Spanish regulation of euthanasia and physician-assisted suicide

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ABSTRACT

In March 2021, the Spanish Congress approved the law regulating euthanasia, that regulates both euthanasia and physician-assisted suicide (PAS). In this article, we analyse the Spanish law regulating euthanasia and PAS, comparing it with the rest of the European laws on euthanasia and PAS (Netherlands, Belgium and Luxembourg). Identified strengths of the Spanish law, with respect to other norms, are that it is a law with many safeguards, which broadly recognises professionals' right to conscientious objection and the specification that it makes on the prior comprehensive care of the patient, including the approach to care dependency. Regarding its shortcomings, the law does not differentiate well between euthanasia and PAS; it barely assigns a role to the healthcare team as a whole (similar to other regulations); it does not clarify the functions of the different professionals involved; it does not detail the specific composition and duration of theevaluation commission; it has not been accompanied by a prior or simultaneous regulation of palliative care; and, lastly, the period of time to implement the law is too short.

INTRODUCTION

Until now, Spain has lacked a national law addressing end-of-life matters. As a response, in recent years, various regions have passed their own regulations on the process of dying.[1] The first region to develop a law was Andalusia, in 2010,[2] and since then most of the Autonomous Communities (the Spanish regions) have developed their own end-of-life laws. These laws have a similar structure and content, seeking, on the one hand, to protect the rights of patients and, on the other hand, to provide legal coverage to healthcare professionals. However, none of these regional regulations allows euthanasia or physician-assisted suicide (PAS).

Until this year, in Spain, euthanasia and PAS were legally defined as crimes of homicide and were punishable by imprisonment through Article 143 of the Penal Code.[3] After several legislative attempts in recent years, proposing either its regulation[4] or its decriminalisation,[5] in January 2020 a proposal for a Law for the Regulation of Euthanasia was approved by the Chamber of the Congress of Deputies of Spain.[6] After the corresponding legal procedures, this law was finally approved in March 2021 (7).

In this article, we analyse the Spanish law that regulates euthanasia and PAS, comparing it with the rest of the European laws on euthanasia and PAS (Netherlands, Belgium and Luxembourg). While writing the present article, a law on euthanasia and PAS was being processed in Portugal, but as this law has not yet been approved, it will not be analysed here. In addition, we identify the strengths and shortcomings of the Spanish law. We do not intend to discuss the arguments for and against the regulation of these practices, nor the relevance of passing a law on euthanasia and PAS in the current health crisis. Our objective is to analyse the Spanish law to detect its strengths and weaknesses, therefore, also analysing the other European laws that have previously been put into practice.

SPANISH REGULATION OF EUTHANASIA AND PAS

The law seeks to 'provide a legal, systematic, balanced and guaranteed response to the current society's demand for euthanasia'. In Spanish society, there is an increasing openness to approach and deliberate the process of dying and the needs of end-of-life care.[7] In addition, the surveys carried out among the population—both healthcare professionals and the general public—show a growing interest in the subject and an increasing majority acceptance of the regulation of euthanasia and PAS.[1 8 9]

However, in Spain, as in other countries, the debate on the regulation of euthanasia and PAS remains open. The defence of its legalisation is based on the freedom and autonomy of the patient,[10] while those who oppose it defend that death is not a right and that medicine must protect life (instead of causing death) or they take refuge in the 'slippery slope' argument.[11] For this reason, the law argues that the regulation of euthanasia is based on the compatibility of, on the one hand, essential principles and fundamental rights such as life and physical and moral integrity, and on the other hand, constitutionally protected values such as dignity, freedom or autonomy of will. The law, in addition to trying to respect all these rights and principles, tries to make them compatible.

