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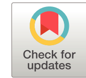
First official report on euthanasia in Spain: A comparison with the Canadian and New Zealand experiences



Primer informe oficial de la eutanasia en España: comparación con las experiencias canadiense y neozelandesa

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Introduction

In mid-February 2022, the Spanish Ministry of Health released the first annual report on the provision of aid in dying in our country. Spain is the fourth country in Europe and eighth in the world to regulate this type of health provision. The document has gathered information on euthanasia requests submitted since the respective law came into force on 25 June 2021, to 31 December 2021. So, the report only includes data from the first semester that medical aid in dying was implemented.

This article seeks to compare the first months of applying this new practice in Spain, with the experiences from the two countries that have most recently regulated euthanasia and have provided national reports, namely: Canada (2016) and New Zealand (2022). Contrasting Spain's experience with that of these two countries will allow us to present a brief overview of the implementation of euthanasia in three different continents, thus enriching the global debate on medical aid in dying.

Summary of the applications

During the first semester covered by the report, 173 requests for euthanasia were presented, of which 75 were carried out, while the remaining 98 were not carried out due to different reasons (death while request was being processed, withdrawal, postponement, rejection of the request).[1] These figures contrast with those provided by New Zealand, a country with approximately nine times less population than Spain and which registered 206 requests, of which it approved 66, in the first five months of legalising aid in dying (from 7 November 2021 to 31 March 2022).[2] Likewise, the obvious disproportion between the number of population and the number of applications is even clearer when considering that in a country like Canada, with 38.25 million inhabitants (almost 9 million less than in Spain), there were 803 applications approved in the first semester of law enforcement, between 17 June and 31 December 2016.[3]

In addition to this possibly being due to the cultural differences associated with the varied environments found in the three countries studied, we also believe that the disproportion with respect to Spain may have been affected, in part, by the irregularities in implementing the law in different jurisdictions. For example, Guarantee and Evaluation Commissions were established in the 17 autonomous communities and 2 autonomous cities that make up the Spanish State, to collectively resolve euthanasia requests, but they were inaugurated on different dates. This meant that some communities began processing requests long after the law had come into force. As a result, extremely varying data was received from Catalonia with 65 requests, the Basque country with 34, and Andalusia with 0 requests, despite Andalusia having a slightly larger population than Catalonia and being almost four times larger in population than the Basque country.[4]

Regarding the procedure itself, 100% of the euthanasia processes were carried out using intravenous injections of a coma-inducing drug (propofol) and neuromuscular blockers (atracurium, cisatracurium or rocuronium) preceded by adjuvant premedication (midazolam and lidocaine), as recommended by the Spanish Ministry of Health Good Practices Manual.[5] The predominance of this medical aid in dying method compared to oral self-administration (also known as 'medically assisted suicide') coincides with that which occurred in Canada and New Zealand, where in the first

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semester of registering applications, only 0.4 % and 9%, respectively, chose the latter procedure.

Regarding the setting where it is performed, 45.3% of euthanasia processes in Spain took place in the patient's home, 40% in a hospital and 6% in a social health center or residence (no information is available for the remaining 8%). Canada stated that 37% of euthanasia processes were carried out in a private home, while in New Zealand the percentage was 73%.

In this first semester of the implementation of the euthanasia law, the average time it took to process the entire procedure in Spain was 7.7 weeks, which was slightly longer than New Zealand which reported a range between 4 and 6 weeks during the first 5 months of receiving applications. The slight difference between one country and another may be due to the fact that the law in Spain requires the applicant to make two requests, with a minimum interval of 15 calendar days between them, to the responsible medical professional. This does not happen in New Zealand. On the other hand, it should be noted that New Zealand legislation is similar to Spain in that it establishes the obligation for a commission to carry out a control prior to performing the euthanasia. However, this review does not seem to have a relevant impact on the deadlines, since it must be carried out at least 48 h before the day agreed upon by the patient and the responsible doctor to receive the aid in dying. Furthermore, compared to Spain this New Zealand law does not promote the powers of this commission in such a mandatory manner, so its role is limited to a review on paper without the explicit possibility of interviewing the applicant.

Demographics

Regarding the profile of people who received euthanasia in Spain, the average age was found to be 66.37 years for women and 67.32 years for men. These numbers do not differ greatly from the average in Canada in the period mentioned above, which was 72.27 years (taking into account both sexes). Regarding the sex of the accepted applicants, we found an almost perfect balance: 38 women and 37 men. This proportion was also present in other countries during the first semester of the legalization of aid in dying, for example in Canada (51% women, 49% men) and slightly greater in New Zealand (55.3% women, 44.7% men).

