



Relationship Between COVID-19, Euthanasia and Old Age: A Study from a Legal-Ethical Perspective

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Abstract

The global pandemic situation created by COVID-19 leaves many questions open in areas as diverse as politics, economics, society and ethics. The scarcity of health resources and the use that has been made of these by some governments raises the question of whether the distribution of health resources has been equitable, or whether the allocation of health resources depended on criteria such as age. The present work investigates whether those countries or geographical areas where euthanasia is legalized, decriminalized or socially accepted, have followed selective policies limiting access to healthcare by the elderly, thus undermining what is understood as quality of life.

Keywords Euthanasia · Coronavirus · COVID-19 · Elderly · Quality of life

Introduction

What is the relationship between COVID-19, euthanasia and old age? The extraordinary situation the coronavirus pandemic has created has given rise to numerous studies on this pathogen and how to address it, not only as it continues to spread and its impacts are becoming more pervasive, globally, but also after it has been contained or eradicated and people are no longer dying. Perhaps, with a cooler mind, one can better understand the how's and why's of the various responses and arrive at some conclusions.

This study aims to analyze the effects COVID-19 has had and continues to have on the elderly. The approach is not so much an assessment of the overall impact of the pandemic, but it is framed in the context of a reality that seems to be on the rise: legalized euthanasia. The question we are asking is, to what extent does legislation that approves this procedure influence the healthcare measures that are applied to

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the elderly during a global health crisis? On the one hand, there is a feeling of social solidarity in relation to the elderly, COVID-19's hardest-hit demographic, and the positive lessons we can draw from their experiences. On the other hand, the upward trend in the legislation of euthanasia seems to point to older people as no longer having much to contribute to society.

Civil society cannot be driven by such utilitarian criteria. The value of a human life cannot be measured by the person's age, since the right to life is inalienable and a person, regardless of their life stage, should always be accorded the same dignity. Further, the elderly have a vast store of valuable life experience they can share with society. However, the human landscape is not the same in all countries and, thus, the effects of euthanasia policies on the allocation of health resources differ, particularly in the context of the COVID-19 pandemic and the stressors it places on healthcare systems.

This study considers the regulations on euthanasia in the Netherlands, Belgium and Spain, where this procedure is legal, and the particularity, on this issue, of the autonomous community of Catalonia, in Spanish territory. Next, we investigate how the fundamental aspects of life, dignity and freedom are understood from a pro-euthanasia perspective. Here, we study the trends, both theoretical and practical, in those countries whose citizens have the right to freely choose when and how to die and how these policies have led to the increasingly widespread assumption that extending this right constitutes a "slippery slope." This analysis should provide insights into current policy changes that have been adopted during the coronavirus crisis in relation to the health care of the elderly and the influence a pro-euthanasia approach to life and death may have on these decisions.

Conceptual Delimitation

When we talk about euthanasia, what exactly are we referring to? From a medical perspective, euthanasia can be defined as "the process by which a physician deliberately administers a lethal substance or performs an intervention to cause the death of a patient who has decision-making capacity at that patient's voluntary request" (World Medical Association, 2019); assisted suicide or physician-assisted suicide "refers to cases in which, at the voluntary request of a patient with decision-making capacity, a physician deliberately allows a patient to end their life by prescribing or providing medical substances intended to cause death" (World Medical Association, 2019). From a moral point of view, when we talk about euthanasia we refer to the deliberate act of ending a patient's life, either by administering a lethal substance or by ceasing to provide the necessary care required to sustain life, even if this act is carried out according to the patient's own free will or at the request of family members; assisted suicide can be defined as the action by which, at the express request of a capable person, the necessary means are provided to this person so that they can commit suicide (Observatorio de Bioética, 2020).

At the doctrinal level, euthanasia is defined as "the act of killing another person at their request, with the aim of relieving their suffering" (Malaespina, 2017), or as an action performed by another person or persons that causes the quick, effective

and painless death of a patient who is physically or psychologically suffering from an incurable disease that has made their life intolerable, at the express and repeated request of that patient (Malaespina, 2017). These actions are carried out for the benefit of the person and in accordance with their expressed will—an essential requirement that distinguishes euthanasia from homicide—in order to put an end to or avoid unbearable suffering. In euthanasia, there is a direct and immediate causal link between the action performed and the death of the patient. In an assisted suicide, the person who is suffering from an irreversible disease ends their life with the help of another person who provides the knowledge and the means to do so. When the person who helps is a physician, we call this medically assisted suicide (De Miguel and López, 2016).

There are authors who, when addressing this issue from an ethical perspective, maintain that euthanasia occurs when a person, usually a physician, actively and intentionally ends a patient's life through medical means. These authors differentiate assisted suicide as occurring when the physician prescribes or supplies lethal drugs at the patient's request and the patient then self-administers these drugs with the aim of ending their own life (Emanuel, 1994). On the contrary, another part of the doctrine argues that when the factors are the same and the legislation applies to cases of patients with decision-making capacity and who are experiencing unbearable suffering and prefer to hasten their death rather than continue to suffer, there is no real ethical difference between euthanasia and assisted suicide (Sumner, 2013).

From a legal perspective, in countries where legislation that favors euthanasia have already been passed, both euthanasia and assisted suicide are defined as "the conduct of a physician who has terminated a patient's life or has assisted in the patient's suicide at the request of the patient" (Wet van houdende toetsing van levensbeëindiging op verzoek en hulp bij zelfdoding en wijziging van het Wetboek van Strafrecht en van de Wet op de lijkbezorging (Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding, 2001). In a country where the law refers only to euthanasia, euthanasia is defined as the act, practiced by a third party, which intentionally puts an end to a patient's life at the request of that patient (Loi relative à l'euthanasie, C-2002/09590, 2002). In short, when talking about euthanasia, there must be a series of constituent elements: The patient requesting the procedure must do so voluntarily, and the patient must have been diagnosed with a terminal illness from which they are experiencing unbearable suffering. Euthanasia should not be confused with other end-of-life medical decisions, such as withdrawing life-prolonging treatment, intensifying pain-relieving measures that will hasten death or ending the patient's life without their having made an explicit request (Rietjens et al. 2009).

Euthanasia Legislation in the Netherlands

Three legal systems as they relate to euthanasia were investigated for this study; however, the results could also be extrapolated to other countries that have legalized euthanasia and even to societies that are leaning toward its legalization but have not yet debated it and brought legislation into force.

The Netherlands seems appropriate for our first case as the debate over euthanasia has been going on in that country for decades. In 1990, the Ministry of Justice, together with the Royal Dutch Medical Association, which had been in favor of euthanasia, established an official notification procedure so that any discussions about euthanasia could be carried to achieve greater transparency. The legal text had yet to be drafted, but what the debate of this process implied was the possibility that if physicians were to provide assistance in a patient's death while following the criteria of due care, then these physicians would not be prosecuted. The notification procedure involved the physician who had performed euthanasia on a patient filling out an extensive questionnaire that informed the local coroner of that fact immediately following the procedure's completion. The coroner would then inform the prosecutor, who would decide whether the doctor had met the criteria for due care or whether they should be prosecuted (Rietjens et al. 2009).

In 1990, the Dutch Parliament set up a commission on euthanasia, chaired by Dutch Supreme Court prosecutor Dr. Remmelink, who wrote a report on the commission's findings, which he submitted to the Dutch Parliament. Specific legislation was drafted in 1994, but the Dutch criminal code remained unchanged and its Articles 293 and 294 continued to consider euthanasia a criminal act. However, Remmelink's report did result in a revision to Sect. 10 of the Act on the Disposal of Corpses, which also occurred in 1994. A new form was also drafted and brought into use. It was administered by the local coroner, an official intermediate between the examining magistrate and the forensic doctor, and had to be filled out by the doctor who had performed euthanasia on the patient, certifying that the conditions required by Dutch legislation had been met. The form was then sent to the public prosecutor's office; this would ensure that the doctor's action would not be penalized (Aramany, 1998).

Prior to this, when euthanasia was illegal but tolerated, the euthanizing doctor was obliged to consult the relatives of the person who had asked to die. Due to qualms over personal autonomy and patient-doctor confidentiality—an entirely proper concern to protect vulnerable people from unscrupulous relatives—this obligation was not entered into the 2002 law that legalized euthanasia in the Netherlands (Bellaigue, 2019). The law legalized euthanasia but, in reality, it legalized a procedure that had already existed. The most notable difference between the existing reality and the new law was that the latter reduced the extent of legal interference in medical practices that provided euthanasia (Rietjens et al. 2009). Between the two possibilities presented by the law, assisted suicide and euthanasia, the former was responsible for far fewer deaths than the latter. Perhaps this was because physicians themselves preferred to guide the whole process toward death in anticipation of the difficulties that might arise (Groenewoud et al. 2000). The legalization of euthanasia was mainly motivated by three changes that were becoming integrated into society: individualization, fewer taboos around death and the conviction that prolonging a patient's life was not always the most appropriate treatment (Weyers, 2006).