The Spanish law specifies that it is not enough to decriminalise euthanasia. It argues that in order to respect the patients' autonomy and will, only people who are in a situation of serious and incurable disease, or people suffering from a serious, chronic and disabling disease with unbearable and continuous physical or psychological suffering that cannot be alleviated, may have the possibility of deciding to end their life. To reinforce this argument, the law points out that the European Court of Human Rights (Alda Gross vs Switzerland)[12] considered that it is unacceptable that a country that has decriminalised euthanistic conduct does not promulgate a specific legal regimen. In order to prevent the punishment of a person who helps

Table 1 Procedure for euthanasia and PAS in the bill to regulate euthanasia

Requirements	► Serious, chronic and incapacitating illness or serious and incurable disease, causing intolerable physical or psychological suffering. ► Competent and conscientious patient. Non-competent patient: possibility of advance directives. ► Absence of external pressures. ► Be 18 years old or older. ► Spanish nationality or registration of more than 12 months.
Step 1	**First request:** to the assigned doctor and signed by doctor and patient. ► Interview of the assigned doctor: assessment of compliance with the requirements. ► Maximum of 2 days: deliberation process on its diagnosis, therapeutic possibilities and expected results, information on palliative care and help for care dependency. ► Maximum 5 days: the patient receives the information in writing.
Step 2	**Second request:** to the assigned doctor. At least 15 days after the first, except for situations that do not allow delay due to the risk of loss of competence. ► 2–5 days after submission: new deliberation process. ► 24 hours after the end of the deliberation process, if the request persists, the assigned doctor informs the healthcare team (especially the nursing staff), family members (if the patient requests it) and collects the document of informed consent. ► If the applicant withdraws, the healthcare team is also informed.
Step 3	Assigned physician informs the consulting physician, who will: ► Interview the applicant. ► Review of medical history. ► Maximum of 10 days from the second request: report confirming if the requirements are met. ► Communication of the conclusions of the report to the patient.
Step 4	Assigned physician notifies the president of the EC of the favourable report of the consultant. ► Maximum of 3 days.
Step 5	President of the EC: appoints two members of the EC (a doctor and a lawyer) to verify if the legal requirements for the application are met. ► Maximum of 2 days.
Step 6	The two members of the EC carry out: ► Review of documentation and medical history, interview (if they consider it necessary) with the assigned doctor, health team and/or with the applicant. ► Maximum of 7 days: report assessing whether the requirements are met. If it is favourable, the aid to die will be given. ► Maximum of 2 days: the decision is reported to the president of the EC.
Step 7	The president of the EC informs the assigned physician.
Step 8	**Approval of the procedure**: ► Date that the applicant proposes. ► Method chosen by the applicant: euthanasia or PAS. ► Accompaniment of professionals. ► Possibility of revocation or delay of the procedure.
Step 9	**After the procedure**: ► Maximum of 5 days: the assigned doctor sends the EC: – First document: data of the applicant, the assigned doctor and the consulting doctor. If there is an advance directives document, from the applicant's representative. – Second document: clinical data of the applicant, compliance with the requirements and detailed description of the procedure. ► Maximum of 2 months: the EC supervises whether the procedure was carried out in compliance with legality.

EC, evaluation commission; PAS, physician-assisted suicide.

a patient to die, the law modifies Article 143 of the Spanish Penal Code.[13] The new formulation of Article 143 specifies that 'whoever causes or actively cooperates in the death of another person shall not incur criminal liability in compliance with the provisions of the Law regulating euthanasia.'

The main objective of this law is to recognise and regulate the right to request and receive the necessary help to die, the procedure that must be followed, and the guarantees that must be fulfilled. Table 1 details the requirements and procedure established by the law. If, after studying the case, the aid to die is denied, the applicant can appeal to the evaluation commission (EC)—a body made up of various professionals who supervise the whole procedure. Ultimately, after consulting the EC, the applicant can make a legal claim. As for the guarantees, the law intends to ensure that the service is provided to those who meet all the requirements, that confidentiality and professional secrecy are maintained, as well as the custody of the medical record and the right to conscientious objection (CO) of the professionals directly involved. For this purpose, a confidential registry of professional objectors will be created. The law specifies that the service cannot be prevented by the CO of the professionals. Therefore, so that inequalities in access to euthanasia or PAS do not occur, the administration must ensure professional replacement without undermining the quality of the service.

ARE THERE DIFFERENCES WITH OTHER EUROPEAN EUTHANASIA LAWS AND PAS?