In these two countries the main conditions that led to euthanasia were related to some type of cancer. However, in Spain, a neurological diagnosis was at the helm (53.33%), followed by the oncological diagnosis (29.33%) and, in third place, a link to multiple serious organic pathologies (5.33%). However, Albert Tuca, chair of the Catalonian Guarantee and Evaluation Commission, believes that the prevalence of neurological diseases will change in favour of oncological diseases, and will follow the trend of other European countries with more experience managing euthanasia.[6]

A further point of interest is that the requesting person was competent to make decisions throughout the process in almost all the 75 euthanasia processes carried out, and only three cases were processed using prior instructions or similar legally recognised documentation. Unlike Canada and New Zealand, in the European country it is possible that a person who does not have de facto capacity at a given time can request aid in dying if they have previously formalised an advance directive document. This is consistent with the panorama of the continent, since in European countries where euthanasia as well as assisted suicide is legal (the Netherlands, Belgium and Luxembourg) some type of advance directive is accepted to begin the aid in dying process.

Regarding the profile of the personnel who carried out the healthcare provision acting as the assisting doctor, we observed a predominance of family doctors (57.33%), followed by neurologists (22.66%), internists (12%), and a minority of oncologists (8%). In this respect, in Canada there was no information on the health personnel specialities until three years after the implementation of medical aid in dying, but in 2019 it was found that 65% of the professionals who provided the service were specialised in family medicine, 9.1% in palliative medicine, 7.1% in nursing, 5.0% in anesthesiology, 4.7% in internal medicine and, to a lesser extent, in critical and emergency medicine, oncology and psychiatry.

Challenges

Without a doubt, the period included in the report and the resulting data are insufficient to generate definitive conclusions from the countries studied. There are substantial differences between the three jurisdictions that prevent an adequate comparison. One is the fact that, since the enactment of the law in Spain, people who do not have a limited life prognosis can request aid in dying. On the contrary, in Canada, until the law was reformed in 2021, access to euthanasia was reserved for patients whose natural death was considered foreseeable.[7] For its part, New Zealand legislation has always required that the applicant suffer from a terminal illness.[8]

However, with the help of the information offered by other relevant actors, we can get a glimpse of some of the trends and identify certain challenges. One is the institutional support received by the doctors assisting the euthanasia processes. As we have seen, in Spain, as in other countries, patients usually turn to family doctors to request euthanasia, so these are key figures. Their role is crucial, taking into account that the law limits the coordination of the process to physicians, although in practice nursing staff and other professionals collaborate closely. For these reasons, when faced with testimonies of doctors who have had to manage euthanasia requests outside their working hours, some Guarantee and Evaluation Commissions, such as that of Catalonia, in their first report, ask health institutions to allow time and flexibility and give support to these professionals for the benefit of exercising a high level of citizens' rights.[9]

Another challenge that professionals and patients' families have identified and expressed in different communication channels is that of the rigidity of deadlines in the different stages of processing a euthanasia request. Although the law provides leeway to shorten the minimum 15 days that should exist between the two requests in the event that the assisting doctor confirms an imminent loss of capacity in the patient, a reduction to the period due to imminent death is not legally contemplated.[10] In this sense, it is worth mentioning that, according to the national report itself, there were 32 applicants who could not complete the procedure because they died beforehand.

Similarly, the Guarantee and Evaluation Commission of Catalonia, after verifying excessive periods between the second request and the opinion of the consulting doctor, estimates in its first annual report that there may be some difficulty in finding specialist doctors to carry out the second evaluation. Due to these types of obstacles, there have been reports of people suffering a progressive worsening of their illnesses, and some newspapers have even reported about a terminally ill person with pancreatic cancer who resorted to suicide due to the long delays in processing his request of euthanasia, and the difficulty in finding medical personnel in Andalusia who did not object to assisting.[11]

Furthermore, some associations that defend the right to euthanasia have denounced the lack of equity when accessing this new health benefit in Spain.[12] For this reason, it would be very opportune for future annual reports to collect more sociodemographic data, such as statistics on access to euthanasia in rural and urban areas as seen in Canadian reports, and the ethnicity of applicants, as is the case in New Zealand reports.

Final thoughts

Despite the irregularities in implementing this new health service in the autonomous communities, we can confirm that the first months of euthanasia in Spain have been functional in general terms. Even so, despite the titanic efforts and rigorous work carried out by all the people and organisations involved in the development and application of the law, it is inevitable that in practice problems will arise that will have to be correctly analysed and resolved. Along these lines, Enrique Arrieta, member of the Guarantee and Evaluation Commission of Castilla y León, describes this first year as "fundamentally a learning curve".[13]

Likewise, in the strictly legal field, the Constitutional Court has recently rejected the constitutional challenge made by fifty MPs of the Vox parliamentary group against the euthanasia law.[14] Therefore, it is now indisputable that the current wording of the law is in line with the Constitution and enjoys full legal legitimacy. Without a doubt, however, serious questions still arise, such as requests for euthanasia made by minors. These cases are managed in Belgium, the Netherlands and Colombia, but are not addressed by the Spanish law. In the same manner, appropriate responses to other situations that involve specific complexities are also required, such as cases of requests due to mental disorders. In fact, these have already given rise to opposing interpretations in the courts.[15] Therefore, a continuous analysis, both from the medical practice and from bioethics is absolutely essential.

Ethical considerations

This work does not resort to any type of experiment with living beings nor does it use information under data protection.

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Conflict of interests

The author of the article declares that no conflict of interest that may have influenced the research exist.

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