In contrast to the Belgian case, the protracted debate on euthanasia that had lasted for decades in the Netherlands led to the emergence of associated discussions around the legal implications for euthanasia. Two cases in particular stand out for their influence on public awareness of this practice, on the process and on its

legalization. The first dates to 1973 and is the so-called Postma case, concerning the death a doctor provided to his mother after she repeatedly requested euthanasia. Although the court found that the doctor had committed murder, the case nevertheless helped break the taboos that existed in a society with strong Christian traditions and it raised awareness among medical professionals who understood that a doctor has no reason to keep a patient alive against their will when the patient is terminally ill and experiencing needless suffering. The second case, and the first to be heard by the Dutch Supreme Court, was the Schoonenheim case in 1984, in which a 95-year-old person, who had been suffering unbearably from various physical impairments, was euthanized. The court introduced the concept of necessity applied to medical personnel, which meant that the physician was sometimes subjected to a conflict of interest between their duty to alleviate the patient's suffering and the injunction to do no harm, so the court decided to acquit the physician of the charge of murder (Rietjens et al. 2009). So important was the value of the Dutch court's judicial decisions that it can be said that the Dutch euthanasia law of 2001 was the codification of this court's jurisprudence (Rozemond, 2010).

The law that currently regulates euthanasia, known as the Act on the Termination of Life at One's Request and Suicide Assistance, dated April 12, 2001, not only permits euthanasia, as was the case with the previous legislation, but also considers it to be legal for a doctor to apply a direct and effective intervention to cause a patient's death. A number of requirements must be met. First, the patient's request must be voluntary and well-considered. Second, their suffering must be unbearable and there must be no hope of improvement. Third, the patient must have been informed of their diagnosis and prognosis. Fourth, there must be no other reasonable alternative course of care for their condition. Fifth, at least one independent physician must have seen the patient and issued a written opinion on their case. Lastly, the termination of the patient's life or assistance in their suicide must be carried out with the utmost care and attention. Minors may also request euthanasia, in some cases with parental consent (between 12 and 16 years of age), or without consent, although the parents participate in the final decision (for those between 16 and 17 years of age). Compliance with these requirements is verified by a series of regional commissions, which, if they find that the doctor who had performed the euthanasia had committed any irregularities, they will notify the State Attorney General and the regional healthcare inspector, who will then expunge any possible criminal responsibility or consequences arising from the medical action.

One of the questions the Dutch legislation leaves open is that of "unbearable suffering." This is a concept that is loaded with subjectivity and difficult to set limits for, especially when it refers not so much to physical suffering but to psychological or existential suffering or to cases of dementia. The problem lies in the fact that "to assess insupportability, physicians need to know how their patients experience suffering, and there is no specific instrument that can do so" (Rietjens et al. 2009). Some authors argue that since the physician cannot assess the patient's suffering, this should be left to the patient (Buiting et al. 2008).

In the Netherlands, the law considers euthanasia to be an exception; it does not regard it as a right but as a possibility that, under certain circumstances and with the fulfillment of the required conditions, is not subject to criminalization (Boer,

2009). Although decisions around euthanasia may seem to be based on strict criteria, the law's text contains open rules that makes it possible to administer euthanasia under a fairly broad range of contexts. This has given rise to the fact that euthanasia has gone from being considered a last resort in the case of someone facing a horrible death to a remedy for an unbearable life (Boer, 2019). Other authors argue that the fundamental principle on which this law is based is not that of the subject's self-determination but that of mercy, which is understood as a justification for ending a patient's suffering. From this perspective, whoever approaches the text of the law can understand that the law is based on a restrictive norm since it leaves little room for the patient to exercise their own free will in requesting euthanasia and, instead, transfers the decision-making process to the physician who examines the case (Rozemond, 2010).

Euthanasia Legislation in Belgium

The history of the legalization of euthanasia in Belgium parallels the process followed in the Netherlands. From 1994 to 1996, various political parties submitted to Parliament as many as eight bills on regulating euthanasia, and the Christian Democratic parliamentary majority systematically rejected each one. June 13, 1999, marked a turning point in the whole process. After the general elections, that year, the Christian Democratic Party lost power after more than forty years in office; this allowed the formation of a coalition government with six parties that spanned liberal, social democratic and green ideologies. The newcomers agreed to raise the issue of euthanasia in a parliamentary debate. Following this approach, in December that year, six senators from the various parties agreed to jointly submit three legislative projects to the House: one on euthanasia, another on the creation of a commission to control euthanasia and a third on palliative care. The Senate Justice and Social Affairs Committee debated these initiatives, to which were appended more than 600 amendments. Ultimately, two legislative proposals were approved: one on euthanasia, the other on palliative care. After full Senate approval, the proposal on euthanasia went to Parliament, where it was debated and approved over two days of discussions and became law on May 28, 2002 (Simón & Barrio, 2012).

Unlike what had occurred in Spain, the Belgian process that led to the final approval of the law on euthanasia had also received the approval of the Advisory Committee on Bioethics. In its Recommendation No. 1 of May 12, 1997, the committee pointed out the advisability of establishing a legal regulation for euthanasia. On July 2, 2001, the Council of State gave its consent to the bill on euthanasia, established that its text conformed with international instruments that protected human rights, and pointed out that the jurisprudence of the European Court of Human Rights does not establish the state's obligation to protect a person's life against the will of that person (Herremans, 2011).

The Belgian euthanasia law was less specific than the Netherlands on the development of its text; the latter already had a long-established practice and jurisprudence on euthanasia. In Belgium, not only was there a lack of jurisprudence but also the text was the result of political confrontation between liberals

and conservatives in a society where a high percentage of physicians were against the legalization of euthanasia (Adams & Nys, 2003). In fact, no Belgian medical association supported the law on euthanasia. They saw this as opening the door to ending a person's life even in cases where the person had an incurable disease but nevertheless years to live (Cohen-Almagor & Phil, 2009). Dr. Marc Moens, president of the Belgian Association of Doctors' Unions (BVA), even said that "doctors know that this law is simply flawed and find it totally unacceptable that individuals who are not terminally ill will also be eligible for euthanasia" (Nys, 2002). The Dutch law was the subject of an extensive public debate that had begun in the 1970s, whereas the Belgian euthanasia law was the result of a debate that lasted only three years, both in Parliament and within the Bioethics Advisory Committee (Deliens, 2003). Some go so far as to argue that "the 2002 Act on Euthanasia was a hasty and flawed piece of legislation which served to justify a preexistent practice" (Saad, 2017).

Belgium's euthanasia bill was developed outside criminal law, establishing a specific law on the matter. In contrast, the new Dutch legislation on euthanasia was linked to criminal law, the procedure being considered legal as long as the act was carried out by a physician who used the proper procedures. Technically speaking, this makes it possible to point out that in the Netherlands euthanasia has not been decriminalized (Judo, 2013). Another important difference between the two provisions is that the Belgian law does not provide for assisted suicide, even though the ethical differences between this and euthanasia are minimal. This is perhaps because the country's criminal law does not criminalize euthanasia. In contrast, Dutch law includes both euthanasia and assisted suicide (Adams & Nys, 2003). Although one of the basic principles of euthanasia is patient autonomy, it cannot be considered absolute since it is not enough for the patient to request euthanasia. The physician must verify that the legally required conditions are met: voluntary patient request, unbearable physical or psychological suffering, and an incurable disease or physical condition (Herremans, 2011).

One of the advantages of the Belgian legislation is that, along with the law on euthanasia, a law on palliative care was passed on June 14, 2001. At first sight, this offered the patient the possibility of choosing their preferred end-of-life modality. Since they now had a third option in the form of palliative care, they were not compelled to choose between suffering and euthanasia (Delfosse, 2011). This assumption raises an important question: Can the patient's situation really be considered hopeless and, therefore, amenable to euthanasia, when they have refused viable medical alternatives that might improve their situation? Some authors argue that euthanasia cannot be justified in cases where a patient refuses medically significant treatment (Gevers & Legemaate, 1997). The requirement to consult a palliative care expert prior to requesting euthanasia was rejected in Parliament during the period of the law's passage (Cohen-Almagor & Phil, 2009). From the definition of euthanasia contained in the legal text it can be deduced that, even though it grants the patient the right to request euthanasia, it does not elevate euthanasia to the status of a right (Delfosse, 2011). The final text that legalizes euthanasia in Belgium was based on three fundamental principles: patient autonomy, medical participation in the euthanasia process as an ethical act of compassion for suffering and social pluralism,

which implies respect for a person's convictions and values regarding their concept or understanding of suffering, and life and death, even if these are not shared by others (Vermeersch, 2004).

The Belgian law on euthanasia states that the doctor who performs the procedure does not commit an offence if the following criteria are met: The patient is an adult or an emancipated minor; the request is made voluntarily, thoughtfully and repeatedly; the patient has an unbearable medical condition with no hope of a cure or improvement; the patient is informed of their state of health and life expectancy; the patient is consulted on their request for euthanasia and informed of the therapeutic and palliative care options and their consequences and arrives at the conviction that there is no other reasonable solution to their situation; another doctor is consulted about the severity and incurable nature of the condition; and when the patient is a minor who is not emancipated, a child psychiatrist or psychologist is consulted, who must verify the minor's ability to discern their situation and the choice they are making. If it is believed that the death of the emancipated adult or minor patient will not occur in the short term, a second doctor, psychiatrist or specialist must also be consulted and the reasons for the consultation must be specified. At least one month must be allowed to elapse between the patient's written request and the euthanasia. The patient's request, as well as the agreement of the legal representatives if the patient is a minor, must be recorded in writing, and the patient must be able to revoke their request at any time (Loi relative à l'euthanasie, C-2002/09590, 2002).