In Europe, euthanasia and PAS are legally regulated in the Netherlands, Belgium, Luxembourg and now Spain. Table 2 compares the characteristics of the European regulations.

In Switzerland and Germany, there is no law on euthanasia and PAS, but assisted suicide is decriminalised in certain circumstances. In Switzerland, there are organisations that supervise the procedure. The requirements are set by the organisation itself; in this way, some accept applications from foreigners, while others do not. The procedure does not have to be medically assisted: the applicant pays an amount to the association and, if the patient meets the requirements, the organisation contacts the doctor to get the prescription. After death, the police verify that the requirements have been met. The Swiss justice system has specified that the patient must be competent, capable of committing suicide by themself and the request must be the result of calm and considered reflection. The European Court of Human Rights (Alda Gross case)[12] concluded that in Switzerland the decriminalisation of aid to suicide is regulated without clear assumptions or norms that restrict the exercise of this right, which generates conflicts and lack of protection for the applicant and the doctor.[14] A large part of the requests for suicide assistance in Swiss organisations were from German citizens, so some organisations opened a delegation in Germany. In 2017,

Table 2 Regulation of euthanasia and PAS in Spain and in other European countries

	Spain	Netherlands (11)	Belgium (12)	Luxembourg (13)
Regulated practice	Euthanasia and PAS	Euthanasia and PAS	Euthanasia and PAS	Euthanasia and PAS
Year	2021	2002	2002	2009
Subject	► Of legal age. ► Resident in Spain or stay in Spanish territory for more than 12 months. ► Aware and competent at the time of the request.	► Of legal age, minors 16–18 years old if the parents have participated in decision-making and minors 12–16 years old with parental authorisation. ► Resident in the Netherlands. ► Aware and competent at the time of the request.	► Of legal age, emancipated minor or minor endowed with the capacity of discernment. ► Non-emancipated minors: consult with a psychologist or psychiatrist and authorisation of the legal representatives. ► Aware and competent at the time of the request.	► Of legal age. ► Resident. ► Aware and competent at the time of the request.
Petition	► Voluntary, repeated, reflected, free and in writing. ► Two requests. ► If the patient cannot make the request in writing, it may be submitted by a person of legal age chosen by the patient. ► Possibility of revocation or request postponement. ► Possibility of advance directives.	► Voluntary, repeated, thoughtful and free. ► It is not specified whether verbal or written. Verbal requests are accepted. ► Possibility of revocation. ► Possibility of advance directives.	► Voluntary, repeated, thoughtful, free and in writing. ► Two requests. ► Minors: request of the patient and agreement of their legal representatives. ► If the patient cannot make the request in writing, it may be submitted by a person of legal age chosen by the patient. ► Possibility of revocation. ► Possibility of advance directives.	► Voluntary, repeated, thoughtful, free and in writing. ► If the patient cannot make the request in writing, it may be submitted by a person of legal age chosen by the patient. ► Possibility of revocation. ► Possibility of advance directives (valid for less than 5 years).
Clinical situation	► Serious, chronic and incapacitating illness or serious and incurable disease. ► Constant and intolerable physical/psychological suffering.	► Prognosis of non-recovery. ► Serious incurable disease. ► Constant physical/psychological suffering, without relief, desperate and unbearable.	► Prognosis of non-recovery. ► Constant and insurmountable physical or mental suffering caused by an accidental or serious and incurable pathological condition.	► Medical situation without a solution and a state of constant and unbearable physical or mental suffering without the prospect of improvement, resulting from an incurable accidental or serious pathological illness.
Minimum time from request	► 15 days between the two requests (lower period if capacity loss is imminent) and 40 days in total.	► Not specified.	► One month between the request and the completion, this time span being shorter for people with terminal condition.	► Not specified.

PAS, physician-assisted suicide.

