ULUSLARARASI SAĞLIK YÖNETİMİ VE STRATEJİLERİ ARAŞTIRMA DERGİSİ
INTERNATIONAL JOURNAL OF HEALTH MANAGEMENT AND STRATEGIES RESEARCH
Cilt/Volume : 6 Sayı/Issue : 3 Yıl/Year : 2020 ISSN -2149-6161
*Usaysad Dergi, 2020; 6(3):503-514 (Derleme makale)*

# AN OVERVIEW OF PHYSICIAN-ASSISTED SUICIDE TOURISM

**Lecturer Elif Nisa YAYLA**

Kayseri University, Vocational School of Social Sciences, Healthcare Management, elifnisayayla@kayseri.edu.tr, orcid.org/0000-0002-4343-0954

**Lecturer Fatih ALTAN**

Erciyes University, Halil Bayraktar Health Services Vocational School, Medical Documentation and Secretarial, fatihaltan@gmail.com, orcid.org/0000-0003-3913-309X

Makale Gönderim-Kabul Tarihi (22.10.2020-01.12.2020)

**Abstract**
Travel of individuals to visit physicians for a planned death is referred to as Physician Assisted Suicide (PAS) Tourism. This study was prepared in order to analyze secondary data due to the lack of conceptual discussion on the phenomenon of PAS Tourism, which has recently been included in the tourism and health literature. The aim of this study is to examine the studies in the literature, the concept of death that the individual wants to end his life with the support of a physician, the scope of Physician Assisted Suicide Tourism, which is seen as a niche market today, the concepts that are compared with this scope and causing confusion, and finally the legal to examine the functioning of institutions providing Physician Assisted Suicide services within the framework. As a result, although HDI is prohibited in many countries and therefore it is not considered as tourism, it is seen that there is such a niche market today and as the demand for this service increases, the number of countries that have changed the law on HDI is increasing. It is thought that HDI will commodify health services and bring ethical problems such as discrimination among patients.

**Keywords:** Physician Assisted Suicide, Euthanasia, Death Tourism, Dark Tourism, Suicide Tourism

**Özet**
Bireylerin planlanmış bir ölüm için hekimleri ziyaret etmek amacıyla yaptıkları seyahat Hekim Destekli İntihar (HDİ) Turizmi olarak ifade edilmektedir. Bu çalışma son dönemlerde turizm ve sağlık literatüründe yer alan konulardan HDİ Turizmi olgusunun kavramsal tartışmanın eksikliğine bağlı olarak ikincil verilerin incelemesi amacıyla hazırlanmıştır. Bu çalışmanın amacı alanyazındaki çalışmaların irdelemesi, bireyin hekim desteği ile hayatını planlı olarak sona erdirmek istediği ölüm kavramı, günümüzde niş pazar olarak görülen HDİ Turizmi'nin kapsamı, bu kapsam ile karşılaştırılan ve anlam karışıklığına yol açan kavramlar, son olarak ülkelerin izin verdiği yasal çerçeve içerisinde HDİ hizmeti veren kuruluşların işleyişi incelemektir. Sonuç olarak HDİ'nin birçok ülkede yasak olduğu ve bu nedenle turizm olarak değerlendirilmemesine karşın günümüzde böyle bir niş pazarın olduğu ve insanların bu hizmete talep arttıkça HDİ konusunda yasa değişikliğine giden ülke sayısınında giderek arttığı görülmektedir. HDİ'nin sağlık hizmetlerini metalaştıracağı ve hastalar arasında ayrıma gitme gibi etik sorunları da beraberinde getireceği düşünülmektedir.

