthanasia is decriminalized under certain clinical circumstances. This regulation follows those approved and developed in European countries such as the Netherlands, Belgium, and Luxembourg, which set precedents. With its approval, Spain becomes the seventh country in the world to implement such a regulation (see Figure 2). The figure below shows the world map on the regulation of euthanasia and assisted suicide. It is worth noting that in countries like Colombia, euthanasia has been a constitutional right since 1998. However, that country does not have explicit legislation regulating this act (Mena, 2021).

The approval of Organic Law 3/2021, of March 24, on the regulation of euthanasia, overrides what was established by Constitutional Court Ruling 120/1990, of June 27, and requires modifications to the wording of Article 143 of the current Penal Code, an adaptation that legalizes euthanasia and exculpates those who cooperate in it.

Figure 2. Global Map of Euthanasia Regulation.



Source: Own elaboration based on data from Mena, M., in Statista, 2021.

This regulation becomes a protective instrument, as it allows individuals to end their lives with absolute freedom and autonomy, informed about the act, its medical process, and the modalities of provision outlined in its articles. Therefore, euthanasia becomes a novel individual right subject to deadlines, meaning it requires repeated requests by the applicant (Law 3/2021). This right, personal and non-transferable, depends on the will and capacity of the person granting it; a decision evaluated by a specific commission established for this purpose. However, the approval of this provision by such commission may exempt the person from its practice, as they can unilaterally revoke this decision. Finally, this regulation supports the right to confidentiality and ensures conscientious objection for healthcare professionals who disagree with its principles under any circumstances.

It should be noted that for this provision to be considered, it must be included in the document for the declaration of AHD, necessitating the modification of this latter figure.

On Content and Interpretation

In Spain, the right to end one's life voluntarily and instrumentally reaches its highest recognition in Organic Law 3/2021, of March 24, on the regulation of euthanasia. It came into force on June 25, 2021, becoming the sole Spanish legislation developed in this regard; thus, the socio-health rights of patients are expanded. Structurally, this regulation consists of a preamble, five chapters, 19 articles, seven additional provisions, one transitional provision, one repealing provision, and four final provisions; elements that give meaning to the act of euthanasia and allow its practice three months after publication in the Official State Gazette.

The implementation of this regulation into the Spanish legal framework requires an amendment to the Penal Code. In order to decriminalize euthanasia acts, Organic Law 10/1995, of November 23, amending certain aspects of its content. Specifically, its Article 143 (fourth paragraph) is altered, with a fifth paragraph added. Consequently, this article establishes that:

> *Whoever causes or actively cooperates in acts necessary and directly leading to the death of a person suffering from a serious, chronic, disabling condition or a serious and incurable illness, with constant and unbearable physical or psychological suffering, at the explicit, serious, and unequivocal request of that person, shall be punished with a penalty one or two grades lower than those stipulated in paragraphs 2 and 3.*
>
> *Notwithstanding the provisions of the preceding paragraph, no criminal liability shall be incurred by those who cause or actively cooperate in the death of another person in accordance with the Organic Law Regulating Euthanasia (Law 10/1995).*

This circumstance turns euthanasia into a protective provision of the individual's exclusive right.

Organic Law 3/2021, of March 24, on the regulation of euthanasia, establishes the clinical situations eligible for this right, as well as the clinical conditions under which it can be carried

out. In other words, this provision can be accessed in cases of severe, chronic, disabling suffering or incurable serious illness, through the direct administration of a substance or through medical prescription (Article 3). However, its statement of reasons and legislative articulation overlook the social aspect of illness processes, disregarding the definition of health established by the WHO in 1946. Similarly, it does not anticipate whether the request for this provision is accelerated by social deficits associated with the patient's condition that cannot be addressed through other means. Socioeconomic, familial, housing conditions, etc., of palliative care patients may precipitate the request for aid in dying, complicating a peaceful grieving process. When analyzing the role of the responsible physician and consulting physician, as defined in Article 3 of this regulation, it is evident that the responsible physician, who coordinates the patient's care process (directly involved in providing aid in dying), may exercise their right to conscientious objection. This measure can lead to feelings of abandonment and helplessness in the requester of aid in dying, who typically relies on their responsible physician (often their primary care doctor, knowledgeable about the progression of their illness) and now must trust a different professional unfamiliar with their case. Objecting at such delicate and crucial moments, such as the end of life where a prior relationship has been established, may be interpreted as an act of withdrawal from accompanying the patient. This circumstance requires awareness-raising, as it pits the right to self-determination against the personal ethical principles and constraints arising from this act. The distance that can arise between the directly involved parties in aid in dying can create emotional fractures.