In the event the person is unable to express their will, provision must be made for drawing up a document that provides advanced declarations that reflect the person's desire to be euthanized by a doctor if they are suffering from an incurable pathological condition, if they are unconscious and if their situation is irreversible under the current state of science. In order to proceed with euthanasia, another doctor who must be informed of the reasons for the consultation must confirm the irreversibility of the patient's medical situation. The physician who performs the euthanasia must complete and submit a document of registration to the Federal Monitoring and Evaluation Commission, which is responsible for verifying that the euthanasia has been performed in accordance with the conditions and procedures laid down by law. If the doctor considers that the requirements of the law have not been met, they must send the entire file to the public prosecutor's office that has jurisdiction over the location where the death had occurred. Every two years, this commission is obliged to draw up a report that provides statistics, evaluations and recommendations on euthanasia, which it then remits to the various legislative chambers (Loi relative à l'euthanasie, C-2002/09590, 2002).

It is often a general practitioner who intervenes in the euthanasia process and this requires knowledge of the law, professional training in the use of the most appropriate techniques and a doctor-patient relationship of trust (Figa, 2006). The physician's ability to act is limited since they only decide whether the patient's condition is incurable, while it is the patient who determines whether their physical or mental suffering is unbearable. This is one of the negative consequences of this law, since it gives too much power to the patient's subjective decision making (Adams & Nys, 2003). Further, this law opens the door to the possibility of applying euthanasia to psychiatric patients. This raises the question of whether this prerogative is viable,

since mental suffering is irreconcilable with a voluntary and premeditated expression of one's wishes, as required by the legal text, and this would generate legal uncertainty when applying the regulation (Adams & Nys, 2003).

In 2014, an amendment to the original text was approved. It allowed access to euthanasia not only to emancipated minors, as was recognized in the 2002 law, but also to minors in general. Only minors who are suffering from a terminal illness that causes irremediable suffering can request euthanasia. The suffering can only be physical, and it must be proven that the patient will die in the short term. The patient themselves must make the request in writing, but they cannot undergo euthanasia without the consent of their legal representatives and without having been previously examined by a child psychiatrist or psychologist. In contrast to the fixed criterion established by the Dutch euthanasia law, which sets the age limit for requesting euthanasia at 12 years, the Belgian law introduces a variable criterion that depends on the assessment of the minor's mental maturity. This raises many questions about the subjective criteria that may accompany this assessment, about the autonomy of the minor, about their capacity to understand the meaning of life and death and about their life experience and whether this gives them the capacity to make such a major decision (Loi modifiant la loi du 28 mai 2002 relative à l'euthanasie, C-2014/09093, 2014).

Euthanasia Legislation in Spain: The Case of Catalonia

On March 18, 2021, the Draft Organic Law on the regulation of euthanasia was approved in the Congress of Deputies by 202 votes in favor, 141 against and 2 abstentions. Once the changes that had been in the Senate were voted on and ratified, with 198 votes in favor, 142 against and 2 abstentions, these changes were incorporated into the legal text and Spain became the sixth country in the world to legalize euthanasia. The law will come into force three months after its publication in the Official State Gazette (BOE); the exception is for Article 17, which refers to the creation and composition of the Guarantee and Evaluation Commissions, which will come into force the day after the article's publication.

The legal text contains an explanatory memorandum that reiterates the definition of euthanasia and describes the "context of euthanasia" as the specific area in which this practice must be developed. The law makes it clear that given the importance of the circumstances surrounding euthanasia, the law is required to be strict and unequivocal when it comes to guaranteeing legal security for both patients and physicians. Euthanasia is established as an individual right that has become part of the legal system. It is a right that is closely related to other rights the Constitution regulates, such as the right to life, to the physical and moral integrity of the person, and to privacy and the freedom of expression and thought. The legislation is based on the principles of the autonomy and dignity of the person, closely associating the latter with the idea of the quality of life. The Council of Deputies has the same jurisdiction as the European Court of Human Rights (ECHR) in that it can support the new law's normative content and the entire process of the legalization of euthanasia.

The development of the articles of the new law began by establishing the scope of the legal standards and by defining a series of concepts to better understand the text. The law's content is clarified by addressing a number of potential questions such as who the law is for: people of legal age and Spanish nationality, or with legal residence in Spain, who suffer from incurable diseases and who freely express the desire to end their lives; the criteria the applicant must meet: The patient's request must be presented in writing in a document that is dated and signed by the patient in the presence of a healthcare professional who witnesses the patient's signature and adds the document to the patient's clinical history. This request may be canceled at any time, according to the patient's wishes when acting under their own free will; the procedure that is established for the process and its development: The attendant doctor can accept or reject the patient's request for euthanasia. If the request is rejected, then the patient can file a claim to have the request reconsidered. If the request is accepted, then the doctor must carry out a careful, deliberate process with the patient, where they ensure the patient understands their medical situation, the alternative treatments available and the expected results, and the type of palliative care available. Once this procedure has been carried out, the healthcare team and family members are informed of the outcome and the consent document is signed. A different doctor, who must corroborate in compliance with all of the legally required conditions, must be consulted on a regular basis, after which the Evaluation and Control Commission is informed of the impending procedure and is in charge of carrying out the control process. If the commission delivers an unfavorable report on the prospective euthanasia, then its decision may be appealed through the local administrative jurisdiction for conflict resolution. If the report is favorable, then it will be brought to the attention of the doctor who has agreed to assist the patient through euthanasia. The doctor will assist the patient by either directly administering a lethal substance or by prescribing said substance to the patient, who will then self-administer it at a healthcare center or in their home. After the patient's death, the doctor who performed euthanasia on the patient then prepares two documents in which a variety of data are reported regarding the patient and the procedure followed and which must be delivered to the Control and Evaluation Commission. Another important issue the new law addresses is the role of conscientious objection. This will be the subject of study at a later point in the work.

In Spain, the state and the autonomous communities share jurisdiction over healthcare delivery and outcomes. Article 148.1.21 of the Spanish Constitution states that the autonomous communities may exert some powers in matters of health care and hygiene. In order to delimit these powers, it is necessary to know which are allocated to the state and which to the communities. Articles 149.1.16^a and 17^a assign to the state exclusive authority on matters of external health, the bases and general coordination of health care, legislation regarding pharmaceutical products, and on basic legislation concerning the economics of social security, without prejudice to the execution of its services by the autonomous communities. The autonomous communities have control in all areas in which the state has no assumed authority.

Respecting the requirement of competence, the Department of Health of the Generalitat de Catalunya published "The Charter of Rights and Duties of Citizens

in relation to Health and Health Care," which it revised and approved in June 2015. In the chapter on autonomy and decision making, Point 5.1.8 states that "a person has the right to live in a manner according to their understanding of maintaining dignity until the end of life. A person has the right to refuse any treatment, even if this treatment is life supporting and already in place, provided that this decision is competent and well-informed. In this context, a person also has the right to receive quality care that alleviates suffering, whether physical, psychological, social or spiritual, that is provided in an appropriate environment (home, hospital, etc.) in accordance with the person's wishes. When a person in full possession of their faculties is in a situation of unbearable suffering and expresses the desire to die and requests help in doing so, they have the right to be treated with respect and to receive help that is proportionate to the intensity of their suffering. A person also has the right to receive assistance from health-care professionals to facilitate a death with dignity and without suffering, always within the existing legal framework" (Generalitat de Catalunya Departament de Salut, 2015).

In 2006, the Department of Health of the Generalitat de Catalunya published its "Report on Euthanasia and Suicide Assistance." This document addresses the situation of a person whose condition places them beyond the help palliative care can provide and who is suffering unbearably from an incurable and disabling disease, while retaining the ability to make decisions, and freely and repeatedly asks for death. Even though the idea of one person acting to end the life of another lacks social roots, it can nevertheless be based on three fundamental aspects that alter this social perception: compassion for the sick; the idea that a life may not be worth living; and the concept of the freedom and autonomy of the patient, who should have the exclusive capacity to decide about their own life. Based on these criteria, the report calls for legislative change to respond to a growing social demand in favor of the right to euthanasia.

The report also makes a distinction between euthanasia and assisted suicide. It establishes a series of requirements to guarantee the adequate practice of assisted suicide or euthanasia, including the presence of a terminal illness (advanced and incurable) that causes permanent, severe suffering; the patient's competence to understand all of the information pertaining to their case and euthanasia and to express a serious, unequivocal and persistent request to terminate their life; the presence of a doctor willing to certify the patient's physical condition and to perform euthanasia; and the opinion of a second doctor, who makes a similar decision on the patient's need for euthanasia. To guarantee a correct application, an *ex ante* control procedure was implemented so that each request must be submitted for authorization by specific bodies, ensuring that all of the regulatory requirements are met. In addition, an *ex post* control commission is in charge of reviewing those cases that are deemed susceptible to non-compliance with the legally established requirements (Generalitat de Catalunya Departament de Salut, 2006).

With regard to the issue of euthanasia, Article 143.4 of the Spanish penal code (1995) states the following: "The conduct of the doctor or physician who through necessary and direct acts causes or cooperates in the death of a person, when this person suffers from a serious and incurable illness or serious, chronic and disabling

illness, under the terms established in the health regulations, will not be punishable". As has been noted, the new law was ratified on March 18, 2021, and will come into force three months after this date. For its part, the regional parliaments of some autonomous communities have approved laws that do not openly refer to euthanasia but to issues related to the rights and guarantees of the dignity of the person at the end life.

