

HELP FOR THE TERMINALLY ILL AND THE DISPUTE OVER THE PERMISSIBILITY OF EUTHANASIA

INTRODUCTION

Currently, there is an observable global phenomenon of aging societies, which is associated with the extension of human lives. However, a longer life is one of the reasons for the recording of a growing population affected by “terminal diseases”. These include malignant tumours (*neoplasmamalignum*)¹ and AIDS². The late stages of these diseases include the appearance of paresis, paralysis³, aphasia, dementia, and coma. Similar symptoms are observed in the case of neurological conditions such as:

1. Alzheimer's disease⁴;
2. cerebral haemorrhages⁵;

¹ *Malignant tumour* – characterised by a high degree of disorder of differentiation, maturation and tissue and cell construction. It is characterised by rapid growth, lack of cyst and infiltration and compromise of the affected tissue. Infiltrating the lymph and blood vessels, it enters into them. As a result, cancer cells are able to journey to distant sites in the body, where they give rise to a new tumour (“*metastasis*”). These cells can be transmitted via the cerebrospinal fluid, as well as implanted in serous membranes. After surgical resection, the tumour often grows back within the post-operative scar or in its vicinity (relapse “*recidiva*”). The malignant tumour is often mistakenly equated with *cancer* (tumour of the epithelial tissue), which is only one of its many forms.

² *AIDS (Acquired Immunodeficiency Syndrome)*. As the final stage of HIV infection it is characterised by a very low level of CD4 lymphocytes and thus destruction of the immune system, resulting in the incidence of indicator diseases (some forms of cancer, fungal infections, atypical pneumonia) which may cause the death of the patient.

³ *Aphasia* – changes in the ability to speak.

⁴ *Alzheimer's disease* (Latin *Morbus Alzheimer*) – is a progressive, degenerative disease of the central nervous system, characterised by dementia. The name comes from the German psychiatrist and neuropathologist Alois Alzheimer, who described the disease in 1906.

⁵ *Cerebral hemorrhage (stroke)* – a sudden focal or generalised brain dysfunction lasting more than 24 hours or leading to death by vascular causes. The following forms are distinguished: 1. *ischaemic stroke* – caused by sudden stoppage of blood flow to the brain, resulting from obstruction of the supplying artery or insufficient blood flow through a given area of the brain contributed to by heart disease (valvular, myocardial infarction, arrhythmias), or

3. brain oedema⁶;

4. multiple sclerosis⁷

and post-trauma (accident), which means that these may be added to the diseases that require a similar procedure as in the case of the aforementioned. People suffering from these require specialised treatment and care. This involves considerable financial outlay by the state (research, treatment). In addition, the economy is unusually burdened by factors such as: care allowances to be paid, employment of qualified staff, and the creation of appropriate assistance centres. The search for budget reserves for this social group encounters insurmountable obstacles. At the same time, the existing focus on productive people (laws of economics) causes a lack of perception and a lack of willingness to address the chronically ill at the end of their lives, or the terminally ill⁸, putting up barriers to them (lack of funding for hospices, palliative wards, and care allowances). In view of the growing demographic and earnings problems we are increasingly confronted with pseudo-rational claims to allow *euthanasia* (from the Greek meaning *good death*), contrary to natural law. It has been accepted that this is defined as the compassionate

cardiogenic embolism; atherosclerosis in other arteries undergoing fragmentation, and displacement of the cerebral arteries, or *intra-arterial embolism*; or conveyed material from the venous system (lower limbs or lesser pelvis), or *paradoxical embolism*; and others.; 2 *haemorrhagic brain stroke* – which is the result of blood exiting the brain's blood vessels, which leads to tissue destruction by extravasated blood, and the most common cause is the rupture of small cerebral arteries in the course of hypertension or vascular abnormalities (vascular malformations, hemangiomas); 3 *subarachnoid haemorrhage* – caused by haemorrhage into the fluid surrounding the brain, usually the cause is rupture of the aneurysm.

⁶ *Brain oedema* – due to the accumulation of water and increased sodium concentration there is an enlargement of brain tissue. This occurs during brain injuries, strokes, central nervous system infections, and osmotic plasma imbalance. It is particularly dangerous due to the limited capacity of the intracranial space.