On the other hand, the consulting physician is detached from this dilemma. However, their impartiality, though justified, may also contribute to this division. The report they must issue, based on: a) the information provided by the responsible physician, b) the study of the medical

history, c) the review of advance directives, d) consultations with the healthcare team, and e) discussions with the legal representative, may reflect interpretative biases.

Furthermore, this regulation in its Chapter II (on the right of individuals to request aid in dying and the requirements for its exercise), Article 5, establishes that:

To receive aid in dying, the following requirements must be met:

- Have in writing the information available about their medical condition, the different alternatives and possibilities for action, including access to comprehensive palliative care covered under the common portfolio of services, and any entitlements under dependency care regulations (Law 3/2021).

With this argumentation, this regulation does not take into account the arduous and lengthy administrative procedures currently in place to access any of the resources outlined in the Services Catalog of Law 39/2006, of December 14, on Promotion of Personal Autonomy and Care for Dependent Persons. Nor does it consider the limited maneuvering room available to social work professionals to ensure its implementation. It should be noted that currently, the waiting period for an applicant under Law 39/2006 to be evaluated, as required by the law itself, can extend up to two years. This waiting time becomes more complex when a terminally ill patient lacks sufficient informal support to transition with dignity towards the end of life or death.

A deeper analysis of the content of this recent regulation and its regulations reveals that among the levels of dependency established therein (Article 26), the highest level is designated as Grade III, equivalent to what this regulation terms "high dependency." Focusing on its Services Catalog, for example, the Home Help Service allocates a maximum assistance of 70 hours per month for Grade III, translating to less than three hours per day. Considering the deterioration experienced by patients in advanced palliative states, this daily duration of assistance is

insufficient to meet their socio-health needs, especially since basic daily living activities for these patients are impaired due to the progression of their conditions. Moreover, not all home assistance companies provide services seven days a week, further exposing patients with Grade III or lower dependency to inadequate protection and exacerbating their vulnerability (Law 39/2006).

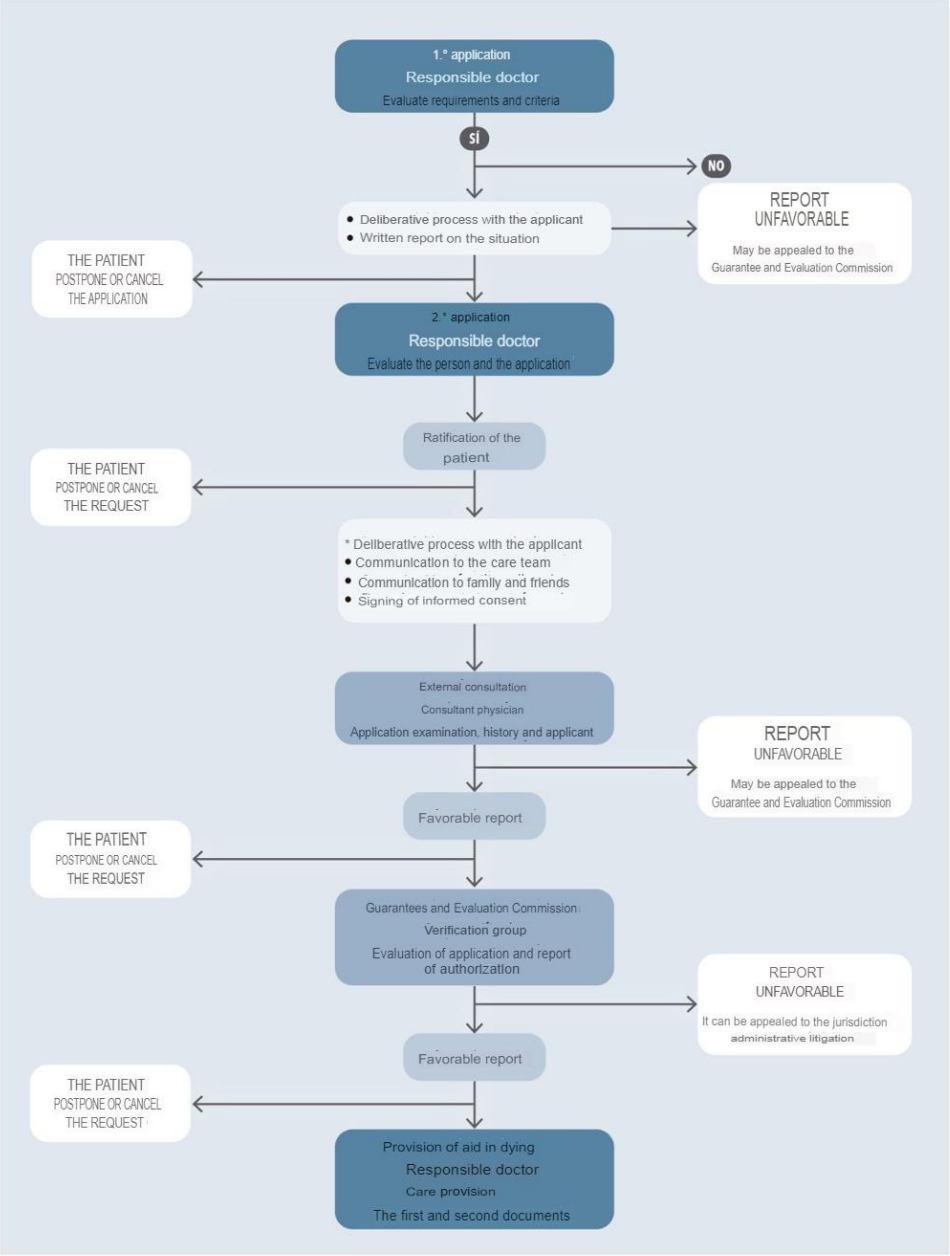
Upon reviewing this provision, it is evident that granting the right to aid in dying should not be left to the discretion of administrators, as final decisions on these provisions often come after the applicant has passed away. Even when implemented, these provisions often inadequately cover the actual needs of the patient, thereby compromising their level of protection.