The case of Catalonia, which is the one that concerns us here, is paradigmatic. Although it lacks an autonomous law that regulates issues related to the end of life, the Catalan Parliament is the only one to propose reforming the Spanish penal code on the matter of euthanasia before the Congress of Deputies. The first proposal dates from September 5, 2017, and contains a single article that proposes an amendment of the current Article 143.4 of the Criminal Code as follows: "Notwithstanding the provisions of the preceding paragraphs, anyone who, at the express, free and unequivocal request of a person who is suffering from a serious illness that will necessarily lead to death or an incurable pathology that causes serious physical or mental suffering and that is expected to be permanent, causes, by necessary acts, the safe, peaceful and painless death of this person or cooperates in this, within the established legal framework, is exempt from criminal liability" (Proposición de Ley de reforma de la Ley Orgánica 10/1995, de 23 de noviembre, del Código Penal, de despenalización de la eutanasia y la ayuda al suicidio, 2017). This text was discussed and adopted in Parliament, on May 8, 2018, by 175 votes to 136, with 32 abstentions. However, it was soon decreed to be outdated due to the dissolution of Parliament and the call for new elections that had taken place on April 28, 2018. In the XIII legislature, the Catalan Parliament presented the same bill again on July 3, 2019, but the short duration of this parliamentary period again led to the bill's expiration. In the current legislature, the Catalan Parliament presented the same bill for a third time (Proposición de Ley de reforma de la Ley Orgánica 10/1995, de 23 de noviembre, del Código Penal, de despenalización de la eutanasia y la ayuda al suicidio, 2019), an initiative that is still under discussion prior to a vote.

The explanatory memorandum that preceded each of the bills stated that palliative care and euthanasia are complementary and not contradictory concepts. The right to a dignified death means not only legalizing euthanasia but also providing the necessary means to ensure the patient's appropriate care in the final stages of their life and to cover all dimensions of the person, not just their physical needs. At the same time, the memorandum also emphasized the need to strengthen the use of advance directives and to facilitate their registration, to create an oversight group to record causes of death in Catalonia and to ensure compliance with the legislation.

What do we mean when we talk about advance directives and instructions? The Convention for the Protection of Human Rights and the Dignity of the Human Being with Respect to the Applications of Biology and Medicine, which took place in Oviedo, on April 4, 1997, established its Article 9 to define advance directives, noting that "they take in consideration the wishes that have been previously expressed with respect to a medical intervention by a patient who, at the time of the intervention, is not in a position to express their will." This article addressed the essential points that this law on euthanasia should cover, including a clear definition of the concepts, the conditions that must be

met in order to carry out euthanasia and medically assisted suicide, the characteristics the patient must have, the requirements that health personnel must meet in decision making and action, and the composition, tasks and competencies of the supervisory and control bodies. In drafting this article, the Catalan Parliament in the Congress of Deputies emphasized the fact that no autonomous Spanish community had made as much progress in euthanasia as Catalonia. In fact, the Esquerra Republicana de Catalunya, in particular since it has been represented in the Lower House, has supported all euthanasia-related proposals that have been presented in the Spanish Parliament since the first legislatures that discussed the issue, especially by the parliamentary group of Izquierda Unida. This shows that in Catalan society there has been an attitude in favor of euthanasia for many years and this has been echoed by political and legislative bodies.

Based on this situation and in the context of the COVID-19 pandemic, on March 14, 2020, the Catalan Department of Health published a document entitled "Recommendations for support in decision making in regards to limiting therapeutic effort (LTE) for patients with suspected COVID-19 and hypoxaemic Acute Respiratory Failure (ARF)." This publication sets out a series of recommendations that allow medical staff to limit the extent of therapeutic effort offered to the elderly patients, thereby presenting as beneficial what is in fact medical triage.

The situation described above raises two questions. The first is whether The Charter of the rights and duties of citizens in relation to health and health care, published by the Department of Health of the Generalitat de Catalunya, is an exception in this Spanish state or whether the health councils of other autonomous governments have made similar proposals. The answer to this question is "no," and the reason for this is that no Spanish territory has been presided over by a government with a majority favoring independence, as is the case in the autonomous community of Catalonia, nor has there been another government with a political and ethical climate that is favorable to the cause of euthanasia. Within the autonomous communities there are political groups with pro-independence and progressive agendas, despite having parliamentary representation, but not only do they not govern in their respective territories, but they also do not represent a majority of citizens that are capable of implementing a social program that is favorable to euthanasia, as is the case in Catalonia.

The second question that arises is whether the decision expressed by the Department of Health of the Generalitat de Catalunya is truly the result of an altered mindset that favors euthanasia or whether this is the consequence of an emergency situation such as that caused by COVID-19, which shifted emphasis to a distribution of health resources that excluded the elderly. At first glance, a text such as the one presented in Catalonia might seem logical if it were not because, at the time the document was issued, the seriousness of the situation in the autonomous community of Catalonia was neither greater nor lesser than those of the other autonomous communities. This being the case, in this Spanish territory, why is depriving elderly residents the medical services they need during COVID-19 viewed as a solution to limited health resources, while in the rest of Spain such measures were not adopted? The answer cannot be other than that defended

in this work, which is that for many years a mentality favorable to euthanasia has been growing in Catalan society and in emergency situations such as those caused by the pandemic it has been deemed desirable to legalize euthanasia as the most reasonable plan.

Consequences of Accepting Euthanasia

Legalizing euthanasia implies a series of consequences that are not only legal but also ethical, social and anthropological. What are the concepts of life, dignity or freedom implicit in the social acceptance of euthanasia? The answers to each aspect of this question will help us understand the measures that have been taken in regard to the elderly in response to the COVID-19 pandemic in the geographical areas studied. A study of these criteria with a view to a possible regulation will be carried out based on proposals made in the Study Commission on Euthanasia, which was created in the Spanish Senate on March 17, 1998, during its sixth legislature. The legislature ended and the houses were dissolved before the Commission could finish its work. Later, when the seventh legislature began, it did not resume the debate on euthanasia. However, the ideas that emerged from the study during the sixth session, both in favor and against euthanasia, enriched debates in society, politics and the legislature on the suitability of legalizing euthanasia in Spain.

The Concept of Life

With regard to the concept of life, Gracia (1998) maintains that in classical times life generally was given precedence over freedom. Societies argued that life was the foundation of all other values, even though those other values, such as spiritual ones, may be considered superior to it. On the contrary, the modern argument starts from the idea that life without respect for personal autonomy is not worth living (Gracia, 1998).

From the point of view of purely subjectivist ethics, which denies the existence of universal values, life is considered a subjective good, where the person autonomously decides whether to give a positive or negative value to their life. This would imply that every person, regardless of their situation, has the right to ask the state to help to them end their life. If the basis of the dignity of the person lies in their right to self-determination in shaping a life project, then it makes no sense for legislation to permit euthanasia in some cases and prohibit it in others, since this would be contradictory. When life is understood as the biological support required for an individual's existence, then this means the person is allowed to exercise control over their life until it ceases to be satisfactory or becomes a burden, at which they can freely dispose of it. In this way, life "ceases to be an event and becomes a decision to be made by each human being" (de Montalvo et al. 2020a, 2020b, marzo).

Another aspect related to this issue is the quantification of life in terms of quality. Torío (1999) states that the quality of human life is an empirical principle

that holds that human life is presented as a sinuous reality because it has different periods from the fetal stage to adulthood and old age, and each of these periods can be the subject of differentiated considerations. In this regard, Cabré (1998) points out that the value of a life varies throughout a person's existence. If represented graphically, the curve that represents the trajectory of the value of a person's life would be low at birth, at its peak during adolescence and youth, and decrease from there as the person ages. The value of a life is not a constant throughout one's existence because this value cannot be an absolute. What a person says about what they believe and what they have in mind for their life must be respected as their personal estimation of their life's value (Cabré, 1998). For Ramírez (1999), a life loses much of its value if the person does not have the option of living it; it loses its totally when the quality of one's life is far below what an individual is willing to accept.

A human life has a basic value par excellence on a rational scale since without life the realization of other values is impossible. However, Monés (1999) claims that a life does not have an absolute value and, in exceptional circumstances, other values can displace it. Therefore, we must admit that there may be subjects who, in the face of extreme situations, may decide that their quality of life and their dignity have become so diminished that the most basic values of their life are no longer present. The concepts of the quality of life and dignity are subjective values whose meanings depend on the individual and not on the decisions of others. Consequently, if a subject in these extraordinary conditions decides, after an internal assessment, to take their own life, the legal system should not punish them (Monés, 1999).

Bajo (1999) maintains that in the legal system, life is more valuable than freedom, but when it comes to one's life versus one's freedom, the issue is more complicated. There is no right to die that is similar to the right to hold property, meaning that one cannot buy, sell, encumber or transmit "life," but there is a right to what is called the "*agere licere*," which is the freedom to act. There is no right to die, but there is a freedom to live or not to live. Therefore, the state cannot accuse anyone of depriving themselves of life. Life might be a fundamental right, but there is no duty to live, hence the impunity of suicide (Bajo, 1999). Starting from this concept, Ballesteros (1999) notes that life is understood from the perspective of utilitarian philosophy, which distinguishes between the concept of the human being and that of the person. A human being is a member of the human biological species, but not every human being would be considered a person. A person would be a human being who presents certain qualities, such as self-consciousness and freedom, which make them capable of living a biographical life. Only this biographical life would be defined as a life with quality and would have the right to be defended (Ballesteros, 1999).