⁷ *Multiple sclerosis* (lat. *sclerosismultiplex, SM*) – chronic, inflammatory, demyelinating condition of the central nervous system in which multifocal damage occurs (demyelination and axonal degradation) in nerve tissue. Most frequently in the course of multiphase periods of exacerbation and improvement. Generally, this is a disease of the nerve cells (neurons), glial cells (oligodendrocytes), or brain immune cells (microglia), which causes damage to the myelin sheath surrounding nerve cells making it impossible to properly transmit impulses along nerve pathways in the brain and spinal cord. The name of disease reflects the pathological process in various locations in the nervous system, as well as changes spread over time. It is now believed that it is an immune disease in which the immune system combats the body's own cells (nervous system). The disease was first described by Jean-Martin Charcot in 1868.

⁸ *Terminally ill* – patients in the terminal stages, that is, one in which the possibilities of further extending the life of the chronically ill are exhausted with a direct impact on the cause of the disease, and the patient's condition requires that he be taken care of. This is the time for proper palliative care, usually lasting approximately 6-8 weeks.

killing of someone who is suffering and terminally ill. Euthanasia is to be carried out in the name of the “human freedom” to decide for ourselves, but also to interrupt the pain or end the suffering in a phase in which nothing more can be done (resulting in death). From time to time, various countries are swept by a wave of discussion about its permissibility, and this dispute has been going on for centuries.

The aim of the study is not only to approximate the size of the problem of the dying and their families, but also to show the possibilities for social and medical solutions in both a rational (economic) and human manner, without resorting to experiments with euthanasia. Our study was conducted using a diagnostic survey, in which the following techniques were used: an analysis of documents; observation; interview. The observation and interview were conducted in 2011 in two hospices (the St. Lazarus Hospice in Krakow and the St. Brother Albert Hospice in Dąbrowa Tarnowska). Interviews were given to: the management, the volunteer manager, and staff at both institutions. In addition, research on social attitudes towards euthanasia was carried out in the same year in Tarnów (Part 5).

THE SCALE OF TERMINAL DISEASE

In Poland, there has been a rise in the incidence of cancer (more among men than women). Data from 2009 indicate that the highest number of deaths occurred in the following provinces: Masovia (12,832) and Silesia (11,953), and the lowest number in Lubuskie (2,346), Opole (2,424), and Podlaskie (2,790). The remaining provinces recorded an average mortality rate, but a fairly high rate was maintained in: Greater Poland (8.258), Lower Silesia (7.614), and Lesser Poland (7.316). Similarly, to take these indications including the distribution of the provinces, the numbers of cases or their ratios are recorded (Krajowy Rejestr Nowotworów 2013).

The NIH shows that of AIDS patients recorded – 2,867 – 1,192 died (from the implementation of research from 1985 to 28 February 2013). (Narodowy Instytut Zdrowia Publicznego 2013, <http://www.pzh.gov.pl/20.03.2013>) In terms of registration, the majority of such people were diagnosed in Lower Silesia (1.4), and the least in Świętokrzyskie Province (0.2).

The commencement of Alzheimer's disease usually begins in people over 65 years of age; below this age it affects less than 1% of the total (Rowland 2005), increases with age, and over 65 about 14% suffer from it, and over 80 it is close to 40% of the population. It is estimated that there are nearly 250 thousand sufferers (Barcikowska, Liberski 1998).

In Poland, over 65 thousand strokes per year (krs.udarmozgu.org/20.03.2013) are recorded, at a scale of 175 per 100 thousand men and 125 per 100 thousand women. It is a major cause of disability in people over the age of 40, and 30 thousand Poles die from the disease each year (30% in the first month).

In Poland there is a high probability of risk of developing multiple sclerosis. This mostly affects young people, with peak incidence between 20 and 40 years of age, and with a slight predominance in the female population. MS patients live almost 20 years shorter than those not affected. According to the Polish Multiple Sclerosis Society, only 2% of patients take the appropriate medication. Poland is the only country in the European Union where you can die of MS (as a result of complications: bedsores, congestive heart disease, urinary tract conditions).

However, in the case of accidents of various types (transport and others) the statistics for numbers, complications or deaths varies from day to day.