On the other hand, among the procedures established in Organic Law 3/2021, of March 24, regulating euthanasia, is the requirement for assessment of dependency status by healthcare social workers. However, the granting of any of these benefits can never be used as a criterion to deny a request for aid in dying, as these benefits are themselves influenced by socio-economic and familial factors that consequently operate. Such factors must be considered by healthcare social work professionals, a detail not explicitly specified in this regulation, which can impact the timing and location of the act of dying. Lack of adequate formal (public or private) or informal support, appropriate income levels, etc., can lead a terminally ill patient to end their life in a hospital environment, sometimes hostile and indifferent, far from the intimate and comfortable environment of home, and away from their loved ones (family, close friends, etc.).

Regarding the procedure to request aid in dying, Organic Law 3/2021, of March 24, on the Regulation of Euthanasia, in its Chapter III (on the procedure for providing aid in dying), Article 8, mandates the need for multiple motivations of this request by the individual, which slows down this provision. This is especially true when the criteria are clear and the requirements set

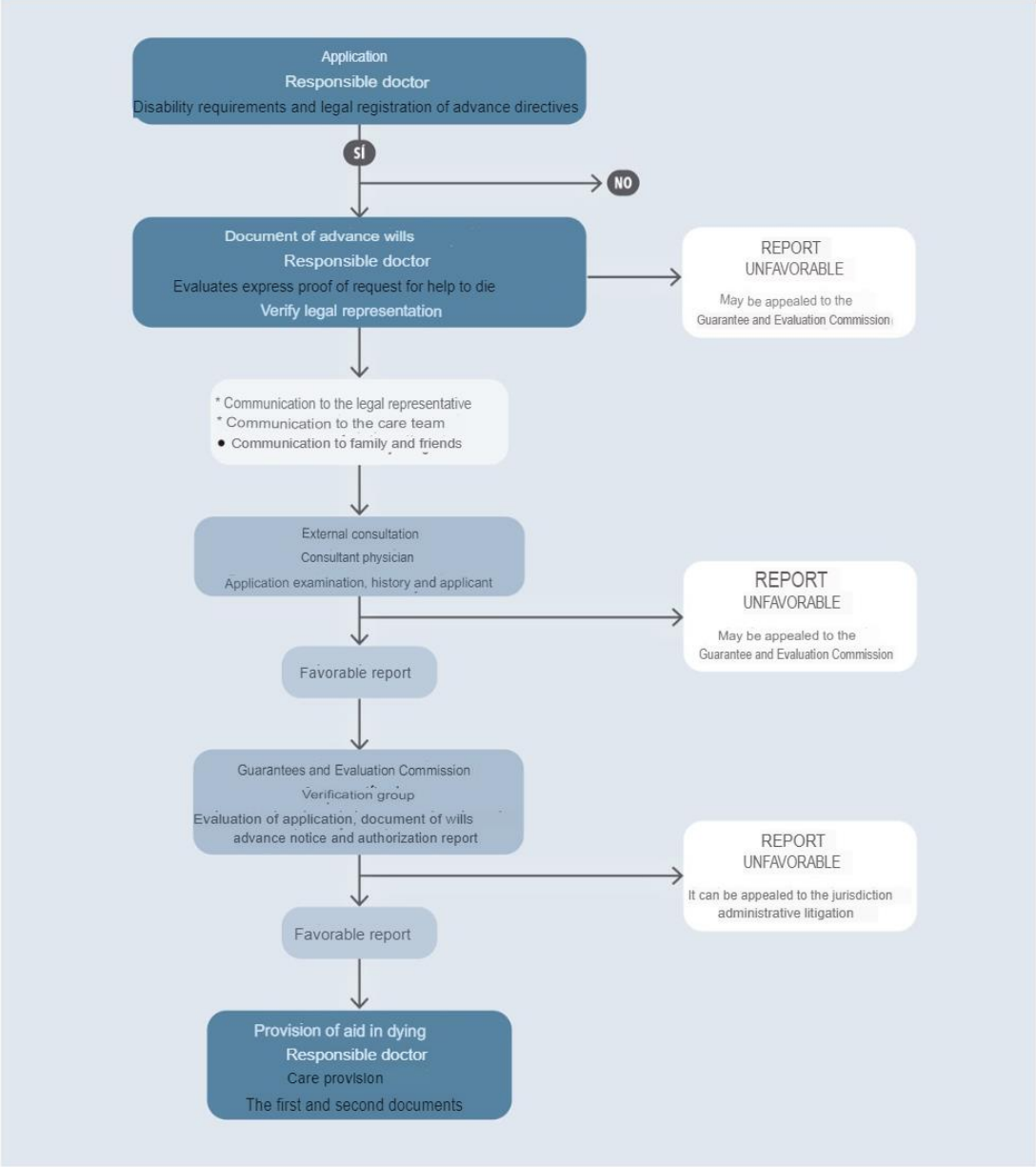
forth by the law are met. Being a regulation based on "periods" that requires double application and bureaucratic verification complicates the dignified act of dying and generates uncertainty (Law 3/2021). The figures presented below illustrate the process of requesting aid in dying in situations of capacity and incapacity, highlighting some of the sequences and response times that are subject to analysis (see Figures 3 and 4).

Figure 3. Procedure for the request for assistance in dying by a capable patient. Source: Melguizo and Sánchez, 2021.



Source: Melguizo and Sánchez, 2021.

Figure 4. Procedure for the request for assistance in dying by an incapable patient. Source: Melguizo and Sánchez, 2021.



Source: Melguizo and Sánchez, 2021.