Germany modified its Penal Code,[15] specifying that whoever collaborates with suicide cannot do it repeatedly or obtain an economic benefit, in clear reference to Swiss organisations. In February 2020, the German Constitutional Court ruled against this modification, claiming that it violates the freedom and self-determination of the individual.[16 17]

General aspects

The four European laws currently in force share ethical and legal grounds based on the respect for the freedom and autonomy of patients.[18] The concept of euthanasia and PAS is also similar in the norms of the four countries. In all of them it is a procedure with public guarantees and is free for the applicant. In Spain, the Netherlands and Luxembourg, the laws regulate both practices. In Belgium, although the law does not explicitly regulate PAS,[19] the Federal Commission for the Control and Evaluation of Euthanasia has stated that the law does not exclude assistance in the event of suicide, provided that the conditions and procedures established for euthanasia are met.[20] The Luxembourg law is the only one that also regulates palliative care. In Belgium, the same year that the euthanasia law was passed, legislation on palliative care was established. In the Netherlands, Belgium and Luxembourg, the Penal Code was also modified to exempt the doctor from criminal responsibility if euthanasia or PAS is carried out following legal requirements and procedures.

All laws contemplate the possibility that, in situations of incapacity of the patient, the service is to be carried out through Advance Directives. In Luxembourg this document must have a validity of under 5 years, and in the other countries its validity is not specified. Since the situations of incapacity of a patient can vary a lot, the Spanish law defines incapacity as follows: a situation in which the patient lacks sufficient understanding and will to act themself in an autonomous, fulfilling and effective way. These situations of incapacity include many specific assumptions that cannot be spelled out in a law.

In Spain, in addition to doctors, other professionals directly involved in the procedure are also exempt from criminal responsibility, thus covering the legal loophole existing in these other countries, such as the Netherlands and Belgium, regarding the actions of nurses.[21]

Responsible physician and consulting physician

In all four European laws, the entire process is coordinated by the assigned responsible physician, who must inform and start the deliberation process with the patient. In order for the procedure to have the best possible guarantees, it is also supervised by a consulting physician, who reviews and ratifies the entire process. As in Belgium and Luxembourg, the consulting physician must be independent from the responsible physician, and must have specific training in the area of the patient's pathology. The Spanish law also includes that the doctor in the EC that revises the case, must be also independent fro the responisble physician, the care team and the patient. In the Netherlands, if the consulting physician does not have the required specialty to evaluate the case, the assessment of a second physician with specific experience (eg, psychiatry or geriatrics) is requested. In Belgium, if death is not expected to occur in a short period of time, a second doctor, psychiatrist or specialist in the patient's pathology, is consulted. Table 3 shows the roles of professionals in the four European norms.

One aspect that differs from the other three European ones, is that in Spain the consulting physician's report is delivered to the responsible physician, who then informs the patient and the EC of the outcome: (1) If it is unfavourable (patient's petition is not accepted), the responsible physician will contact the patient and inform them of the possibility of appealing the final decision to the EC within 15 calendar days and (2) If it is favourable (patient's death petition is accepted), the responsible physician will inform the patient within a maximum period of 24 hours of the outcome and therefore the possibility of continuing with the

Table 3 Functions of professionals in euthanasia and PAS in Spain and in other European countries