AID FOR THE TERMINALLY ILL – DIAGNOSIS, THERAPY, AND COST

The final stage of a terminal disease only allows for the treatment of symptoms (palliative medicine)⁹, without conducting causal treatment by teams of doctors, nurses, therapists and volunteers, and other people (family, priests, nuns, administrators). This involves not only costs related to the medical staff, but also drugs and possible visits to health or extra-medical centres. In the diagnosis of cancer (though not limited to this) the following

⁹ *Palliative medicine* – one of the newest medical specialties. It is derived from the Latin word *pallium* – a coat, or in its meaning accepting the importance of covering and supporting the patient. The WHO in 2002 defined it as activity that improves the quality of life of patients and their families facing the problems associated with life-threatening illness. This includes the prevention and combating of suffering, early diagnoses, careful examination and treatment of pain, and solving other problems – physical, psychosocial and spiritual, including: – ensuring relief from pain and other distressing symptoms; – affirming life and respecting death as a natural process; – not seeking to accelerate or postpone death; – integrating psychological and spiritual aspects of care; – offering a support system to help patients live as actively as possible to the end; – offering a support system to allow the patient's family to cope during the illness and the period of mourning after death; – is characterised by comprehensive action in solving the problems of patients and their families, including bereavement; – improving the quality of life can positively influence the course of the disease; – in combination with other methods, which aim to prolong life (chemo/radiotherapy), it may be introduced in the early stages of the disease and also includes diagnostics allowing a better interpretation and combating of disturbing complications.

are used: ultrasound, computer tomography, magnetic resonance imaging, positive emission tomography PET-CT¹⁰, mammography, and single-photon emission tomography SPECT¹¹. Treatments used: chemotherapy, radiation therapy, surgery, immunotherapy, local hyperthermia, and a group of medications (taking into account the underlying disease and comorbidities, or those which are a secondary consequence of the initial condition). In the debilitation stage, substances are used in order to obtain an improvement in appetite and a subjective feeling of strength (Maltoni at all 2001). From Department of Health information of 5 January 2011 on the treatment of oncological diseases, it is clear that hospital treatment costs 1.4 billion PLN, outpatient specialist services 200 million PLN, chemotherapy 1.4 billion PLN, and drugs 550 million PLN. Non-standard treatments are not reimbursed (Ministerstwo Zdrowia 2011a).

With respect to AIDS, anti-virus multiplication preparations are applied as well as those preventing its penetration into cells. The most common method is intensive antiviral therapy (HAART) which simultaneously applies several drugs from the group of reverse transcriptase nucleoside inhibitors¹², reverse transcriptase non-nucleoside inhibitors, HIV inhibitors, and fusion inhibitors and prevents viral entry into the cell targeting different stages of development of the virus (Gładysz 2007). Currently, treatment is fully reimbursed, under certain conditions (T-20 – the most expensive medication, priced at about 8,500 PLN – is non-refundable). The cost of HAART is about

¹⁰ *Positive emission tomography PET-CT* – positrons created in radioactive decay collide with electrons in the body to form together two quanta of electromagnetic radiation (photons) moving in opposite directions at an angle of 180 degrees. Detectors positioned at different angles relative to the patient's body allow determination of where the positrons arise, and this information is transmitted in digital form and recorded on a computer disk, which enables the construction of cross-sectional images of the patient. This test utilises the fact that lesions are accompanied by a specified change in the metabolism of certain chemical compounds. It detects tumours 90% of the time. It is part of nuclear medicine.

¹¹ *Single photon emission computed tomography SPECT* – is single-photon tomography which enables the visualisation of cerebral blood flow and its metabolism. The emitted gamma radiation is recorded by sensors placed in a camera connected to a computer that processes the information and presents it in the form of complex maps, and makes them available for three-dimensional imaging. The image is obtainable by the use of a multihead system (multiple sensors distributed around the head) or by a mechanical system which ensures the movement of the recorder around the patient's head. The test takes about 15 minutes (it may be shortened by the use of a gamma camera), it is used to diagnose brain disorders, mental illness, dementia syndromes, cancer of the brain. It is already a part of nuclear medicine.

¹² *Inhibitor* (Latin *inhibeo* – stop) – a chemical compound that causes inhibition or slowing down of a chemical reaction. This process is called inhibition.

40,000 PLN (Gładysz 2007). The financial calculations of the Ministry of Health in 2013 provided for a total of 198.258 million PLN (at 7,100 patients, there is only enough to treat 4,720 of them) (Ministerstwo Zdrowia 2011b).