In another aspect, regarding the establishment and composition of the Guarantee and Evaluation Commission, Chapter V (on guarantee and evaluation commissions), Article 17 of this regulation refers to the need for a multidisciplinary team composed of a minimum of seven members. However, only categories of medicine, nursing, and legal experts are considered,

without including figures related to the social sphere such as social healthcare workers; professionals experienced in providing assistance or support, active listening, diagnostic assessment, psychosocial evaluation, etc. (Law 3/2021). Although health competencies, like others, are constitutionally designated at the autonomous community level, only several autonomous communities, including the Autonomous Community of Madrid or the Valencian Community, incorporate the figure of social healthcare workers in these commissions. With respect to this latter argument, it should be noted that social healthcare workers have a professional tradition of over a century, which makes them a suitable professional category to assess the socio-familial, economic, etc., conditions surrounding the health-disease process and end-of-life issues. They are also suited to initiate discussions on euthanasia with interested individuals and to provide support throughout the process and during bereavement.

This professional historical trajectory, along with the academic training acquired, endows members of this discipline with specific competencies analogous to other healthcare categories, hence it should be taken into account. Studies such as those conducted by Kwon and Kolomer confirm that social workers have a positive attitude towards advance care planning and feel comfortable discussing issues related to death (Kwon & Kolomer, 2016). Additionally, research by Francoeur, Burke, and Wilson asserts that social workers are capable of intervening effectively with culturally diverse populations and providing spiritual support based on individuals' beliefs. These authors argue that social work education should address humanistic, existential, religious, and spiritual aspects beyond traditional approaches. They also emphasize that social workers should engage in processes of bereavement and dignified dying planning, taking into account various theological perspectives (Francoeur, Burke, & Wilson, 2016).