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**Anahtar Sözcükler:** Hekim Destekli İntihar, Ötenazi, Ölüm Turizmi, Dark Turizm, İntihar Turizmi

## INTRODUCTION

It is seen that the meaning of the phenomenon of "death", which is an inevitable consequence for all living things, varies relatively from one culture to another, from time to time. The concept, which is “mevt” in Arabic, “death” in English, “mort” in French, “tod” in German and “death” in Turkish; it means ending, exhausting, extincion, disappearing. As you can see, although many words mean death, an inevitable end and the destruction of existence, (Hökelekli, 1991: 152-153), not every human being has evaluated death in the same way. While the thought of death sees the source of stress as annihilation and anxiety for some, it sees it as a way of getting rid of stress, starting an immortal life and a source of joy for others. The phenomenon of death can take on a relative structure according to the belief, thought, idea, moral and spiritual structure of people (Yakıt, 1993: 85). Therefore, the meaning attributed to death varies depending on the perspectives of the people. For example, while Montaigne thinks that death is the heaviest and most distressing, indescribable pain, that the world of things is dying with her as she dies (Montaigne, 2006b: 7), Mevlana sees death as a longing-awaited "friend" (Çelik, 2009: 123). Confucius sees death as a form of birth, that is, the death of one thing as the birth of another (Chen, 2012).

Unlike traditional periods in which individuals whose death is approaching give emotional reactions such as denial, anger, bargaining, depression and acceptance, death, which is often marginalized and interpreted as a source of fear in modern societies, (Kübler-Ross, 1992) although it is seen as a known but unapproved experience, it is handled in an adapted and medicalized form today. Today, instead of dying in the home of uncertain and uncontrolled possibilities in the societies dominated by science received “good death” with reduced pain, which provides the opportunity to fight with the support of professionals and machines offered by advanced medicine in hospitals. In the modern era, where there is no place for waiting and permanence, death is also, in order to be remembered as a memory that must be erased as soon as possible patients want to spend their last time in hospitals with their loved ones, not waiting for a tragic death on their deathbed. At the same time, the departure of the deceased, whose suffering is not witnessed, will not be perceived as a complete departure from memories (Demir, 2017: 194).

The desire for death to return to life as well as to death, to the inanimate matter that is the essence of life, is more common in contemporary culture. This subconscious desire and longing for death is interpreted as the expression of returning to a comfortable and peaceful life in the womb. One's disposition to calmness, silence, comfort, balance, and sleep is due to the longing for death. Death, which is described as untimely occurring at an unexpected moment, contradicts with “good death”.Practices extending human life and euthanasia studies are the result of the desire to try to reduce this premature death. The necessity of looking happy always pushed people away from mourning. Therefore, people have professionalized in the way of death and funeral procedures in order not to encounter the appearance of death. This development has led to the creation of new markets (Ünal, 2011: 129). Over time, the evolution of attitudes and perceptions towards death has made the experience of death itself a separate business in the modern world.

For a planned death of people; The distance to visit medical professionals creates a special market called Physician Assisted Suicide Tourism (Mondal ve Bhowmik, 2018). In the tourism definition made by Leiper (1979), which is widely accepted in the literature; Suicide tourism and its derivatives initially because the tourist needs to travel to other destinations temporarily in their region and then return home, and tourism includes reasons such as pleasure, business, congress, education, sports, religion, medical treatment, cooking, volunteering and special interests It is not considered within the scope of tourism. The lack of conceptual discussion about death in tourism

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branches raises the research problem of this study. In this context, information on Dark Tourism, Suicide Tourism and Assisted Suicide, PAS Tourism will be shared, and this niche market of tourism and the assisted suicide practices within the legal framework of governments for the right to die will be discussed. In addition, the services provided by some organizations providing PAS tourism services will be discussed.

**Dark Tourism**

The fact that people want to experience different experiences with various motives gives tourism a versatile commodity feature, which makes it necessary to consider and evaluate different tourism types (Hartmann, 1988). Today, areas related to disasters or wildness are now evaluated not only in memories but also as tourist attraction centers. MacCannel (1976), as "negative sightseeing" (negative sightseeing); Rojek (1993) "black spots tourism" (black spots tourism), Seaton (1996) "thanatourism"; Foley and Lennon (1996) "dark tourism"; Lippard (1999) "tragic tourism"; Blom (2000) "morbid tourism" and that concepts that O'Neill (2002) defined as "grief tourism" it means that the consumption of the grief that occurred in the recent or distant past about death, disaster and poverty for tourism purposes. In dark tourism, the temporal distance must be close. That is, events must be remembrance distance of living people, and suspicious and alarming for modernity and its consequences(Lennon ve Foley: 2000: 11-12). Thus, the shooting locations and fields can evoke "dark" emotions such as revenge, sympathy, empathy, depression, sadness, fear and hate on visitors (Miles, 2002).