In Alzheimer's disease the NINCDS-ARDA criteria are used, which are designed to rule out other disorders with similar symptoms, and genetic testing is conducted. Monitoring of the nervous system is conducted with the use of the diagnostic devices mentioned previously, and additionally, functional magnetic resonance imaging (fMRI) and magnetic resonance spectroscopy are used. In neurological and neuropsychiatric diagnosis, MMSE¹³ and depression diagnosis are used. In treatment, the drugs used are to halt the progression of the disease, including: 1. increasing the level of acetylcholine¹⁴; 2. reducing the stimulation of the glutamatergic system; 3 other (cognitive improvement, psychopathological symptoms, and slowing down the process of brain cell destruction) (Szczeklik 2010). The diagnosis and therapy of the patient entail enormous costs, not only mental, but also material, especially for families. A stay in a specialised centre for patients with Alzheimer's disease in Poland costs approximately 4,700 PLN per month, charges for drugs and even diapers (reimbursement for 60 units per month) are covered out of the caregivers' pockets. In the advanced stage, close to 25-35% go to social welfare homes, personal care homes, or hospices (Puls Medycyny 2013).

In the case of stroke, it is essential to determine its type (ischaemic, haemorrhagic). To this end, a CT scan of the head is carried out, and in case of doubt, additional magnetic resonance imaging. With ischaemic strokes, determining the artery occlusion is carried out by angiography, which allows for possible surgical treatment (angioplasty, stenting, mechanical thrombectomy removing the thrombus). In order to determine, for example, the source of embolic material, arterial ultrasound, angiography, and echocardiography are used. In the acute phase, there is monitoring of vital signs, supplementation of water and electrolyte insufficiencies, blood pressure monitoring, blood glucose control (insulin), body temperature-lowering drugs, anticoagulants, anticonvulsants, and decongestants (Szczeklik 2006). According to the Stroke Foundation of Łódź the annual cost of treating strokes in Poland amounts to 675 million PLN (<http://krs.udarmozgu.org/> 20.03.2013) whereas the sum spent on one patient equals about 60,000 PLN (Czernecki, Prędotą-Panecka 2008).

The diagnosis of multiple sclerosis uses the McDonald criteria (2001, 2005) (McDonald at all 2011) based on clinical data, the results of additional

¹³ *MMSE* – a brief assessment tool for dementia. The original test was established in 1975.

¹⁴ *Acetylcholine (ACh)* – an organic compound, an ester of acetic acid and choline. It is a neuromediator synthesised in cholinergic neurons.

tests carried out by nuclear magnetic resonance MRI of the head (shows areas of demyelination within the white matter of the brain) and spinal cord, evoked potentials (visual, brainstem, somatosensory) and examination of cerebrospinal fluid (via lumbar puncture the presence of oligoclonal bands is tested, i.e. immunoglobulin produced by plasma cell clones within the nervous system) (Rudick, Whitaker 1987). To date, no drug has been found that would allow the total halting of the progression of the disease and cure, although there are many treatment methods that may be helpful. Therapies vary depending on the type of disease and the symptoms presenting. Treatment allows the patient to recover functions lost due to relapse and slow its development. *Interferons, glatiramer acetate, mitoxantrone, natalizumab, fingolimod* (Gilenya), *corticosteroids*, and also plasmapheresis are used. Symptomatic therapy covers treatment of common side effects, including: spasticity, sphincter disorders, paresis, difficulty in walking, ataxia, tremor, dizziness, sexual dysfunction, fatigue syndrome, paraesthesia¹⁵, chronic and sudden pain, and others (Liberski at all 2005). Reimbursement of medicines in Poland lasts two years, and the cost of treatment exceeds 2,000 PLN per person (Choroby Seniora.pl 2013), which the patient must pay for themselves. It should be understood that the modern drug Gilenya already costs approximately 9,000 PLN per month, which is about 100 thousand PLN per year and is not reimbursed (Imsm.blox.pl 2013, <http://imsm.blox.pl/20.03.2013>).

In the diagnosis and treatment of posttraumatic conditions all the procedures are used as in the cases shown above (taking into account the specifics of the damage), which in turn leads to the generation of a financial burden. However, it should be noted that the information presented in this paper on the costs of therapy for each condition becomes outdated every month. The costs continue to increase rapidly.