In line with this discourse, a study by Jiménez on the knowledge and attitudes of social healthcare workers in Primary Health Care towards dignified dying planning demonstrates that these professionals are knowledgeable about advance care planning regulations, hold favorable attitudes towards the right to dignified dying, and do not consider personal values and beliefs as impediments to this act. Comparatively, Jiménez suggests that social healthcare workers show greater affinity and openness to deliberate end-of-life decisions compared to medical and nursing professionals, exhibiting less resistance to advance care planning processes (Jiménez, 2018).

Similarly, the Organic Law 3/2021, of March 24, regulating euthanasia, does not extend this right to minors. Nor does it apply to individuals in legal emancipation who, for certain matters, act as adults. Focusing on this legal status, and reviewing Title X of the Civil Code (on adulthood and emancipation), articles 239 to 248 make it clear that an emancipated person can act as if they were an adult, although they are subject to exceptions established by the Code. However, these exceptions pertain to handling money, loans, alienation of real estate, business matters, etc., where the emancipated person must have reached legal adulthood, that is, be 18 years old to engage in such actions. These limitations do not extend to acts of civil life, self-governance, etc., (articles 246-247), thus the right to self-determination in euthanasia cases is not restricted (Law 8/2021).

Regarding individuals with limited capacity to act (capacity in fact), Article 9 of this regulation only refers those involved in euthanasia to the provisions of advance directives. However, it does not address aspects included in the Consolidated Text of the General Law on the Rights of Persons with Disabilities and their Social Inclusion, approved by Royal Legislative Decree 1/2013, of November 29, related to independent living, autonomy and freedom in decision-making, normalization, etc.

Finally, the Euthanasia Regulation Law restricts this right to all immigrants of European origin who have come to Spain for work reasons (economic immigrants) and are registered with the National Institute of Social Security. However, it does not apply to those who have not been registered for the required period under this regulation. Nor does it apply to irregular immigrants who, despite having free healthcare assistance, cannot obtain a fixed residence. This highlights the gaps created by this regulation in cases where illness occurs unexpectedly and progresses rapidly.

CONCLUTIONS

Euthanasia is a contentious issue fraught with ethical dilemmas and entrenched political and healthcare debates. The controversies it engenders invite a convergence of diverse ideological standpoints and resistance forces. Its debate is steeped in a conservative dogma that places paramount value on life, regardless of any potentially dire consequences. The approval and implementation of the current Organic Law 3/2021, of March 24, regulating euthanasia, silence these controversies and focus on the individual's right to self-determination. This circumstance endows individuals with a personal right that accentuates their autonomy and decision-making capacity in the final moments of life, where only this principle grants such authority.

The deliberative process associated with dignified death demands the freedom of the interested party, for which comprehensive information and full support are crucial. Only then does informed consent take on strict significance, sidelining any constitutive approach that designates it as merely a procedural safeguard.

Consent from a position of absolute freedom requires knowledge and awareness of one's own reality. Understanding the possibilities, limits, alternatives, etc., without value-based conflicts causing distress, is essential. This necessitates the skill, expertise, and sensitivity of the person involved in the accompaniment process, where any conditioning factors are eliminated.

Primary Health Care (PHC) becomes an ideal environment to initiate this discourse and process, as it is here that continuity of care and the onset of certain health-disease processes with the individual are anchored. As the first level of care, PHC serves as the gateway to the Public Health System, channeling demands and clinical situations requiring other levels of attention. However, elevating the request and procedure for euthanasia assistance, not the consultation with the consulting physician, to a secondary level of care can cause a fracture in this continuity of care. This also includes the exercise of the right to conscientious objection by the professionals involved in the care team.

Life and death are realities encountered throughout the life cycle of every person. Approaching the end of life, regardless of age, nationality, etc., must be structurally supported. Since anyone can face it at any time and circumstance, reconciling oneself and one's environment in a non-judgmental manner should be an added value. For this, it is necessary to eliminate any type of suffering that detracts from the meaning of life itself, allowing for a calm and conscious farewell. Healthcare social workers play a crucial role in the process of euthanasia assistance, underscoring the need to strengthen this commitment. The cited studies substantiate the expertise of these professionals in listening, advising, supporting, and accompanying, which is why their representation in this regulation should be motivated and more active. Supported by the debate on the analyzed research, their results should serve as a catalyst to reconsider the role of healthcare social workers in the euthanasia process and its evaluation commission. It is impossible to discuss social health factors in health-disease processes, social determinants of health, social medicine, etc., without including these professionals and their diagnostic assessment.

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