	Spain	Netherlands (11)	Belgium (12)	Luxembourg (13)
Assigned physician	► Verify the requirements. ► Inform about alternatives and possibilities, including palliative care. ► Deliberation process with the patient. ► Communicate the decision to the healthcare team and relatives. ► Inform the consulting physician and the EC. ► Carry out the practice of euthanasia or PAS. ► After the procedure: send the documentation to the EC.	► Verify the requirements. ► Inform about alternatives and possibilities, including palliative care. ► Deliberation process with the patient. ► Inform the consulting physician. ► Carry out the practice of euthanasia or PAS. ► After the procedure: inform the coroner, who is given a form with the documentation of the procedure.	► Verify the requirements. ► Inform about alternatives and possibilities, including palliative care. ► Deliberation process with the patient. ► Communicate the decision to the healthcare team and relatives. ► Inform the consulting physician. ► Carry out the practice of euthanasia or PAS. ► After the procedure: send the documentation to the EC.	► Verify the requirements. ► Inform about alternatives and possibilities, including palliative care. ► Deliberation process with the patient. ► Communicate the decision to the healthcare team and relatives. ► Inform the consulting physician and the EC. ► Carry out the practice of euthanasia or PAS. ► After the procedure: send the documentation to the EC.
Consultant Physician	► Corroborate compliance with the requirements. ► Review the medical history, visit the patient, meet the healthcare team and write a report. ► Independent and, if necessary, competent in the patient's pathology.	► Corroborate compliance with the requirements. ► Review the medical history, visit the patient and prepare a report. ► Independent and, if necessary, competent in the patient's pathology.	► Corroborate compliance with the requirements. ► Review the medical history, visit the patient and write a report. ► Independent and competent in the patient's pathology.	► Corroborate compliance with the requirements. ► Review the medical history, visit the patient and write a report. ► Independent and competent in the patient's pathology.
Nurse	► Not specifically established. ► Will be informed of the result of the deliberation between the patient and the assigned doctor.	► Not specifically established.	► Must participate in the deliberation process.	► Not specifically established.
EC	► Before the procedure: review the case and the requirements. ► After the procedure: review the aid to dying provided.	► Only after the procedure: review the aid to dying provided.	► Only after the procedure: review the aid to dying provided.	► Only after the procedure: review the aid to dying provided. ► In non-competent patients: ask if there are advance directives.
Conscientious objection	► Right of the professionals directly involved in the practice. ► Register of objectors.	The assigned doctor.	► No doctor is obliged to carry out an act of euthanasia, but must communicate it to the patient or representative, stating the reasons and looking for another to do it. ► No professional is obliged to provide assistance in a euthanistic procedure.	► No doctor will be obliged to practice euthanasia or PAS. ► If the doctor refuses to practice it, he must inform the patient and/or the trusted person, specifying the reasons for his refusal and delegating to another doctor.

EC, evaluation commission; PAS, physician-assisted suicide.

procedure. The responsible physician must also communicate the outcome to the EC, within a maximum period of 3 days. The consulting physician's report will be included in the patient's medical history, and may be consulted by the EC.

Evaluation commission

All norms have an EC of the procedure. In Spanish law, unlike the others, the EC is required to carry out a verification of the requirements prior to the procedure, not just a posteriori, as in other laws. The reason for this, the legislator argues, is to develop a scrupulously guaranteeing law that ensures that the decision is exclusively the patient's, who is requesting this and will benefit from the service. For this reason, a prior verification by two members (doctor and lawyer) of the EC has been introduced in the procedure. Before applying the aid to die, these two members have to verify that the whole process is being carried correctly. In Luxembourg, the EC only acts in advance on requests for euthanasia of non-competent persons, to guarantee the existence and consultation of the patient's advance directives.

In the other three European laws, the EC has a role towards educating physicians and improving quality of practice, and also in providing societal transparency about the euthanasia practice. In the Spanish law, the training of professionals is not the responsibility of the EC, but of the Health Administration. The EC has the following functions: (1) Resolve appeals when the request for aid to die is denied; (2) Settle the disagreement between the two appointed members to verify the procedure; (3) Resolve conflicts of interest; (4) Require the centre to provide the service granted (through another doctor or external personnel) in the case of a favourable resolution after an appeal; (5) Carry out subsequent control (verify documentation); (6) Standardise criteria, exchange good practices and propose improvements in protocols and manuals together with the other EC and with the Health Ministry; (7) Be a consultative body in it's territorial scope in relation to the application of the law and (8) Prepare an annual report on the application of the law.

Regarding its administrative regime and composition, in Spain each Autonomous Community will create its own EC and its internal regulations. They must be multidisciplinary and have a minimum of seven members, including doctors, nurses and lawyers. In the Netherlands they (the EC) are also regional commissions, made up of an odd number of members, one lawyer (the president) and at least one doctor and one expert in Bioethics. In Belgium it is a 16-member Federal Commission; eight doctors, four lawyers and four specialists in the patient's illness. In Luxembourg, as it is a smaller country, the EC is national and is made up of nine members: three doctors, three lawyers, one member from another health profession and two patient representatives. Finally, one should point out that the Spanish law is the only one that does not specify the duration of the membership of the EC, in other words, how often each EC must be renewed.