THE AID STRUCTURE FOR THE TERMINALLY ILL – PALLIATIVE CARE

People in the last stages of their disease are routinely managed by general practitioners (who are not always prepared for this) and hospital care (which often dispose of these uncomfortable, expensive, and incurable patients). The solution for someone with a terminal disease is palliative medicine, which is often referred to as the opposite of euthanasia. The WHO (2002) clearly

¹⁵ *Paraesthesia* (paraesthesiae) – in other words phantom feelings such as tingling, numbness, body temperature etc.

states that this care neither accelerates nor delays death, but includes the relief of pain and other symptoms, and control of the patient's mental health, social and spiritual problems. Equally important is family bereavement following the death of a loved one. Hospices, beyond their mission to work with the terminally ill, do not break off contact with the family, monitoring the regularity of the transition between stages of bereavement (phases – the acceptance of true loss, emotional and vegetative experience of grief, adaptation to the changed environment, renewal of strength, and focusing on new goals) (Hebanowski, de Walden-Gałaszko, Zylicz 2004).

Poland hosts at least 400 palliative care centres defined as such or by the term hospice (Jarosz 2007). Hospices are distinguished as: 1. for adults; 2. for children; 3. households. They work in 1. closed (fixed); and 2. daily systems. These hospices, as far back as 2006, had 918 places, and accepted 12,520 people as outpatients. The scale of the need for the establishment of such facilities may be seen in data from Lesser Poland province in 2011, in which various forms of palliative care were used by 3,500-4,000 people per year, and over ten thousand people needed it (<http://wiadomosci.gazeta.pl/20.03.2013>). Every year this type of centre is founded in Poland. In general, they are managed by secular or religious NGOs. They tend to be subsidised, as previously mentioned, by local governments, but in general still struggle with financial difficulties. For example, in Krakow (2011) the daily stay for 1 person cost close to 400 PLN, and under contract the National Health Fund gave 210 PLN (<http://wiadomosci.gazeta.pl/20.03.2013>). In the opinion of Dr. T. Grądalski at the St. Lazarus Hospital, the NHF refunded 21 beds while there were 30-40 people in need (now the number of beds has increased to 44). In contrast, home care involved 30 patients, when 50-60 were needed at this time (<http://wiadomosci.gazeta.pl/20.03.2013>). And, so the costs incurred are high (in 2011, the NHF allocated 24.7 million PLN to palliative care in Lesser Poland (<http://wiadomosci.gazeta.pl/20.03.2013>), and the annual budget of the Hospice in Krakow was about 6.5 million PLN, of which only part was covered by the NFH (<http://wiadomosci.gazeta.pl/20.03.2013>). This is why, alongside hospices, foundations are created to support their activities, whether through a collection of funds or creating and preparing the entire administrative structure.

The groups of people who gather around hospice work are generally those who have in some way come into contact with terminal disease (particularly cancer). The most common form of organisational structure is home care teams and patient wards. In contrast, the state creates palliative care wards in selected healthcare institutions or nursing homes. However, even more often we hear of these being closed as unprofitable for the institutions.

However, so far in Poland there are no specialised centres for daily and full-time care for patients with Alzheimer's disease. There are at most fifteen such facilities, of which Warsaw has two (one has 12 beds, and the other 40).

EUTHANASIA AS THE HIGHEST EXPRESSION OF LOVE OR A ROAD TO NOWHERE

Recently, more and more often the question is raised on the admissibility of shortening human life upon request, i.e. euthanasia. The reason, it seems, why fashionable ideas are transferred from other European countries relating to the human right to freedom of personal choice (including death), is to avoid pain, and for a dignified death, and even the specific interests of whole societies. The result is that nowadays we see on the one hand, a departure from timeless values, their devaluation in the formula approach to life and death on request (suicide, euthanasia), while on the other hand trying to give them the proper dimension, whose culmination is *humanity*. Dynamically developing medicine prolongs human life and improves the chances of survival for weak individuals, thus causing unforeseen consequences and posing challenges to humanity, which should be met, as long as it they can be regarded as such. Those who perceive the value of the individual through the prism of a resource of vital forces agree with the theory that natural selection should have a decisive influence on human life and death. Darwin (1809-1882) himself lamented the fact that human lifesaving medicine provides the opportunity for weak individuals to survive. He expressed his view by stating that *we build asylums for the imbecile, the maimed, and the sick. We institute poor-laws; and our medical men exert their utmost skill to save the life of every one to the last moment* (Darwin 2007). The possible consequences of this way of thinking are given by the German philosopher A. Tille (1895), who indicates that *He who makes an ideal of the encouraging (purity) of the race and wants to realise it has to reach for selection. The direct elimination of the weak, the unfortunate and unnecessary, have not yet been proposed by any serious person, but why not do this in an indirect way* (Bołoz 2007: 211). The consequences of the acceptance of Darwinian ethics can have unforeseen consequences for humanity. This may be confirmed by V. Frankl (1905–1997)¹⁶, who himself was convinced of the terrible implications of this way of thinking as a prisoner in a concentration camp. He cautions against this way of