Life as a juridical good is not simply the biological fact of living but is valued according to a structure that can be ascribed to any juridical good. For example, property is not a book but something that is said to be what that book is about. Berdugo (1999) explains that the same would be true of a life. Having a life is not simply about being alive but is related to the concepts that are said to belong to being alive. If personal juridical goods are individual, then it is difficult to say that they are not available, as would be the case with a life (Berdugo, 1999). In short, when

we speak of the sacredness of life we must also relativize the concept of life; this is because the modern state is based on regulations and its reality is based on pillars that relativize the right to life (for example, legitimate defense, the death penalty, etc.) (Queralt, 1999). If a person exists for the good of society, then why should the person themselves not decide whether someone else should end their life for them when they are unable to physically do so (Queralt, 1999)?

The Freedom-Dignity Binomial¹

Cabré claims that human dignity can be understood in four fundamental ways. From an ontological point of view, every person has a sublime dignity by the mere fact of being a person. According to those who support this theory, this dignity is absolute and cannot be modified under any circumstances. Kant's moral philosophy views human dignity from an ethical point of view and holds that a person should be treated as an end in themselves and never as a mere instrument or means. The legal meaning of dignity views the human person as worthy of rights that protect them against certain abuses or violations precisely because of their ontology and the ethics around human dignity. Finally, human dignity would be that which corresponds to volitional dignity. According to this thesis, the human person is worthy precisely because they are a free being and their dignity is violated when their freedom is violated and they cease to be worthy. It is this conception of dignity that serves as the basis for the pro-euthanasia viewpoint (Cabré, 1999).²

It can be said that "dignity has, as a superior value, a double aspect that is external in that it limits the capacity of the state and third parties to act insofar as they may hinder the development of the person, and is internal, insofar as said development of the person may also be hindered by themselves" (Spanish Bioethics Committee, 2020). Today we have moved from a concept of ontological dignity to a subjective and relativistic concept that is framed in terms of the quality of life. This is a subjective measure because the quality of life is an arbitrary concept with an infinite number of degrees and each person is the judge of their own dignity. When this fact is accepted, a logical syllogism develops: It is accepted that dignity is the foundation of human life, but illness can diminish the quality of life to extreme levels where its value and therefore its dignity are relativized. In these cases, as Fernández-Crehuet (1999) maintained, far from being a form of homicide, euthanasia becomes a supportive aid for those whose lives have lost all dignity.

¹ The link between the concept of dignity and the idea of the self-determination, autonomy or freedom of the person was analyzed by Tomás-Valiente (2014), who pointed out that "apart from cases in which recourse to the notion of dignity (through its connection with the notion of suffering or prostration) adds a "plus" to the appeal to pure and simple self-determination, the use of the concept as equivalent to the latter is of little use."

² Feldman (1999) differentiates three levels within the concept of dignity. First, there is the dignity of the human species as such, which is identified with the objective dimension of the concept. Secondly, the dignity of groups, which have both objective and subjective aspects in relation to how they conceive themselves. Finally, the dignity of the individual, which constitutes the subjective dimension and which is related to personal autonomy (Feldman, 1999).

Dignity is linked to the concept of freedom and less to the concept of responsibility. This volitional dignity is rooted in the essence of the person, inasmuch as every person must be able to choose freedom in their own way. Freedom must be respected, notwithstanding that there are limits. There are those who maintain that every person is worthy of respect simply because they are a person and no attempt can be made on their life because that would be an attack on a human right. There are those who maintain that when a person wants their life to end for whatever reason, this desire must be respected since the fundamental characteristic of a person's dignity is centered on the exercise of their personal freedom (Abel, 1999). Dignity is not simply a corollary to freedom but a quality that is intrinsic to being human, so it cannot depend on physical or psychological conditions. Dignity constitutes each person belonging to the human species, so that to say that someone is a person is equivalent to saying that they are a being who deserves treatment as an end in itself (de Montalvo et al. 2020a, 2020b, marzo). Dignity is conceived of as a cultural element individuals attribute to themselves because they have the capacity to make rational judgments. If dignity were intrinsic, then it would have to be genetic; and if it were genetic, then it would have to carry the burden of all the beings who preceded us. From this concept of dignity, a set of principles has emerged that are the basis of human rights, among them the principle of freedom as an expression of autonomy (Palacios, 1999). If it can be said that all of the values we have attached ourselves to stem from dignity and one of these values is freedom, then how can we be worthy if we cannot be free? To be worthy, the subject needs to be free and autonomous (Palacios, 1999).

There are certain rights that are inalienable; they are attached to the person regardless of whether they consent to these rights. This means that the holder cannot dispose of these rights even when they are attached to the person against their consent. This fundamental characteristic extends to all human rights, and in the specific case of the right to life, it is linked to dignity and freedom. The problem arises when the idea of dignity is understood from a subjective perspective, such that it is the individuals themselves who see themselves in relation to the values they cherish, their aspirations, their bonds with their loved ones, all of which, therefore, may differ considerably from one person to another and may change more with old age or poor health (de Montalvo et al. 2020a, 2020b, marzo).

Applicable Bioethical Principles

Bioethical principles are important because in certain ethically complex situations that may arise in the event of a confrontation the hierarchy that has been established will determine attitudes in favor of or against euthanasia. First, there is the principle of non-maleficence, according to which the physician must always act in a manner that does not harm the patient. Second is the principle of beneficence, which assumes that one must act in such a way as to do good to the patient. The third principle is one by which the patient is the final authority in the decision-making process as it relates to them. The fourth principle is justice as it relates to the distribution of

health resources. In the event of a conflict between the principals who are deciding on how to distribute these resources, if the principles of beneficence and non-maleficence are guaranteed and the patient has an illness from which they can recover, then everything therapeutically possible should be done for them (Cabré, 1998). If there is no chance of recovery, then the extent of the therapeutic effort should be chosen based on the patient's decision-making autonomy, or that of their relatives in the event that they cannot do so (Cabré, 1998).

When these principles come into conflict, although all of them are represented by *prima facie* evidence, those of non-maleficence and justice would be considered supportive of the correct action from a medical point of view, where the founding principle of *primum non nocere* (first do no harm) is found to be in opposition to the idea of causing a death. Fernández-Crehuet (1999) affirms that if we start from the contrary position of favoring legal euthanasia, then the prevailing principles will be those of autonomy and beneficence. If what prevails in the field of bioethics is subjectivism and relativism, then it is almost certain that the option to choose freedom will reflect the consensus opinion from an ethical point of view (Fernández-Crehuet, 1999).

Perhaps in the context of euthanasia the dominant principle is that of autonomy. This principle is built on intelligence and will, both of which require the absence of coercion and presuppose the patient's ability to discern between alternatives. Autonomy is also related to freedom, although the two are not comparable since freedom entails directionality and autonomy is the condition that makes the free action possible (de Montalvo et al. 2020a, 2020b, marzo).

Euthanasia and Old Age

In the case of the elderly, Ribera (1998) states that older people may be tempted more than younger people to resort to euthanasia because their levels of defense are lower, the scruples of the people who can apply these measures are also lower, and as the thinking goes, the idea that they have lived long enough, they are very old, and they have no chance of recovering, therefore let them die, is easier in relation to the aged. Caillavet (1999) points out that, in some countries, this demographic is commonly subjected to what is known as administrative or economic euthanasia, which occurs when a sick person cannot be provided with costly care or when funds or medical devices are scarce. This attitude constitutes a form of "age-related" prejudice, where the choice of treatment is made based on prevailing arguments of the worthiness of a life or the lack thereof under certain life situations. Although the distinction between a worthy and an unworthy life from the perspective of euthanasia is ostensibly made to alleviate the patient's suffering, the decision between whether or not a life's value runs the risk of being interpreted not in a hedonistic sense in favor of the patient but in favor of the person who must attend to him or, even worse, in an economic sense, in accordance with the idea that "your life is not profitable for the community" (Ballesteros, 1999).

In this sector of the population, in the context of euthanasia, the principle of utility applies and this leads to extending euthanasia to cases in which the person cannot

consent but suffers from unbearable and irreducible pain. This principle is also related to the slippery slope argument discussed below. A worrying consequence of the decriminalization of euthanasia would be that what is granted to the patient as a right would subjectively become an obligation in the face of the economic and family problems associated with the elderly. If one of the requirements of the law is the embodiment of the values that are in force in a society, then it does not seem out of the question to think that the incorporation of euthanasia into a country's legal system could imply a tendency to choose to end the life of someone who is no longer useful to society, as can be deduced from the report presented by the Department of Health of the Generalitat de Catalunya in Spain (de Montalvo et al. 2020a, 2020b, marzo).

The so-Called 'Slippery Slope'

A "slippery slope" in the context of legislation is a trend that leads to the adoption of a legislation that is originally conceived in restrictive terms but that ends up leading to progressive modifications in relation to the applicable cases and ultimately to the relaxation of the requirements originally demanded. In the case of euthanasia, the slippery slope began with legislation that restricted the action to terminal patients with very serious illnesses and unmitigated physical suffering. In time, a more lax interpretation was accepted, where psychological suffering is considered, disabling non-terminal illnesses also entered the picture, and doctors were permitted to make decisions on euthanasia without determining whether this was the will of their patients and even in some cases going against patients' will (Germán, 2019). It can be stated that "the slippery slope argument is commonly used in connection with the expansion of intentionally ending the lives of patients who had not made explicit requests" (Luzon, 2019).