Procedure

In Spain, as in the other countries' regulations, when requesting assistance to die, the patient must be given complete information and all possible alternatives must be offered, including access to comprehensive palliative care. Spanish law specifies that care-dependent patients must be guaranteed access to the benefits they are entitled to due to their condition of care dependency. After the request for help to die, the assigned doctor has to establish a deliberation process with the patient throughout different interviews. In all the regulations, this information

and dialogue procedure must be included in the patient's clinical history. Regarding the involvement of family members and friends in the deliberation process, in Spanish law the assigned doctor will inform them if the applicant wishes to do so. The Belgian and Luxembourg regulations state that the doctor must make sure that the patient has discussed their request with the people they want, in order to ensure that the patient's environment is informed.

As for the time that passes from the first request until the benefit is actually given, in Spain it is at least 40 days; which is 10 more days than in Belgium, for example, where at least 30 days are stipulated to perform the benefit. To reduce delays that may hinder the procedure, if the responsible physician considers that the applicant's loss of capacity is imminent, the time between the two requests can be reduced (15 days). Any shorter period of time will be accepted depending on the patient's clinical circumstances and the doctor must include evidence of this on the patient's medical history. However, in the following two steps it is not possible to reduce the time (consulting physician 11 days and the EC 14 days); so at least 27 days must elapse. For this reason, in situations of agony, in which a life expectancy of days or hours is estimated, if there are refractory symptoms, only palliative sedation could be applied.

STRENGTHS AND SHORTCOMINGS OF SPANISH LAW

Strengths

Law to ensure safeguards

Regarding a request for help to die, in all the regulations there are three filters to assess the legal criteria and requirements: assigned physician, consulting physician and EC. Spanish law provides more guarantees because the EC reviews each case before and after the procedure, while in the other countries it only does so afterwards. In this way, it is ensured that the patient meets all the requirements. Once the request is made, the responsible physician must initiate a deliberation process with the patient, the consultant physician must carefully review the case, and the EC assessment must be diligent, ensuring that all cases are evaluated in an agile and fast way. These additional safeguards in the process do not try to complicate or hinder a decision on euthanasia, but ensure that the person is being well cared for and that their decision is deliberate, free and voluntary. However, this excess of guarantee has also been criticised for being excessively complex and for exceedingly prolonging the time until the procedure is performed (at least 40 days), bearing in mind that, according to the experiences of other countries, many of the applicants are in an end-of-life situation.

Wide recognition of CO

A positive aspect of Spanish law is that there is a broader recognition of the right to CO for professionals. The CO is not the sole responsibility of the assigned doctor (as in the Netherlands and Luxembourg), but of any professional directly involved in the procedure, such as nurses. In Belgian law, which is closer to Spanish regarding CO, doctors can object and, in addition, it is specified that no professional will be obliged to perform the service.

Optimal comprehensive patient care

The goal of medicine is not to restore health (healing) and prevent death, but to care for health in a broader sense,[22] which includes care for suffering in very sick patients. In most, if not all, cases the reasons for which a person requests help to die are related to suffering.[23 24] An intervention that ends a patient's life can only be considered acceptable if it is within the framework of a commitment to put the available resources and knowledge at the service of the patient to alleviate their suffering. To discern whether the patient acts voluntarily, without external pressure and with extensive knowledge of the benefit requested, it is important to assess whether the request for euthanasia or PAS is derived from inadequate social and healthcare, which would imply previously solving the patient's social, economic and care problems to then ensure that the patient receives adequate comprehensive care. A requirement in the Spanish norm, as in the others, is to have received information about the medical process, about the different alternatives and possibilities of action, including access to comprehensive palliative care. The Spanish regulation also adds that the patient must have received the benefits to which they are entitled in accordance with the care dependency regulations. All these requirements should not entail a delay in the provision, since before the second request the patient must already have all this information at hand and, if there are any doubts or one needs more information, this would be given. However, the latter often does not happen.[25] Many care-dependent and terminal patients in Spain do not receive the social and health benefits they should receive.[26] This law should serve to improve the social and health support of care-dependent, terminally ill or incurable patients. It is an essential requirement for the implementation of measures to help people die.