According to Seaton, grief tourism refers to "travel to symbolic or real death sites" (Seaton, 1999: 131). Considering their tourism attractions, it is seen that different types of grief tourism have emerged. These are "Instant Death Tourism", "Post-Death Tourism", "Religious-Symbolic Death Tourism". It is possible to divide the "Post-Death Tourism" into sub-groups. Similarly, Sharpley (2005) suggests that different "shades" of dark tourism can be determined based on different intensity of objectives in terms of both supply and demand. Depending on both the degree of interest in the tourist's interest or death, and to what extent an attraction has been developed to take advantage of that interest or admiration, different places / experiences can be 'paler' or 'darker'. Thus, the darkest or blackest tourism occurs through the deliberate provision of experiences that are attracted to death. The visitor class, interested in suffering or watching massacres, forms the demand side of dark tourism and can learn about the causes, pain, conditions and motivies of death (Stone ve Sharpley, 2008).

Sharma and Rickly (2019) view dark tourism from an existential perspective, which allows the dark tourism experiences to reevaluate the lives of tourists and track existential individuality. Conversely, Korstanje (2016) argues that the interest in death-related visiting sites is a result of modern neoliberal economic systems based on varying degrees of capitalism. However, with the development of the dark (dark) tourism phenomenon and providing an important tourism experience for tourists, new concerns and moral dilemmas are increasing (Kang vd, 2012).

**Suicide Tourism and Assisted Suicide Tourism**

According to the tourism definition made by Leiper (1979), the tourist is considered to be the system in which the tourist travels from her own region to other destinations for a temporary stay for one or more nights and then returns home. The United Nations World Tourism Organization (2019) stated that tourism can take various forms for different reasons such as pleasure, business, congress, education, sports, religion, medical treatment, cooking, volunteering and special interests. The relationship between death and tourism is full of contrasts, contradictions and irony. According to Becker (2011), although contemporary Western society wants to delay or even deny an individual's death with modern medicine, it is a miracle and a source of fixation that others want

death (Becker, 2011). Given the sensitive structure of suicide tourism, few definitions have been made. Cantrell vd (2010), suicide tourism; It defines it as the practice of traveling to a foreign place to commit suicide. While this death tourism has its roots based on watching the gladiatorial games of the people in Rome (Stone ve Sharpley, 2008), today famous suicide spots in places like the Golden Bridge in San Francisco, Gap in Sydney or New York city center are examples of this (Stack ve Bowman, 2010). Where one has control over death, death is either aesthetic or romantic. Similar to resorts that are often chosen to maximize the aesthetic taste of tourists, the places chosen for suicides are often emblematic structures (Kirillova ve Lehto, 2015).

Death tourism is differs at different points from dark tourism, which includes visiting an area where persecution or massacres have occurred in the past. In dark tourism, the individual travels to feel the feelings of death, while in suicide tourism, they are traveling to commit death. Procedures may be illegal for ending life in his own the country of who the applicant for death tourism. It may also be looking for a final solution that does not leave his desire unfinished, or seek the romantic idealism of "death with dignity" on the deathbed that does not involve pain and suffering (Shondell Miller & Gonzalez, 2013).

Death or suicide tourism does not just involve jumping or falling off a cliff, bridge or monument. Assisted Suicide Tourism involves the travel of a suicidal person to complete suicide with the help of others and focuses on the element of moving from a prohibitory to a permissive jurisdiction (Huxtable, 2009). Therefore, it would be more correct to use the term “tourism-assisted suicide” instead of “assisted suicide” to describe this tourism phenomenon (Yu vd, 2020).