Some authors claim that the slippery slope argument tries to establish that the legalization of euthanasia would lead to the acceptance of non-voluntary euthanasia (Bgaric, 2002). What it means, perhaps, is that the proclamation of access to compassionate homicide as a right "has an expansive force in some cases and a tendency to blur the limits, giving rise to a non-negligible proportion of cases of non-voluntary euthanasia" (de Montalvo et al. 2020a, 2020b, marzo). However, the approach advocated in this paper is not so much to discern whether there is an increase in involuntary euthanasia, an aspect that is difficult to measure, but rather whether a euthanasia mentality could gradually be generated in a society and could lead to triage criteria in health care such as those proposed for some COVID-19 cases. In other situations, a person may believe that they are a burden to society or the family and wish to end their life. In expanding the practice of euthanasia, subjective criteria such as depression or quality of life may come into play or, as in the case of minors or the insane, the final decision may be placed in the hands of third parties.

Vega (2007) proposed a scheme to verify the existence of a slippery slope situation for euthanasia in relation to cases in Belgium. Four fundamental levels were defined: Level A places us at the beginning of the slippery slope, where there is a law that authorizes medically assisted suicide when three requirements are

met: full voluntariness, and the condition of being terminally ill and of suffering unbearable pain. The descent down the slope to Level B would occur when non-voluntary and involuntary cases are allowed (demented elderly, mentally disturbed patients, etc.). The descent down the slope to Level C would occur when medically assisted suicide is allowed for incurable non-terminal patients, or for those whose conditions are reversible or whose illnesses could be cured. The descent down the slope to Level D would occur when medically assisted suicide is allowed for reasons such as psychological suffering, loss of autonomy, poor quality of life or the feeling of being an economic burden.

Nevertheless, there are some authors who deny the slippery slope argument, pointing out that it is based on purely psychological and speculative reasoning. This argument must be answered with different data, both quantitative and qualitative. With regard to the former, it should be pointed out that since the legalization of euthanasia, in 2002, in both Belgium and the Netherlands, there has been a significant increase in the number of cases. In the Netherlands, between 2003 and 2008, the number of cases increased from 1,815 to 2,120 or by 16.8% (Regionale Toetsingscommissies Euthanasie, 2003–2008). Between 2009 and 2013, deaths by euthanasia further increased from 2,636 to 4,829 or 76.3% (Regionale Toetsingscommissies Euthanasie, 2009–2013). The period from 2014 to 2019, the latest period for which data are available, saw a further rise in euthanasia deaths in the Netherlands, from 5,306 to 6,361 or 19.8% (Regionale Toetsingscommissies Euthanasie, 2014–2019). Although the trend is not constant, it seems clear that the increase in the number of deaths by euthanasia has been progressively growing. Since the approval of the law regulating this practice, the number of cases in the Netherlands has increased by approximately 250%. Although the percent increase in the number of euthanasia deaths was very high in the second five-year period, it remained stable in the first and third five-year periods in all years except 2018, where there was a slight decrease in euthanasia deaths. Since euthanasia was approved in the Netherlands last year, there has been an increase in the number of deaths from this procedure.

In Belgium there has also been an annual increase in the number of cases since the law was passed in 2002. Examining the data in five-year periods, we see that from 2003 to 2008, the number of cases increased from 235 to 704, an increase of 300% (Commission Fédérale de Contrôle et d'Évaluation de l'Euthanasie, 2003–2008). In the second five-year period, between 2009 and 2013, there was a further increase in deaths by euthanasia, from 822 to 1807, or by 120% (Commission fédérale de Contrôle et d'Évaluation de l'Euthanasie, 2009–2013). The latest period, covering 2014 to 2019, saw a further rise in euthanasia deaths in that country, from 1,928 to 2,656, or by 37.8%, the latest year for which official data are available being 2019 (Commission Fédérale de Contrôle et d'Évaluation de l'Euthanasie, 2014–2019). Although the trend in Belgium is not constant, it seems clear that the increase in the number of deaths by euthanasia has continued to grow so that, since the approval of the law regulating this practice, the increase in the number of cases has been approximately 1.030 per thousand. Although the percentage increase in the number of deaths has been decreasing in each five-year period, in every year since

euthanasia was approved in Belgium, there has been an increase in the number of people who have ended their lives through this procedure.

Concerning the qualitative aspect of how widely euthanasia practices have spread, attention is drawn to a study carried out by the so-called End-of-Life Clinic, a second option to which some people can turn after their family doctor has denied their request for euthanasia. The data show that 6.8% of patients who sought access to euthanasia claimed that they were tired of living (Snijdewind et al. 2015). Such a vague, subjective reason not only relativizes euthanasia as a practice, but it also allows its extension to numerous cases whose grounds are far from the ethical ones established as legitimizing it.

In its 2020 report, the Spanish Bioethics Committee argued that the notion of utility—which is being implemented in the field of euthanasia as a fundamental principle together with the principle of self-determination—is causing the idea of death as a decision that evolves from the sphere of the individual to that of society, especially in the case of newborns, terminally ill patients who can no longer express their will and people with mental illnesses (de Montalvo et al. 2020a, 2020b, marzo). The idea of being tired of living carries with it the danger of confusing suffering with old age. This could cause the most vulnerable people to consider euthanasia, especially those over 80 years of age who may experience loneliness or who have ailments that are associated with age and lack of motivation. Such a practice would no longer be considered a compassionate death but as a death *à la carte*. The patient's self-determination would take precedence over the reality of their life, and euthanasia would be presented as the solution to frailty and loneliness. These possibilities should provoke profound reflection in a society, such as the European one, which is getting older every day and in which, more than people being tired of living, there are perhaps people who are becoming tired of caring.

Another issue that points to the validity of the slippery slope argument is that of psychiatric suffering. Although in the drafting of the Belgian euthanasia law it was stated that the psychiatric suffering of the patient could not be sufficient cause for euthanasia, the data show otherwise as 108 people in that country were euthanized for depression between 2014 and 2015 (Ginés, 2020). The concept of "irreversible psychiatric suffering" is problematic from a scientific point of view and raises the question of whether a person in such a condition is capable of making a rational judgment about euthanasia as is required by law. Two further aspects related to euthanasia can be considered fundamental in understanding the slippery slope argument: dementia and autonomy. In relation to the former, many people sign advance directives that stipulate that if their mental state deteriorates to the point of their not recognizing their family, then they would prefer to have their life terminated; however, they might later express wishes against this request. When autonomy has been lost, it is no longer possible to decide about one's own life and it is impossible for a physician to discern whether a patient is suffering unbearably. When a patient can no longer communicate their wishes, they lose their autonomy and become subject to a decision they might have made some time ago that perhaps they would not maintain now. "The underlying problem with advance directives is that they imply the subordination of an irrational human being to their rational former self" (Bel-laigue, 2019).

Economic savings is another argument that supports the reality of the slippery slope. A study carried out in Canada indicates that the state would save CDN\$13,000 for each patient who undergoes euthanasia. In some parts of Canada, 1% of the population who are terminally or seriously ill account for 20% of total healthcare expenditures (Trachtenberg & Manns, 2017). Another aspect to bear in mind is the degree of paternalism physicians manifest in relation to their patients. The legalization of euthanasia could serve as an argument for physicians to be able to decide on the life of their patient. A study by Smets et al. (2011) shows that 60% of physicians think they should be able to end the life of a patient who is suffering unbearably and who is incapable of making decisions about their life. Empirical data seem to support the slippery slope argument. Nevertheless, there are those who deny this connection by using a syllogism, arguing that the fact that B (non-voluntary euthanasia or euthanasia for the non-terminally ill) is reached once A (voluntary euthanasia), has been enacted, does not mean that whenever A is allowed, this must always lead to B (Smith, 2005). This would support the slippery slope argument, even if only as a possibility. But if applied in practice it would open the door to extending euthanasia to many types of cases and could generate a euthanasia-oriented mentality in society.

In spite of the potential for abuse, studies show that there is strong public support for extending the types of cases in which euthanasia could be legally permitted. This social support is based on a convincing logic according to which it does not make sense to make it legally impossible for an individual to decide how they wish to die (Boer, 2019). An example of this can be seen in the Netherlands, where the *Levensseindekliniek*, or the End-of-Life Clinic alluded to above, was created to put doctors who are willing to perform euthanasia in contact with those patients whose requests for assistance in dying have already been rejected by another doctor because they do not meet the legal requirements. This organization was responsible for the euthanasia of some 750 people in 2017 (Klampfer, 2019).

Bert Keizer, a physician who in 2017 alone assisted 75 patients with euthanasia and is a staunch advocate of the practice, recognizes the veracity of the slippery slope argument. The idea of introducing euthanasia as a response to the most heart-breaking cases of human suffering has set in motion a mechanism that goes beyond the consequences that could initially be foreseen. In 2017, "the Netherlands' health and justice ministers issued a joint proposal for a 'completed life' pill that would give anyone over 70 years of age the right to receive a lethal poison, completely cutting the doctor out of the equation" (Bellaigue, 2019). This proposal was rejected, but this does not mean that it could open a new door to euthanasia on the kind of slippery slope that could increase the number of cases and modalities that would fall within the legal definitions applied to this practice.