¹⁶ V. Frankl – Austrian psychiatrist and psychotherapist, prisoner of concentration camps, including Auschwitz.

thinking, saying that *When we present a man... as nothing more than a product of different instincts, heredity and environments, we support (cherish) nihilism, to which modern man is already vulnerable... I am fully convinced that the gas chambers of Auschwitz, Treblinka, and Majdanek were not really the concept of some Ministry or other in Berlin, but were created on the desks and in the lecture halls of nihilistic scientists and philosophers* (Weikar <http://www.heveliusforum.org/20.03.2013>). In this sense, the human being seen as a thinking machine is not a value in itself; does not deserve decent treatment by virtue of their humanity, as shown by the “scientists” experimenting in the death camps. We may be wondering if these doctors are any different from those who see their patients through the prism of the cost of their treatment. Indeed, they make choices about what action to take, or are discouraged by costly medical procedures which save lives. These new, previously unknown extra-medical problems are forcing people to ask the question of whether life is an absolute value that must be protected at all costs. There are those who see the sustaining of human life at all costs as creating unnecessary suffering (T. Kielanowski 1987; Gadzinowski, Wiśniewski 2003). There is also no lack of voices deploring the fact that technical progress, in perfecting methods of saving and sustaining human life, has weakened the forces of nature that once eliminated weak individuals. And so what had hitherto been regarded as a boon to mankind, some consider a curse and a burden. In justifying *euthanasia*, however, it is not utilitarian but humane arguments that are used. Few dare to say that its legalisation would bring benefit to society in the form of financial relief. And we are not just talking about pensions, which are a burden on the state budget, but also the funding of extremely expensive medical procedures aimed at sustaining life. This courage is demonstrated by the well-known bioethicist P. Singer (2010), saying *Therapy for dying patients who do not want to live is a waste* (Singer 2010: 65). Supporting the humanitarian justifications is the result of a fake concern for the sick. They are seen as beings whose lives marked by suffering do not make sense. Thus, it is an act of kindness to shorten their torments. Extending human existence is thus presented as *creating a life that is long and full of physical and spiritual torment* (T. Kielanowski 1987; Gadzinowski, Wiśniewski 2003: 66). This attitude stems from the denial of suffering as an axiological aspect of human life. Anyone who considers that the problem is only the perception of the elderly as unnecessary because they do not work, and are therefore only a burden on the pension system and health insurance, would be wrong, however.

The contemporary social trend is trying to change existing views on the legalisation of *euthanasia*. It may take an active form (causing the death by

a specific action) or a passive form (it takes place as a result of discontinuing life-sustaining therapy). Another classification distinguishes between voluntary euthanasia (there is a conscious request for death) and involuntary (the patient is unable to express such a request, for example, is unconscious) (Nowa Encyklopedia Powszechna PWN 1995). In Polish legislation, and that of some European countries (Greece, Norway, Finland), it is treated as privileged in relation to the crime of murder. And so taking human life on request and under the influence of a compassionate doctor is a crime, but the responsibility of the perpetrator is lesser (lower penalty than in the case of murder). Other countries, including Sweden, do not provide for any right of preference, but the motives and impulses of the offender as mitigating circumstances affect the strength of the penalty. In 2012, the United Kingdom introduced an "End of Life Patient Charter", which allows the decision to shorten life to be taken by the patient or their family. In contrast, France in 2013 authorised its use in special cases (prolonged agony, uncontrolled pain). Countries that have introduced euthanasia are Australia, the Netherlands, Belgium, and Luxembourg. While in Switzerland, it was accepted that the patient must consciously cause their own death in the presence of a doctor. F. Fenigsen (1997), in the times preceding the legalisation of euthanasia in the Netherlands, described the tacit acquiescence of the State and the use of involuntary euthanasia, or killing without the consent of the patient (11% of all deaths), approved by public opinion. This is practised on infants with birth defects, patients with psychiatric illnesses, those with mental handicaps, patients with senile dementia and those in a coma (for example as a result of a traffic accident). The main promoter of this action was the doctor J. van Berg (Fenigsen 1997), who absolutely damned families who did not notify requests for euthanasia from their relatives, claiming that they were guided by obsolete ethical standards, and therefore committees composed of physicians and laymen that would impose such a decision should be formed. The dangers emerging from this approach do not need setting out (getting rid of inconvenient people, people with different views, or a desire to take over assets). Opponents of its introduction, including M. Szweczyk (1996) derive the ban on euthanasia from the need to give legal norms the nature of a guarantee, saying that: *so long as we live in an imperfect world, in which decisions are taken by imperfect beings, thus must the margin of freedom given for decision making which violates the rights of others be as narrow as possible. (...) Consent to the deliberate killing of a human is always an approval of evil and should therefore be kept to an absolute minimum (death sentence), forced somewhat by the fact of living in an organised society. (...) Therefore, the extension of consent to the legalisation of killing another human creates a very*