Shortcomings

Terminological confusion

One aspect to be improved is that the Spanish law does not clearly distinguish between the two practices (euthanasia and PAS), as is done in Holland and Luxembourg. In fact, the same title leads to confusion (Euthanasia Regulation Law), when in reality both procedures are being regulated, both euthanasia and PAS. Both practices are included as modalities within the provision of help to die, without specifying the characteristics and peculiarities of each one, which can generate ambiguity in both professionals and patients. These are practices with different characteristics and connotations, and these should be detailed to avoid confusion and conflicts when applied.

Minor role of the healthcare team

The four existing regulations, including the Spanish one, place the entire process in the hands of the assigned doctor. However, when a request for help to die occurs, those who really treat and care for the patient are a healthcare team[25] and not solely the doctor in charge. The implementation of this law requires, at the same time, guaranteeing quality palliative care, mental health support to patients and their family and friends, and ensuring social health support that includes the necessary resources to cover disability and care dependence; notwithstanding the care of the emotional and spiritual aspects that the patient needs. Faced with a request for help to die, the need for a doctor responsible for coordinating the team and serving as a reference for the patient is indisputable. However, the continued presence of a multi-disciplinary team (with professionals from psychology, nursing and social work), as in palliative care, is beneficial and recommended, both for the patient and for the doctor in charge.[27] The team, in addition, must participate in the deliberation process with the patient. When a patient makes the decision to end their life, they must do so having previously received optimal care and this can only be guaranteed with comprehensive social health support. For all these reasons, it is

advisable that the legislation (also in other countries) gives more responsibility and functions to the social healthcare team.

It does not clarify functions of professionals

Another criticism of the Spanish regulation, which can be extended to other European norms, is that it does not specifically establish which professionals participate during each procedure or the functions of each one, specifically doctors and nurses. Only Belgian law expressly states that, when faced with a request for euthanasia, the nurse must participate in the deliberation process together with the assigned doctor. However, different studies[28 29] show great variability in the participation of the nurse during the entire process, including functions not included in the law and that could lead to legal consequences, such as the direct administration of the lethal drug. One study indicates nurses' participation during the deliberative process is 100% in cases in care homes, 58.6% in hospitals and 44.4% in the patients' own homes. Regarding the participation of nurses in the administration of the lethal drug, it is 0% in care homes, 43.3% in hospitals, and 13.5% in patients' homes. The legislation of the Netherlands and Luxembourg does not give a specific role to nursing. However, several studies carried out in the Netherlands[30 31] show different roles of the nurse throughout the entire process: in 45.1% of cases they were the first to receive the patient's request, between 50% and 78.8% of the cases they participated in decision making, but also participated in the euthanasia act (accompaniment of the patient and family, preparation of the drug and even its administration). Despite the risk that this entails for the nurse, they reported that they do so due to the doctors' lack of experience with the infusion systems, due to the hierarchical relationship, habit, emotional commitment to the patient or due to ignorance of the possible legal consequences. Nurses also participated in caring for the family after death. Spanish law only includes the participation of the nurse when the patient ratifies the second request, since the responsible doctor must notify the healthcare team, especially the nursing staff. However, in the rest of the law, especially in relation to the administration of the drug, it is ambiguously contemplated that the provision of aid to die must be done by health professionals, without specifying who these 'health professionals' are. It is important to define the role of each professional during the different stages of the process, both in the informative and deliberation phase and in the administration of the lethal drug.

Composition and duration of the EC

As for the EC, each region is left to establish its constitution. A minimum of seven members is required and their appointment is the responsibility of the autonomous communities, so the number of EC members (and applications) will vary depending on the region. Based on the experience of the Netherlands, Belgium or Canada, where in the first year of the law only 1% of deaths were by euthanasia or PAS (2%–4% in successive years), an estimate can be made of the number of applications in Spain and its regions. This would help to estimate the human resources needed to deal with the requests and to know how many members each EC would need. Taking the Community of Madrid as an example, with a population of more than 6 million inhabitants, mortality in 2018 (before the COVID-19 pandemic) was 46 599 people. One per cent would correspond to 467 possible deaths due to euthanasia. In Madrid, an EC of 25 members is foreseen, which may be modified in successive years depending on the requests received. It would be advisable to specify more on how the composition and duration of the EC should be decided, to ensure that it is made up of independent professionals qualified in the evaluation of the procedure of this law. In addition to lawyers, doctors and nurses, the profile of the other members (such as mental health specialists or experts in Bioethics), as well as the competence, experience and training of the members, should be specified.