Euthanasia and Conscientious Objection

In the Netherlands, the euthanasia law establishes the possibility that doctors can refuse to perform euthanasia and nurses can refuse to be involved in preparations for euthanasia on the basis that patients do not have an absolute right to euthanasia

and doctors do not have an absolute duty to perform the procedure (Wet van houdende toetsing van levensbeëindiging op verzoek en hulp bij zelfdoding en wijziging van het Wetboek van Strafrecht en van de Wet op de lijkbezorging) (Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding, 2001). Article 14 of the Belgian law, which decriminalizes euthanasia, refers to conscientious objection, which establishes that a doctor who refuses to participate in the practice of euthanasia has the duty to both inform the patient and justify the refusal and also to transfer the patient to another doctor who is prepared to carry out the procedure (Loi relative à l'euthanasie, C-2002/09590, 2002). With regard to the Portuguese law, after its approval on January 29, 2021, on March 18, 2021, the President of the Republic of Portugal sent the legal text to the Constitutional Court for review. In its ruling, the Court decreed the unconstitutionality of Articles 4, 5, 7 and 27 of the law on euthanasia as being contrary to Article 24 of the country's constitution, which determines the inviolability of human life.

What conclusions can be drawn from a comparison of the above normative texts? First, what is peculiar to the laws in the Netherlands and Belgium is that they both refer to conscientious objection and legal objection, since the right not to perform euthanasia is clearly recognized as long as it is justified, but the sphere of conscience is not mentioned at any time. The requirements stated in most laws consist of communication to the patient within 24 h and transfer of the file to a doctor agreeing to perform euthanasia. The text that imposes the most requirements for the exercise of conscientious objection is a Spanish bill that requires the institution of a registry of objectors. Article 16 of the Spanish Organic Law Project for the regulation of euthanasia, presented to the legislature on January 31, 2020, created a paradoxical situation: While the category of the right to conscientious objection is recognized, a feature not included in any other euthanasia project, it poses an extraordinary demand: the need for health personnel who oppose the practice of euthanasia to register their declaration in a registry of objectors. What are the potential legal consequences for the objector?

Conscientious objection is a private act in the sense that the objector often avoids making the objection public. It follows that compulsory registration in a registry may deprive the objector of their privacy, possibly engendering personal and moral damage in addition to possible discriminatory consequences. What is the current situation regarding the right to conscientious objection in the Spanish health system? It can be said that it went from being a constitutionally protected right to being considered an autonomous right to eventually becoming a right whose exercise is conditional upon the objecting doctor's registration in a registry of objectors.

What must be established is whether a registry of objectors would constitute limiting a doctor's right to their conscientious objection. The doctrine of the Constitutional Court has established as unconstitutional any measure that has a discouraging effect on the exercise of any right; for example, there are texts regarding the exercise of the freedom of expression (110/2000, 5 May, 2/2001, 15 January and 174/2006, 5 June); the right to assembly (196/2002, 28 October and 110/2006, 3 April); trade-union freedom (70/200, 13 March, 265/2000, 13 November, 88/2003, 19 May, 185/2003, 27 October, 241/2005, 10 October, 151/2006, 22 May or

108/2008, 22 September); the right to strike (104/2011, 20 June) and the right to privacy (196/2006, 3 July).

Currently in Spain, Organic Law 2/2010, March 3, on Sexual and Reproductive Health and Voluntary Termination of Pregnancy (*Ley Orgánica 2/2010, de 3 de marzo, de salud sexual y reproductiva y de la interrupción voluntaria del embarazo*, 2010) regulates conscientious objection through Article 19.2, where it states that health professionals directly involved in the voluntary interruption of a pregnancy have the right to exercise their conscientious objection without damaging the patient's access to the procedure and their quality of care. Refusal to be involved in the termination of a pregnancy for reasons of conscience is an individual decision for a health professional who is potentially directly involved in the execution of the voluntary termination; this objection must be stated in advance and in writing. In any case, health professionals will provide adequate medical treatment and care to women who need it before and after their pregnancy is terminated.

The aforementioned law does not include any reference to the existence of a registry of objectors; however, in development of this norm, the Parliament of Navarra approved Formal Law 16/2010, of November 8, created a registry of professional objectors to abortion that was challenged before the Constitutional Court. In its Judgment 151/2014 of September 25, the Court rejected practically all of the petitioners' requests; however, it recognized the unconstitutionality of allowing access the registry data. The ruling of the Spanish Constitutional Court would be applicable to the case of a registry of objectors being included in the draft law on euthanasia. However, we take the side of the dissenting opinion of Judge Ollero Tassara in the aforementioned ruling, in which he states that the existence of a registry of objectors is unnecessary and violates the right to freedom of conscience.

Two requirements in the euthanasia bill relate to conscientious objection: the patient's knowledge of a doctor who is able to carry out the practice and the health system's organizational purpose for its effective application. Both requirements would be more adequately met with the creation of a registry of doctors agreeing to practice euthanasia; thus, avoiding the public exposure of objecting doctors, or the violation of their right to privacy and non-discrimination as well as avoiding a debate on whether the creation of a registry of objectors is a necessary and proportionate measure in a democratic society.

Influence of a Euthanasia Mentality as It Affects Older People

The Case of Catalonia

When the World Health Organization announced that the spread of COVID-19 constituted a pandemic, the *Consejería* of Health of the *Generalitat de Catalunya* issued a report on the protocol to be followed when treating patients suspected of being infected by the coronavirus (*Generalitat de Catalunya Departament de Salut*, 2020). This protocol states the following: First, it is proposed that information on limiting access to hospital centers for the elderly should be presented from the perspective

that, because of their advanced age, treatments that may be standard for other people become aggressive treatments for the elderly, often involve unnecessary suffering and can even lead to death, given the patient's fragility. It was advised that the person who transmits this information should focus on making the elderly person aware that being transferred to a hospital is not only inconvenient, but the treatment they will receive in the medical center could also cause unnecessary suffering. Second, the aim is to clarify to the elderly that not putting aggressive treatment into practice in their case does not mean they are being abandoned. Appropriate pharmacological measures will be used but without hospital transfers and, if effective, these measures will be maintained; otherwise, the treatment will be stopped and the comfort of the elderly person will be the first priority.

Third, the report provides a clear warning in a dictum that is probably at the core of its recommendations: "Do not refer to the fact that there are no beds available." Such a statement had to be made; otherwise, the protocol may be understood to be indicating that there are high-priority lives and low-priority lives. The level of treatment may depend on one's conception of the value of life, for if life does not possess intrinsic value but the same value for everyone at any time during their life, then the elderly will logically be relegated to second place, especially when it comes to allocating scarce resources during a crisis such as the COVID-19 pandemic. When life is circumscribed by utilitarian or economic criteria, those who are considered most useful, or who can contribute more to society in economic terms, will receive the best care. The communiqué sought to justify itself by adding that it is not the members of the *Consejería* of Health who decide who lives and who dies, but by speaking in terms of treatments from a cost/benefit perspective, they are again linked to the reality of utilitarian criteria. The last recommendation is presented almost as a coercion since it seeks to convince the patient that hospital admission implies having to live alone with the disease, while choosing to suffer at home carries the advantage of being in the company of relatives. It is assured that access to intensive or palliative care would be provided if necessary. It is also noted that dying at home is always better than dying in hospital.

It is worth asking whether the autonomous community of Catalonia had the competence to establish internal organizational health measures during the COVID-19 pandemic when the *Generalitat de Catalunya* issued its healthcare protocols. The answer is the affirmative, since the Statute of the Autonomy of Catalonia established in its Article 162 that "the *Generalitat*, in matters of health and public health, has exclusive jurisdiction over the organization and internal functioning, evaluation, inspection and control of health centers, services and establishments" (*Ley Orgánica 6/2006, de 19 de julio, de Reforma del Estatuto de Autonomía de Cataluña*, 2006). Furthermore, *Real Decreto 463/2020*, which established that Spain is in a state of emergency due to the spread of COVID-19, stated in Article 6 that "regional and municipal administrations are expected to retain the powers conferred to them, by existing legislation, in the ordinary management of their services and to adopt the measures they deem necessary within the framework of the direct orders of the Competent Authority for the purposes of the state of emergency." Given that jurisdiction over hospitals' internal operations belongs to what the legal text calls "ordinary management," and that no general criteria were established at the national level

for the treatment of patients with COVID-19, it follows that the *Consejería* of Health of the *Generalitat de Catalunya* had the necessary competence to draw up the recommendations that are the object of this study. One of the premises that should be taken as a starting point when seeking to efficiently and effectively delegate scarce health resources under extraordinary situations such as the COVID-19 pandemic is to treat each situation that arises on a personal and individual basis, starting from the premise that each person is different. This criterion is not met when measures are applicable at a general level and are based on criteria such as the patient's age. Although the scarcity of resources may justify adopting allocation criterion based on a patient's likelihood of recovery, it is still necessary to prevent the spread of a utilitarian mentality that often comes with prejudices against the elderly or the disabled. The term "social utility," which seems to derive from the above-mentioned set of recommendations, seems ambiguous and ethically debatable. Every human being, by the mere fact of being human, is socially useful in terms of the ontological value of their human dignity (de Montalvo et al. 2020a, 2020b, septiembre). The solution to this dilemma lies not in the exclusive application of a principle of utility but in a combination of criteria such as "maximizing benefits, treating every patient equally, promoting and rewarding instrumental value and giving priority to the most disadvantaged" (de Montalvo et al. 2020a, 2020b, septiembre).

When the Recommendations of the Department of Health of the autonomous community of Catalonia were published, the Spanish Society of Intensive and Critical Care Medicine and Coronary Units (SEMICYUC) produced a series of ethical recommendations for decision making in intensive care units (ICUs) in the context of the COVID-19 pandemic. Point 17 states that "In older people, disability-free survival should be taken into account over survival in isolation" (*Generalitat de Catalunya Departament de Salut*, 2020). This argument, which can be connected with some of the criteria we examined from the Catalan *Consejería* of Health, allows us to deduce that unequal healthcare treatment for the elderly and people with disabilities would incur in relation to the rest of the population. This argument would categorize and assign values to human lives according to arbitrary criteria. On the contrary, "in a democratic society, the ownership of rights cannot be linked to the possession or not of a certain level of knowledge, skills, or competencies but to the condition of being a person, since all people are the same, in terms of the recognition and enjoyment of their rights, by the mere fact of their being persons" (de Montalvo et al. 2020a, 2020b, septiembre).