**Physician Assisted Suicide Tourism**

For a planned death of people; The distance to visit medical professionals constitute a special market called Physician Assisted Suicide Tourism (Mondal ve Bhowmik, 2018). Death tourists are motivated by a desire to end their lives and ultimately travel to reach a better state without suffering; In this context, suicide tourism can be seen as a romantic idealism of dying with dignity. These tourists want to put an end to their current pain with the solution that the tourism industry can offer (Pratt vd,2019). According to Kaul and Skinner (2018), the collective perceptions and rituals surrounding death in a destination, especially when it comes to international tourism, can be very different from the tourists' own culture. In this case, visiting medical professionals for a planned death can be seen as an educational opportunity to learn about other cultures, as well as preventing a source of confusion and overhead in the event of the sudden death of a loved one (Kaul ve Skinner, 2018).

Hay (2015) draws attention to the dark phenomenon of hospitality and explores the way people choose to die in a hotel rather than in more traditional places such as homes, hospitals or nursing homes. Hay argues that given the aging population and shrinking family size in the developed world, dark hospitality will be a subject more in the foreground than ever before. When it comes to dark tourism attractions and assisted suicides, death becomes a marketable product. Korstanje's (2016) of the thesis on the rise of thana capitalism show that must be expanded beyond dark tourism to include the various ways death becomes a commodity.

Dignitas, a Swiss-backed suicide organization, can be cited as an example to move from the prohibitor to the jurisdiction that allows it. It is the first official institution to operate in this field and can be evaluated in the context of death and tourism, especially since they accept Swiss and foreign citizens as customers (Higginbotham, 2011). Analyzing 611 “suicide trips” from 31 countries applying to the Dignitas institution, Gauthier et al. (2015) found that the women (58.4%) and their ages (23-97 years) of these “tourists” differ significantly from Europe (Germany, 43.9%; England, 20.6%, France, 10.8%). Although Physician Assisted Suicide (PAS) and euthanasia seem

to be the same concepts, they are different concepts. Active euthanasia involves the injections of lethal drugs that terminate the individual's life cycle, while passive euthanasia involves the withdrawal or withdrawal of benefits that will prolong the life of the patient suffering from incurable disease. The main distinction between the two approaches is to kill someone and let someone die over time (Jecker ve Jonson 2007). In PAS, which includes deadly drugs administered by the patient's own will and the help of the doctor, it is not expected that the patient has terminal period and incurable disease, while these concepts are required in active euthanasia. Higginbotham (2011) denied that assisted suicide, which involves traveling elsewhere in the name of suicide with medical intervention support, can be qualified as a niche segment of medical tourism and a subcomponent of international tourism. The medical tourism framework consists of four main parts: disease (ie medical controls), reproduction (ie fertility treatment), development (ie cosmetic surgery) and wellness (ie acupuncture). In accordance with this conceptualization, PAS clearly differs from medical tourism. In this context, Pratt vd (2019) created a conceptual framework that addresses the multiple links between tourism and death in order to eliminate the conceptual confusion. This conceptual work, which maps the diversity of the link between tourism and death, is built on existential philosophy and anthropology, and consists of a theoretical framework that encompasses all elements of four dimensions: Perspective, Intention, Number and Participation The Intention dimension in the Conceptual Map of the Relationship Death and Tourism reflects the intention or motive that death that witnessed or experienced on a trip. Continuity of intention, which is closely related to the perspective dimension, is treated as Intentional at one end and Unintentional at the other. While the former refers to dealing with death as the main purpose of travel (eg dark place visit, assisted suicide), the second indicates deaths that are mostly accidental. The perspective dimension (Self / Others) shows the perspective at which death occurs: it may include the tourist herself or others (the tourists themselves or the residents). A third dimension used to classify the intersections between death and tourism concerns the number of people who die at the target. As with the murders, unintentional deaths of tourists could occur, and this could be the case for multiple tourist deaths. The number that intersects with the above dimensions, focusing on the relationship between the deceased tourist and other people related to his death is the size of participation. This dimension is closely related to the Mortality Perspective, but instead of focusing on who is dead, it highlights the closeness of the relationship between tourists and the facilitator of death (Pratt Vd, 2019). When you look at this model, it is seen that Physician-Assisted Suicide is part of death tourism and is separated from other types of tourism that are included in death tourism.