dangerous precedent, much more harmful than the non-release of an individual from the evil of dying. The possibility of abuse which is borne by permission for legal euthanasia far exceeds the benefits that facilitating dying would bring. (...) The result of relief of suffering can certainly be obtained in other ways than intentional killing. The administration of drugs which dull or halt pain often brings death as a result, but this is not the intention of the individual providing the drugs. And this is the fundamental difference. Thus, acceptance or opposition to euthanasia is an expression of morality and ethics, and the legal solutions to decriminalise or penalise represent only a certain attitude to the moral and ethical principles generally applicable in a given community. However, through its operation the legal system shapes social attitudes. Also, medical ethics (formed in ancient times) set itself the goal of *primum non nocere* (first do no harm). The importance of medical ethics is owed to the fact that its standards were always placed over the principles accepted by society. Only the Nazi doctors rejected those standards, slaying the physically and mentally ill in their country, or conducting extermination in the occupied countries of Europe during the Second World War. As R. Fenigsen (1997) writes: *even just its mental acceptance by physicians would mean a complete reversal of the objectives and values of our profession.* Continuous progress in science raises great hopes, but more and more new ethical problems. The physician should look for a “narrow path” between benefits and possible abuses. There must be no exploration of an ethical alibi for justifying economic problems (living patients cost the state a great deal). The current Polish Code of Medical Ethics (1993) adopted by the National Congress of Physicians, in art. 2 states that: *The vocation of the physician is to protect human life and health (...) the highest ethical imperative for the good of the patient's physician,* and art. 30 states: *The physician cannot employ euthanasia* (Safjan 1998). Additionally, the authors of numerous texts in the field of psychiatry (Siwek 1996) emphasise that in somatic conditions there are almost always emotional and mood disorders and depression. This is influenced by the life-threatening situation in which the patient finds themselves; the risky treatments to which they are subjected; and the biological (metabolic) causes. Also not without significance are external factors, such as the deterioration of the social situation, the loss of prestige, isolation from healthy people, and dependence on the assistance of others. Thus, there is doubt whether a seriously ill individual can make a fully free choice, especially if the goal of this choice is their own death. In contrast, research on the motives for which euthanasia is required has shown that the absence of pain is the primary and most important factor in patient arguments in favour of earlier death. The decision on the willingness to undertake it has primarily

been justified by the conditions in which they happen to get sick, and the relationship of the nearest and dearest (Zaorska 1993). Thus, the argument for the individual's freedom of decision is invalid.

Also, the frequently presented thesis that religion does not always deny the right to euthanasia is not supported. There are various religious systems, but every great religion treats life as valuable. For Judaism, and Islam, human life is an absolute value, sacred, untouchable and only God has the right to decide on it, although now the position of Protestant theologians is not clear (an inalienable right is the right to a dignified death, so that the individual is themselves to the end). In Buddhism, despite the lack of consent to the destruction of man, in the absence of the possibility of patient recovery, they should be assisted in a peaceful death due to the *continuum* of consciousness (Tatarkiewicz 2007). Since St. Augustine (354-430 AD), Catholicism has opposed both active and passive euthanasia. The Catechism of the Catholic Church (Katechizm Kościoła Katolickiego 1994) states that *Action or omission which of itself or by intention causes death in order to eliminate pain, is a murder gravely contrary to the dignity of the human person and respect for the living God, his Creator*. It is also condemned in the encyclical *Evangelium Vitae* by John Paul II, stating that *what might seem logical and humane, when looked at more closely is seen to be senseless and inhumane. Here we are faced with one of the most distressing symptoms of the "culture of death", which is advancing above all in prosperous societies, marked by an attitude based on efficiency, and which sees the growing number of elderly and disabled people as expensive and cumbersome* (Jan Paweł II 1995).