In contrast to the arguments put forward in both reports, the criterion of age can only be used as a form of positive discrimination that prioritizes the treatment of children and minors. It cannot be a criterion that would deny or limit health care to the elderly and, even less so, to those suffering from a disability. Each patient's specific circumstances should be assessed without excluding anyone a priori. This observation is limited to the case of the autonomous community of Catalonia, Spain; however, something similar is occurring in the other two countries considered in this study: the Netherlands and Belgium.

The Dutch and Belgian Cases

The previously analyzed case of the slippery slope had its high point in the Netherlands, where, based on the concept of a "completed life," the choice of euthanasia or assisted suicide is recommended to all people who have reached a certain age. Here, people are given to understand that they have completed their life cycle, that life no longer has much more to offer them and, therefore, the best way forward is to end their own existence. On March 8, 2012, the House of Representatives of the States General, following a citizen's initiative called "The legalization of assistance in dying to older persons who consider that their lives are complete," drafted the following resolution: "After hearing the deliberation, considering that every older person should have the freedom to choose how and when he or she wants to die; the House expresses that, at the express request of the older person and under strict conditions of care and verifiability, assistance in dying is possible for older persons who consider that their lives are complete."

In October 2016, the minister of health, welfare and sport, and security and justice, drafted a letter to the Speaker of the House of Representatives of the States General, which analyzed the situation of those elderly people who consider that their lives are complete and noted that they should therefore have the right to decide when they want to die (Schippers, 2013). In order to clarify the concept, a committee was set up to investigate the matter. This body concluded that "the current legal framework provides sufficient space for most people whose suffering is related to their own life experience as being 'completed,' because their suffering often has a medical basis." Expanding the legal options for assisted suicide for people who consider that their lives are complete could jeopardize these people's safety and care, and this requires that the legislation includes verifiability and transparency. Nevertheless, the current law allows for the termination of a person's existence in the event of a complete life and if it also involves the accumulation of complaints associated with old age, then this could be considered as an objective cause for making a formal application for assisted suicide. The key concept for extending euthanasia and assisted suicide to older people who consider that their lives are complete is that of "these people's complaints being associated with old age." This is a subjective criterion that cannot be measured scientifically and which leaves the door open to assisted suicide for many people who may conclude that their lives have already been completed and that their continued existence can only bring a series of undesirable disorders that they do not want to experience.

Recently, and in line with this, the Dutch government commissioned a study on euthanasia for elderly people who are tired of living, as surveys have shown that a large number of elderly people would like to die by means of suicide with medical help (Haya, A. R., 2020). A study of elderly people, entitled "Ready to give up on life: The lived experience of elderly people who feel their life is complete and no longer worth living," concludes that the concept of a complete life, and the desire to disconnect from reality, is marked by five determining circumstances: a feeling of painful loneliness, the pain of not caring, the inability to express oneself, multidimensional fatigue and aversion to dependency (van Wijngaarden et al., 2015). With the limits to health services brought to light by COVID-19, a series of similar

measures have been implemented in the Netherlands and Belgium and have been echoed by the media.

In Belgium, for example, Nele Van Den Noortgate, head of the geriatric department in Ghent, said, "Do not bring weak and elderly patients to the hospital. We can do no more for them than provide the good palliative care they will already be receiving in a nursing home. Bringing them to the hospital to die there is inhumane" (Rachidi, 2020). The statements of Frits Rosendaal, head of clinical epidemiology at the Leiden University Medical Centre, also reflected a similar attitude. He recognized the cultural differences between Italy, Spain and the Netherlands when it comes to valuing the elderly: They are admitted to hospitals in the first two countries, while, in the Netherlands, they are not accepted because they are considered too old. Also, in the Netherlands, patients who are to be treated in hospitals during the coronavirus crisis are selected according to strict criteria, even when the facilities have plenty of beds (Rachidi, 2020). The age criterion highlights the different value that is given to life, depending on a person's level of productivity and quality of life. Like all actions, it seeks to sweeten what could be difficult for society to accept with logical and persuasive arguments: to avoid overwhelming hospitals in favor of younger more productive people, who may truly need care, and to prevent the suffering of the elderly, who would be happier receiving palliative care at home among their families and because dying at home is far better than dying alone in a hospital. These attitudes are not only prevalent in Europe. In the USA, Texas Lieutenant Governor Dan Patrick, who will turn 70 in a few days, clearly advocated prioritizing the economy over the survival of the elderly, when he said, "Those of us who are 70 and older will take care of ourselves, but let's not sacrifice the country. I want my grandchildren to live in the United States where I lived. I want them to have a chance to achieve the American dream" (Ventura, 2020). We do not know the extent to which utilitarian and economic criteria constitute mainstream thinking and take precedence over life in a state where euthanasia is illegal.

Conclusions

The global COVID-19 pandemic has had numerous consequences on human health, social activities, business, politics and other areas. When society is faced with problems that go beyond the forecasts, it creates a situation where it is possible to measure the social and ideological orientations that prevail in each country. This study has sought to investigate and reflect on whether the measures that the Department of Health of Catalonia established in relation to the health care of the elderly, or the statements of Belgian and Dutch doctors prioritizing insufficient health resources in favor of younger people, are related to the policies on euthanasia in these countries. The arguments to be evaluated are centered on the question of whether in countries where euthanasia is legal or socially acceptable, the elderly are relegated to second place and are deprived of equal access to health care. Have the concepts of quality of life, dignity and individual freedoms that sustain the pro-euthanasia position resulted in the selective distribution of healthcare resources that favors the young over the old in the face of the COVID-19 crisis?

Both Belgium and the Netherlands are countries with long traditions of standing in favor of legal euthanasia. The autonomous community of Catalonia, Spain, does not have a law that legalizes or decriminalizes euthanasia, but it has sponsored projects in favor of its legal implementation. The idea that motivates a country to legislate in favor of euthanasia is the recognition of the right of an individual, who is suffering from a serious, painful and incurable disease, who has been informed of the probable outcome of the condition and the available medical interventions, to seek medical assistance to end their life. This ethical-legal approach implies the recognition of a certain vision of the life, dignity and freedom of the person. These apply not only where it is accepted that life is not only an inalienable right but also a biological reality to which some particularities adhere, such as having reason or will, which differentiates humans from other living beings; only if it is understood that there can be conditions in which the basic value of life can be in conflict with other values that are also fundamental and basic, such as the freedom and dignity of the person and that, therefore, there are subjects who, in the face of extreme health situations, decide that their dignity and quality of life have reached such low levels that they feel that the basic value of their life has become untenable. These also apply only if dignity is understood as an ontological quality of the person, to be conceived as a dimension that varies according to the quality of life that can be enjoyed; and only if freedom is understood not as a right that is subordinated to higher values but also as a reality that is linked to personal will. Only if these and the many other conditions discussed in this work are present can the need to elevate euthanasia to the status of a person's right be legitimately and solidly based.

What are the consequences of such a concept of life for society? Freedom takes precedence over dignity and life itself so that, in the end, some lives are prioritized over others. This constitutes a slippery slope wherein the value applied to the quality of life allows the state to quantify people in terms of their usefulness and productivity. So when there is a shortage of resources, such as in the case of healthcare supplies and manpower due to the present pandemic, one wonders which individuals will be granted access to hospitals, ICUs and their limited staff and supplies. In societies where life is valued as a fundamental and inalienable human right and is not measured in terms of quality and productivity, the elderly—who can still contribute so much to society and who have struggled so hard to build the world we live in today—will share in the same medical facilities and healthcare as any other person. Hospitals, emergency departments and clinics will still prioritize care and resources for the most seriously ill patients, but the same criteria must be applied to elderly patients as to younger ones.

When the situation prevails as in Belgium and the Netherlands, or the peculiar legislation of the autonomous community of Catalonia, in Spain, the values and policies derived from a euthanasia mentality are gradually imposed at a social level. This ends up generalizing the right to die for people who do not fall under the canon for which the law was foreseen. The expected results have now come to pass: The elderly are relegated to the background and lack the same rights a young person or an adult enjoy. This criterion, which seems generalizable to those states with legalized euthanasia, can also be found in other countries which, although they have not reached the extremes of legalizing or decriminalizing this practice, are characterized

by a social acceptance of it. In these countries, selectivity is incorporated into healthcare policies that allow third parties to decide for others whether their lives are worth preserving; in this case, those of the elderly. The elderly are unable to do anything other than wait for a miracle to happen, or for death to come, with no other end than the rubric of a compassionate "rest in peace." This idea, which at first sight seems scandalous and which perhaps if it were coolly analyzed no one could condone, is the solution that is being proposed in some areas of Europe. Priority protocols, selection criteria applied to patients and preferential rights according to age are practices that have quietly been carried out, and only an exceptional and unprecedented situation such as that generated by COVID-19 has been able to bring them to light. Will this action be reduced to exceptional cases, such as those that have occurred with the coronavirus, or is it a policy that is already here to stay in some countries? Only with the passage of time and reflection on certain ethical, legal and anthropological concepts will we be able to answer this question.

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