Yu vd (2019); Physician-assisted suicide supporters examined the inner and external motivations of self-determination. Accordingly, the primary intrinsic motivation for suicide travel is to relieve or avoid pain in during the death process. Indeed, in Turkey, where euthanasia is not legal is obviously that terminal period patients and working health personnel, about one in 5 people are seen to have encountered a request for euthanasia (Çınar vd, 2012). Other in-kind motivations for PAS travel are human rights and the pursue meaning in life. In terms of external motivations, it was determined that religious/social thoughts are particularly relevant. Furthermore, Yu vd (2019) observed that individuals perceived the suicide trip as an informative journey through which they could learn more about PAS by visiting a country several times before they decided to end their life seriously (Yu vd, 2019).

Before deciding to end their lives, individuals there are discussions about whether PAS is included in the scope of tourism, while planning to make trips to get information by visiting the country where PAS is legal. PAS is not considered tourism based on the definition that individuals return as a result of traveling to certain places for the purpose of ending their lives through physicians, or

that tourism is often associated with pleasure travel. Some researchers think that the ultimate benefits of this travel may not be in the form of an improved life or scenario of enjoying a certain length of stay, but the person while traveling to destination will be relieved of prolonged pain and suffering and gain freedom (Pearlman vd, 2005). Yu vd (2020) created the Tourism Application Model Related to PAS to determine whether the event will be considered as a form of "tourism" or "travel", in order to better conceptualize PAS. According to this approach, suicide tourism can be divided into different groups, including people who return to their home country after PAS and people who are interested in PAS and take an informative journey to understand the legal implications. The first group returns to their home country, albeit in a different form (for example, as a funeral), so it fits the traditional definition of tourism. Individuals who travel for informational purposes may travel for reasons such as learning about PAS regulations, completing necessary documents, or consulting professional doctors to understand the assisted suicide process at authorized medical facilities. These candidates do not plan to end their lives at that time and therefore plan to return home, but subsequent relevant trips may eventually result in PAS. Anyone interested in understanding PAS could be a potential suicide candidate; such a traveler would likely engage in suicide tourism to become more knowledgeable / educated about the practice. After consultations with professional doctors, the person can make a final decision to do PAS. If the body of the individual is later returned to their home country, the person has been involved in suicide tourism. Conversely, if the body is not returned, the person has participated in the suicide trip as previously described (Yu, 2020). In addition, a particular patient who wants to end his life usually travels with family and close friends. There are some things for individuals that need to be fulfilled before or after death, and there are concerns about this. The desire of the relatives of the patient who accepts PAS to be informed and to be with their loved ones in the last minutes of their lives will bring tourism activity (Mondal ve Bhowmik, 2018).

**Research Method**

The study was prepared to examine secondary data due to the lack of conceptual debate on the phenomenon of Physician Assisted Suicide Tourism, which is one of the topics in the tourism and health literature recently. In this context; first, dark tourism, then suicide and assisted suicide tourism and finally physician assisted suicide tourism are discussed theoretically and the differences in these types of tourism, which are accepted as similar in literature, are revealed. In addition, information on some institutions providing PAS services was provided. In the selection of the organizations that provide this service, the criteria of providing Physician Assisted Suicide Tourism service for more than twenty years in Europe, America and Australia are based on. In line with these criteria, four organizations were determined and information regarding the organizations; Information on counseling, membership and physician assisted suicide tourism was shared.