The lack of acceptance of this for the majority of Polish society can be shown by research conducted in 2011 in Tarnow by G. Gałek (2011), K. Kawa (2011) and M. Stępa (2011). Particularly important was determining whether the public would be willing to approve legalisation. G. Gałek examined euthanasia as an ethical challenge for modern society using a survey. The survey consisted of 53 persons aged 25-64, mostly with disabilities, working in various positions in the Department of Protected Work in Tarnów (white-collar and blue-collar workers), of whom 3 were nurses, and 1 person had completed a series of chemotherapy a few months previously. The people discussing the reasons for requesting euthanasia in the majority indicated a fear of suffering (83.02%) and a lack of sufficient support (43.40%). In the respondents' evaluation, society is to some extent responsible for the desire for euthanasia (52.83%). Almost half of them (49.06%) admitted that its legalisation would be an expression of society's helplessness in the face of suffering patients. According to the respondents, the recently observed change in ethical attitudes may lead to a reduction in the importance of

human life (69.81%). The vast majority of people felt that good hospice/palliative care could prevent the desire for euthanasia in patients (71.70%). In contrast, the attitude of society (doctors and medical staff, students and non-medical employees, relatives of patients – 30 people aged 18-76) towards euthanasia in four dimensions (cognitive, emotional, evaluative, behavioural) with the help of the questionnaires and clinical trials of J. Wciórka's "White Card" (Wciórka 1996), was investigated by M. Kawa (2011). The attempt to legalise euthanasia often aroused anger (70%) and controversy (13.3%). The reactions were mostly negative, and rejected the idea. In the opinion of the respondents, euthanasia should be prohibited (63.3%). They believed that it should be punished. A significant number of non-medical practitioners were strongly opposed to its introduction (75%), with 53.3% of health professionals. In the group of students 66.7% of the respondents did not accept it. The results obtained by G. Gałek (2011) and K. Kawa (2011) were confirmed in pilot studies conducted by M. Stępa (2011) on a group of 60 students aged 24-42 using a modification of both the previously mentioned survey and projection methods, with a significantly higher negative opinion on its legalisation (96.28%). Men declared acceptance of euthanasia. The results obtained suggest that such tests should be repeated on a much larger population.

SUMMARY

Serious challenges for our society and the country's economy are posed by the increasing number of older and thus unproductive people. The age attained is often accompanied by the emergence of many chronic, and in the end, terminal diseases. The study has shown selected terminal conditions in the stages of unlikely recovery (cancer, AIDS, Alzheimer's disease, strokes, multiple sclerosis, accidents). In general, these are accompanied by: – in the patients: physical and mental pain; – in families: compassion, impotence, financial deficit; – and in the case of countries: cost generation. Perhaps this is the reason for voices to be raised for the acceptance of euthanasia as a solution for all concerned. The justification is a "dignified death" for the patient. However, the desire to preserve *humanity* cannot allow such a solution. The research conducted by G. Gałek (2011), K. Kawa (2011) and M. Stępa (2011) also contradicts the thesis that society approves of euthanasia.

In conclusion, the considerations presented have given rise to the formulation of proposals for the benefit of patients in the terminal stages of illness: 1. developing a base of specialist palliative care in the form of hospices, pallia-

tive wards, and home hospices; 2 receiving the right amounts of reimbursement by increasing them for palliative care; 3 establishing a fund to pay for the period of terminal care for the caregivers of people who want to remain in their own home to the end (certainly significantly reducing maintenance costs).

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Summary

The aim of the study is not only to approximate the size of the problem of the dying and their families, but also to show the possibilities for social and medical solutions in both a rational (economic) and human manner, without resorting to experiments with euthanasia. Our study was conducted using a diagnostic survey, in which the following techniques were used: an analysis of documents; observation; interview. The observation and interview were conducted in 2011 in two hospices (the St. Lazarus Hospice in Krakow and the St. Brother Albert Hospice in Dąbrowa Tarnowska). Interviews were given to: the management, the volunteer manager, and staff at both institutions. In addition, research on social attitudes towards euthanasia was carried out in the same year in Tarnów.

Key words: incurable disease, cancer, euthanasia