Lack of regulation of palliative care

One last criticism, although it cannot be made directly of the law, but to the Spanish regulatory framework, is that in Spain palliative care and end-of-life care are not regulated. As has been mentioned, most of the Autonomous Communities have regulations on healthcare at the end of life, but there are regions that do not have specific regulations and there is no national standard. The regulation of euthanasia and PAS should be preceded or accompanied by a regulation of palliative care, because an essential requirement for accepting requests for help to die is that patients have received comprehensive and quality palliative care. In Spain, there should be a national law on palliative care, therefore priority should be given to its development.

Short period of time to put the law into practice

The measures and the time contemplated to guarantee the proper entry into force of the law are insufficient. The period of time established to put into practice the request for euthanasia or PAS is only 3 months from the approval of the law in March 2021, which does not leave enough time to carry out a thorough process of dissemination of the law among citizens and an adequate training for the health professionals. Before implementing a euthanasia law, a series of conditions and requirements should be met, such as: (1) Carrying out public campaigns to explain the law: requirements, procedure, etc; (2) Creation of all the Ecs beforehand, since currently, after passing the law, they have still not been established in all the Autonomous Regions; (3) Offering training for the health professionals involved in the process, which is stipulated by the law for a period of 1 year after its implementation. The lack of training can generate uncertainty and discomfort in professionals; (4) Creation of a service or team of experts who can advise the professionals involved, as has been done with the project 'Support and Consultation on Euthanasia in the Netherlands', where general practitioners receive training in formal consultation and in giving expert advice to colleagues who have questions about euthanasia and PAS[32] and (5) Preparation of a manual of good practices and the necessary protocols to adequately carry out the service, which will be carried out by the National Health System 3 months after the implementation of the law. Faced with a request for euthanasia, professionals currently do not have the minimum resources necessary to carry it out with guarantees. To ensure the correct application of the law, time should be allowed for training of professionals, creation of committees or dissemination of the law. A period of at least 1 year would have been more adequate and reasonable.

CONCLUSIONS

In the article, we have not analysed the moral character of euthanasia and PAS. These procedures are always accompanied by an ethical discussion, because life has an inestimable value and enables the existence of other values such as freedom or happiness. But in euthanasia there are more values and principles at stake, such as the welfare or autonomy of patients. Any norm that regulates euthanasia and PAS must try to respect the principles and values involved, and must include the possibility that professionals who morally disapprove of euthanasia and PAS can conscientiously object. This is the case in Spanish law,

which allows professionals directly involved in the procedures, not only doctors, to object.

To avoid legal loopholes and the lack of protection for those involved in the process, the law not only decriminalises euthanasia and PAS, but also legalises them, introducing a new individual right into the Spanish legal system: the right to request and receive the necessary help to die. Given that there are sectors in Spain that are reluctant to legalise euthanasia, some authors had proposed that it was preferable to start with decriminalising certain cases and later, if necessary, carry out legalisation. However, the option of legalising these procedures instead of decriminalising them in certain cases means giving greater protection and guarantees to both patients and professionals.

Regarding the strengths and shortcomings of the Spanish law with respect to other European laws, we have found as positive aspects that the Spanish law provides many safeguards, the wide recognition that is made to the CO and the specification that it makes of the prior care that the patient must receive, which must be comprehensive and include the approach to care dependency. Regarding the shortcomings of the law: euthanasia and PAS are not clearly differentiated; hardly any role is given to the healthcare team (nor is it given in other countries' regulations); the functions of the different professionals involved are not clarified (neither are they in other European laws); it does not detail the specific composition and duration of the EC (a fundamental body in these procedures); the norm has not been accompanied by a prior or simultaneous regulation of palliative care; and, finally, the period of time to implement the law is too short.

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