**Functioning of Institutions Providing Physician Assisted Suicide Services**

Globally, governments are trying to balance the right to life and death, thus making changes in laws to ensure freedom. Among the countries that have legalized PAS; Switzerland, Oregon, Colombia, Netherlands, Belgium, Washington, Luxembourg, Montana, Vermont, Quebec, California, Canada, Colorado, Hawaii is located. The United Kingdom and the United States have liberal policies aimed at supporting suicide in the respective countries. Numerous organizations around the world offer options for dying with dignity within the legal framework of their country. The individual who commits suicide needs to be taken care of in to understand. Patients with certain incurable mental or physical impairments must seek counseling before exercising their right to death. The patient has to fulfill the conditions determined by the institutions. It should be recommended by at least two doctors to allow the patient to attempt assisted suicide (Mondal ve Bhowmik, 2018). In

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this context, in this part of the study, the legal admissibility conditions in countries where assisted suicide is legal and the practices of PAS institutions within the scope of honorable death will be discussed.

Table 1 discussed the current legal status of physician-assisted suicide and euthanize in certain countries. Euthanasia is legal in all countries except Switzerland, while physician-assisted suicide is legal in all countries. There is also a difference between age restrictions in physician-assisted suicide among countries. While there are no age restrictions in Switzerland and Belgium, there are age restrictions in Colombia (6), the Netherlands (12), Luxembourg and Canada (18). While no diagnosis of physician-assisted suicide is sought in Switzerland, Luxembourg and Canada, patients in Colombia are in the terminal period; In Belgium, while no diagnosis is sought for adults, there is a requirement for children to be in the terminal period.

Physician-assisted suicide or euthanasia is considered a legal and preferred service in many regions of Europe and the United States. Whether physician-assisted suicide is considered a tourist destination is still a matter of debate, while people travel to learn about or benefit from this service.

| Countries | Euthanasia | Physician Assisted Suicide | Age Restriction | Required Diagnosis | Symptom State |
|---|---|---|---|---|---|
| ***Switzerland*** | Illegal | Legal* | none specified | none | None |
| ***Colombia*** | Legal | Legal | 6 | terminal phase | terminal phase of a disease |
| ***Netherlands*** | Legal | Legal | 12 | none | unbearable suffering with no prospect of improvement |
| ***Belgium*** | Legal | Legal** | none | none adults, terminal children | medically futile condition with unbearable mental or physical suffering |
| ***Canada*** | Legal | Legal | 18 | none | Grievous and irremediable medical condition with enduring and unbearable suffering |
| ***Luxembourg*** | Legal | Legal | 18 | none | Incurable condition with constant unbearable suffering and no prospect of improvment |

* Assisted suicide is only considered a crime if the motivation is selfish. Assistance does not have to come from a physician
** Physician assisted suicide is treated as a form of euthanasia

**Table 1:** Comparison of Specific Countries on Euthanasia and Physician-Assisted Suicide

**Source:** https://www.theguardian.com/news/2019/jul/15/euthanasia-and-assisted-dying-rates-are-soaring-but-where-are-they-lega

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| Business / Country | Consultancy | Membership | Physician Assisted Suicide |
|---|---|---|---|
| ***Dignitas*** *It has been operating since 1998.* ***(Switzerland)*** | It advises everyone who wants to be a member of the organization or not, within the current possibilities, about all end-of-life issues and the difficulties of living conditions. | After people become a member of this organization, they can benefit from the services offered by the organization. All adults, whether they are Swiss citizens or not, can become members of Dignitas. | Dignitas provides training on suicide attempts, as well as engaging in disclosure of the facts to people and protection of these facts. In addition, members are offered euthanasia services only within Switzerland. It carries out the activity of accompanying the death of people in accordance with medical evidence due to unbearable pain, disability or illness that will result in death. |
| ***Exit International*** *It has been operating since 1997.* *(Avustralya)* | It organizes workshops at regular intervals. It provides consultancy and training services to individuals through these workshops. Exit members can benefit from the workshops free of charge. | Membership is granted to individuals over the age of 50 or those suffering from serious illnesses. Membership of individuals under the age of 50 is at the discretion of Exit. Membership is free. Extending membership is $ 100 for singles and $ 150 for married couples. | All of the services of Final Exit Network are legal in the country where it operates. Exit does not provide individuals with illegal drugs or equipment support. It provides information only. It provides accurate and up-to-date information about ending the life of individuals. |
| ***Final Exit Network*** *It has been operating since 1980.* *(Florida)* | It offers counseling to people suffering from intolerable medical conditions and mental competence. Membership is not required for consultancy service. | No membership required. | It approaches its customers impartially. It neither induces death nor discourages its customers. Final Exit Network provides services to individuals who want to die in a year or less. Patients with primary diagnosis of mental illness are not served, but early-stage dementia patients can benefit from the services. |
| ***Death with Dignity*** *It has been operating since 1993.* *(Oregon)* | It provides consultancy and training to patients, patients' relatives, end-of-life care staff, media and the relevant public about dignified death as end-of-life support. | No membership required. | It promotes death with services that are both models for end-of-life care and offering alternatives for individuals. Those who meet the eligibility criteria can benefit from physician-assisted suicide service. Living in California, Colorado, Colombia, Hawaii, Maine, New Jersey, Oregon and Washington, being an adult, not having a mental disability and diagnosed with a fatal disease that will lead to death within six months, can end their lives either with the assistance of a physician or according to instructions. |

**Table 2.** Services Provided by Institutions Providing Physician Assisted Suicide Services

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Table 2 contains some information obtained from the websites of organizations that carry out Physician Assisted Suicide Tourism activities. While Dignitas Suicide Organization (Switzerland) provides the service with the condition of membership in all of its services, other organizations do not require membership for consultancy and education services. In addition, dignitas, final exit network and death with dignity suicide organizations in order to receive services that will result in death, unbearable pain, disability or disease situation reasons, while Exit International organization offers this service to individuals over the age of 50 and leave the admission of individuals below this limit to their own initiative. The common characteristics of the organizations provided in Table 2 are that they do not encourage people to commit physician-assisted suicide or discourag them from benefiting from these services. In other words, it informs people from an objective point of view and serves those who want to benefit from this service.

Organizations in countries such as Switzerland, Belgium, Australia and the United States, which provide physician-assisted suicide services, provide both counseling and training services to those who wish to benefit from this service or who wish to learn about it. Some organizations are required to join the organization for consultancy and/or educational services, while some are not sought. Among organizations, the criteria vary for those who want to benefit from this service. For example, the Swiss-based organisation has announced a 50-year age limit for the Australian-based organisation when reporting that membership is free for all adults and that it can benefit from the service. In addition, some countries only serve patients in their own countries, while others do not want to be citizens. The common requirement of all organizations to provide physician-assisted suicide services is that the individual must experience severe pain or have a terminal illness and the individual's mental health should be in place. All of these organizations claim that they act in accordance with ethical principles and that it is also a right to die with dignity, just as people have the right to live with dignity.

When we look at the situation in Turkey it is seen that euthanasia No. 23420 dated 01.08.1998 Patients' Rights Directive is prohibited under Article 13 of euthanasia. Furthermore there is no legal basis for any physician-assisted suicide in Turkey. A comparison between Turkey and the countries mentioned in the study of euthanasia in Colombia, the Netherlands, Belgium, Canada, even though it is legal in Luxembourg appears to be legal in Switzerland. However, physician assisted suicide practice is legal in all of the countries mentioned. In Turkey, it is a fact that both euthanasia is not legal practice of physician assisted suicide.

## CONCLUSION

Physician Assisted Suicide Tourism, which includes the concepts of tourism and death together, is defined as the travel of people from one location to another in order to make a planned death with the help of medical experts. Dark Tourism, Euthanasia Tourism and Suicide Tourism, which is often confused with Physician Assisted Suicide Tourism; According to Pratt's (2019) Conceptual Map of the Relationship Death and Tourism, they are certainly separated from each other. Nowadays, with modernity changing the understanding of death and the development of a controlling understanding, among the purposes of people in realizing this tourism are the desire to not want their painful deaths to remain in the minds of their loved ones and to be effective in the time and form of death. Death without pain and suffering in which one has control over death seen as aesthetic or romantic. Thus, this "honorable / good death" will make people remember (Shondell Miller & Gonzalez, 2013; Kirillova & Lehto, 2015).

Becker (2011) suggests that the association of tourism, which includes an element of pleasure, with death is full of contradictions. In a period when technology develops and diseases are eliminated, the

use of medicine to end life is seen as fixation. In the tourism definition made by Leiper (1979); Against the idea that the tourist should travel to other destinations temporarily in his / her own region and return home afterwards, and death cannot be included in the scope of tourism due to the pleasure and leisure time, Yu vd (2020) suggests that PAS can be considered within the scope of tourism with the PAS Related Tourism Application Model assert. According to a survey conducted by the campaign group MDMD (My Death, My Decision) in the UK, 88% of the participants found it acceptable for dementia patients to seek help to end their lives, provided they gave their consent before losing their mental abilities(www.theguardian.com [1]). The results of the survey conducted by Dignity in Dying (2015) revealed that 82% of the participants supported the idea of assisted death(https://www.dignityindying.org).

There are several reasons why physician-assisted suicides are prohibited in terms of religion, morality and ethics (Huxtable, 2009). One of the main reasons for these is that assisted suicide practices commodify other medical services. Even though it is accepted that individuals' right to life can be found as well as their right to death, the fact that such transactions are carried out for high sums or that extra fees are charged under the heading of membership, information procedures, and the inability of individuals who cannot afford the fee to benefit from the service are commodity of health services. At the same time, the notion that aided suicides are not only done to patients in the terminal period of the disease offers a preference such as death to individuals with physical and mental disorders.

Before the PAS is made, individuals are examined by physicians and application requests are examined. However, due to the inability of mechanisms to control this process, the moral and ethical suitability of the elections is de questioned. The use of the names of individuals who will make more noise in documentaries published in the press by the institutions implementing the PAS process will make PAS popular.

PAS is considered forbidden in many countries and is not considered within the scope of tourism, but it should not be neglected that there is such a market today and the number of countries that have changed their laws for assisted suicide in accordance with this demand is increasing day by day. There are three countries outside their own countries that provide aided suicide services. These are; Switzerland, Belgium, The Netherlands. Although euthanasia is prohibited according to the Patient Rights Regulation in our country, it is observed that approximately one in five of the terminally term patients and working health personnel face euthanasia (Çınar vd, 2012). Also every year, more than 800,000 people die by suicide (WHO, 2014). In this context, it should be taken into account that PAS's illegality may increase passive euthanasia and suicide. In addition, terminal patients request PAS, which will reduce medical treatment costs. In line with the potential to prefer private in our country, the legalization of PAS will create a demand for this practice. It is thought that this will cause commodification of healthcare services and cause discrimination among patients.

As a result, physician-assisted suicide is supported in the countries studied and people can benefit from this service to the extent that they meet the criteria. Considering that PAS can commodify health services and may cause other ethical problems, governments should be legally and ethically restricted in their hands. Although physician assisted suicide is the subject of discussion, the aforementioned organizations have been providing this service for many years.

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**INTERNET RESOURCES**

Dignitas, http://www.dignitas.ch/?lang=en (Erişim Tarihi: 03.04.2020)
Exit International, https://exitinternational.net/ (Erişim Tarihi: 03.04.2020)
Final Exit Network, https://finalexitnetwork.org/Home.html (Erişim Tarihi: 03.04.2020)
Compassion and Choices, https://compassionandchoices.org/ (Erişim Tarihi: 03.04.2020) Death with Dignity, https://www.deathwitPASgnity.org/ (Erişim Tarihi: 03.04.2020)
The Guardian [1], https://www.theguardian.com/society/2019/mar/03/legalise-assisted-dying-for-terminally-ill-say-90-per-cent-of-people-in-uk
The Guardian [2], https://www.theguardian.com/news/2019/jul/15/euthanasia-and-assisted-dying-rates-are-soaring-but-where-are-they-legal (Erişim Tarihi: 03.04.2020)
Dignity in Drying, https://www.dignityindying.org.uk/news/poll-assisted-dying/